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ABSTRACT

ADVENTIST MEDICAL MISSION IN BOTSWANA: TOWARD  
AN EFFECTIVE AND APPROPRIATE MODEL

by

Olaotse Obed Gabasiane

Adviser: Bruce Bauer

ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University

Seventh-day Adventist Theological Seminary

Title: ADVENTIST MEDICAL MISSION IN BOTSWANA: TOWARD AN EFFECTIVE AND APPROPRIATE MODEL

Name of the researcher: Olaotse Obed Gabasiane

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Date completed: July 2014

Since holistic health is central to Africans, they will seek it from all possible health-care systems that include (1) African traditional medicine, (2) Western-oriented medicine, (3) Christian medical mission, as well as (4) African Independent Churches (AICs) with emphasis on spiritual healing. However, at times this comes with negative consequences.

This research sought to understand why medical pluralism exists in Botswana and the rest of southern Africa, and why it finds concurrent use by Africans; solutions can help Christian medical missions develop more effective and holistic ways to serve Africans. The research can also help Christian medical missions understand how they can especially engage with the African traditional and spiritual healing systems.

This qualitative research conducted a missiological historical study of the origin and development of Adventist medical mission in Botswana. By analyzing and comparing the Adventist methods with those of other Christian medical missions and traditional medical systems, the research developed guidelines for a suggested alternative model for Adventist medical mission in Botswana and beyond. In addition, it provides a documented history of Adventist medical missions in Botswana.

This study examined written and oral sources for research and data collection in order to discover the history of Christian medical missions, the biblical medical mission models, and the present health-care models that exist in Botswana. Thus the data collection process was a combination of documents and texts, as well as interviews with various Botswana government Ministry of Health (MOH) officials, Christian medical mission directors, senior nurses, current and retired chaplains and missionaries, village elders, traditional doctors, and prophet-healers.

This research showed that Africans have a holistic worldview. Any imbalance in the physical, social, mental, emotional, relational, environmental, or spiritual spheres of their lives constitutes illness. The biblical medical mission model revealed that God viewed humanity holistically and desired to restore them in all the aspects of life in the truism of *shalom*. By engaging in medical pluralism, Africans are attempting to optimize their opportunities to restore the imbalance they experience.

However, Western-oriented medicine, including Christian medical missions, was found lacking in this holistic view ideologically and/or practically. Therefore in the conclusion, I develop a suggested alternative biblical model for Adventist medical mission that offers a more holistic approach to health care. In order to serve Africans

more effectively, I recommend that Adventist medical missions consider opening dialogue with African traditional health-care systems. In addition, this research contributed to the body of knowledge on the socio-history of Adventist medical mission in Botswana.

Andrews University  
Seventh-day Adventist Theological Seminary

ADVENTIST MEDICAL MISSION IN BOTSWANA: TOWARD  
AN EFFECTIVE AND APPROPRIATE MODEL

A Dissertation  
Presented in Partial Fulfillment  
of the Requirements for the Degree  
Doctor of Philosophy

by  
Olaotse Obed Gabasiane

July 2014

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Date approved

## DEDICATION

To the Ancient of Days, the Greatest Healer, Sustainer,  
Protector, Counselor, and the Prince of Shalom

To Betty Chandapiwa Gabasiane: Most precious to my life.  
Wonderful companion in the Mission of God

To Itumeleng and Segofalang: Precious flowers we could ever possess

To my late parents, Olefetswe Gaulefufa and Solomon Bagwasi Gabasiane,  
who brought me up and equipped me for a higher purpose

To God Be the Glory!

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## LIST OF ABBREVIATIONS

ACHAP	African Comprehensive HIV/AIDS Partnerships
AIC	African Independent Church
ATR	African Traditional Religion
ATM	African Traditional Medicine
BAMS	Botswana Adventist Medical Services
BHC	Botswana Housing Corporation
BOPA	Botswana Press Agency
BUM	Botswana Union Mission of the Seventh-day Adventist Church
DRC	Dutch Reformed Church
BHS	Botswana Health Services
BLH	Bamalete Lutheran Hospital
DRMH	Deborah Retief Memorial Hospital
IDCC	Infectious Diseases Care Clinic
KCN	Kanye College of Nursing
KSDAH	Kanye Seventh-day Adventist Hospital
LMS	London Missionary Society
MOE	Ministry of Education
MOH	Ministry of Health
MP	Member of Parliament
SDA	Seventh-day Adventist Church



TM	Traditional Midwives
UB	University of Botswana
UNAIDS	Joint United Nations Programme on HIV and AIDS
WHO	World Health Organization

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## CHAPTER 1

### INTRODUCTION

#### **Background of the Study**

Christian medical missions in Botswana began with the mission activities of the London Missionary Society (LMS), which initiated its work in neighboring South Africa in 1798,<sup>1</sup> and was extended into the territory of Bechuanaland (Botswana) in 1842.<sup>2</sup> The most northern LMS outpost was established in 1817 at Kuruman among the Batswana of the Batlhaping tribe by one of its renowned missionaries, Robert Moffat.<sup>3</sup>

Moffat utilized a typical mission station approach, in which a local evangelistic center was established with several institutions such as schools and clinics built around it. It was hoped that the local people would be attracted to this center by the agriculture and other basic industrial skills that were offered.

However, in 1820, Moffat lamented that “the interests of the mission continued to fluctuate, but without any decisive evidence of the influences of the Holy Spirit being

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<sup>1</sup>William David Schermerhorn, *The Christian Mission in the Modern World* (New York: Abingdon Press, 1933), 242.

<sup>2</sup>Andrew Ross, “David Livingstone: The Man Behind the Mask,” in *The London Missionary Society in Southern Africa, 1799-1999—Historical Essay in Celebration of the Bicentenary of the Lms in Southern Africa*, ed. John de Gruchy (Athens, OH: Ohio University Press, 2000), 46.

<sup>3</sup>*Ibid.*, 243. Robert Moffat (1795-1883) was a British missionary of the LMS who arrived in Cape Town, South Africa, in 1817.

poured out.”<sup>4</sup> Among the difficulties that affected the progress of the station was the language barrier, which led missionaries to initially depend on inadequate interpreters, and the dryness of the land due to lack of rain. This necessitated the digging of long watercourses for the purpose of irrigation.<sup>5</sup>

It is imperative to ask some probing questions about Moffat’s mission station approach—the Kuruman model—in which he practiced “the gospel of ‘Bible & plough,’ which meant . . . learning to read the Bible for the eager ones, and more methodical gardening for the hard workers.”<sup>6</sup>

Though he occasionally made expeditions into Bechuanaland north of the Molopo River, visiting the Bakwena, Bakgatla, and the Bangwato tribes, Moffat never succeeded in setting up a mission station among these tribes. He found the tribes resistant to the gospel. Was Moffat’s method of the “Bible & plough deficient”? Was Moffat really addressing the needs of the people among whom he labored? The Bible provided the spiritual needs and the plough, physical needs. How about the social, emotional, and other needs?

For example, was it really the right time to establish a permanent mission when the tribes of southern Africa were going through an uncertain migration characterized by intertribal wars? Was the Kuruman mission station approach a model for future missions? These questions do not nullify or minimize the achievements at Kuruman. For

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<sup>4</sup>Robert Moffat, *The Missionary Labors and Scenes in Southern Africa* (New York: Robert Carter and Brothers, 1887), 160.

<sup>5</sup>*Ibid.*, 165-166.

<sup>6</sup>Cecil Northcott, *Robert Moffat: Pioneer in Africa 1817-1870* (New York: Harper & Brothers, 1961), 184-185.

instance, it was at Kuruman that Moffat translated the Bible into Setswana.

David Livingstone, also of the LMS, joined Robert Moffat in 1841.<sup>7</sup> In contrast, Livingstone was a medical missionary—which became the hallmark of his success in penetrating new territory. Thus through medicine, it was possible to introduce the gospel with more ease among the local tribes of the Batswana.

Livingstone made only a brief stay at Kuruman. By 1847, Livingstone and his wife Mary had established a mission station at Kolobeng among the Bakwena of Sechele, though their stay there was also brief.<sup>8</sup> An additional contrast to the Kuruman model of mission was that Livingstone advocated the engagement of local African evangelists in mission work—something that was minimally practiced at Kuruman.<sup>9</sup> This was of great importance to Livingstone because of his frequent expeditions to the interior as he attempted to open new ground for the gospel. The trained local evangelists remained behind to propagate the gospel while he took others to help him in establishing new work.

Livingstone won the hearts of the Bakwena of Sechele in Botswana amid tribal rejection of Christianity by identifying with the people and providing help for them in times of dangerous external threats.<sup>10</sup> For example, he was against the Afrikaner White settler farmers who, because of their quest for more land, were bent on attacking the

---

<sup>7</sup>Schermerhorn, *The Christian Mission in the Modern World*, 243. David Livingstone (1813-1873) was the famous Scottish explorer-missionary doctor of the LMS who arrived in Cape Town in 1840.

<sup>8</sup>James Macaulay, *Livingstone Anecdotes: A Sketch of the Career and Illustrations of the Character of David Livingstone, Missionary, Traveller, Philanthropist* (London: The Religious Tract Society, 1889), 40.

<sup>9</sup>Geoffrey Moorhouse, *The Missionaries* (New York: J. B. Lippincott, 1973), 16.

<sup>10</sup>J. E. Chambliss, *The Life and Labors of David Livingstone, Ll. D., D. C. L., Covering His Entire Career in Southern and Central Africa* (Philadelphia: Hubbard Brothers, 1875).

Bakwena.<sup>11</sup> Thus, advocacy became a hallmark of Livingstone's mission strategy.

More poignantly, it was Livingstone's medical practice that won the hearts of the people. Livingstone wrote, "Here I have an immense practice. I have patients now under treatment who have walked 130 miles for my advice; and when these go home, others will come for the same purpose. This is the country for a medical man if he wants a large practice; but he must leave fees out of the question."<sup>12</sup> Hence, his medicine and acts of compassion drew more Africans to his mission.

The Livingstone medical mission model had more to offer compared to the Kuruman model of the "Bible and the plough." In addition, the Livingstone medical mission model offered help for the spiritual, social, physical (medical), and welfare needs of the Africans. This made Livingstone's missionary endeavors more promising, especially since he believed in training local people to remain to propagate the gospel when he moved to new territory. Because of this arrangement, it shows that Livingstone made cultural considerations.

While medicine drew the people to Livingstone, charging fees for that service was almost impractical since the people could not afford it. This challenge persisted for decades, and later forced the government of Botswana to negotiate with all medical mission hospitals to operate on a government subsidy so that the communities could be charged only minimum fees for medical service.<sup>13</sup>

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<sup>11</sup>Ibid., 67.

<sup>12</sup>Macaulay, *Livingstone Anecdotes: A Sketch of the Career and Illustrations of the Character of David Livingstone, Missionary, Traveller, Philanthropist*, 35.

<sup>13</sup>Rodgers Keteng K. Molefi, *A Medical History of Botswana: 1885-1996* (Gaborone, Botswana: The Botswana Society, 1996), 28.



Furthermore, Livingstone faced a major issue that challenged his credibility as a Christian medical doctor. That same problem still persists in this opening decade of the twenty-first century: the African parallel practice of traditional medicine administered by the traditional doctor. Edward Dodd observes that in the African tradition “medical relief centered around the witch doctor.”<sup>14</sup>

From the beginning of Christian medical mission there has been an unhealthy competition between the medical doctor and the traditional doctor.<sup>15</sup> The obvious victim has been the patient who ends up with a two-tiered system of medicine, usually taking Western medicine openly while surreptitiously consulting the traditional doctor—for fear of being labeled a heretic—sometimes with devastating results. Livingstone was wise in his dealings with the traditional doctors, choosing never to make “any remark when he saw their ignorance or errors, but when away from the patients he gave these native doctors his advice, and found them always grateful for the instruction.”<sup>16</sup> Is it possible for medical missions today to work with traditional doctors for the common good? Or is this a lost cause?

According to Rodgers Molefi, “[Institutional] Western medicine was introduced into Bechuanaland in the second and third decades of the twentieth century by Christian missionaries led by the Seventh-day Adventists (SDA), who arrived in Kanye in 1922 to

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<sup>14</sup>Edward M. Dodd, *The Gift of the Healer: The Story of Men and Medicine in the Overseas Mission of the Church* (New York: Friendship Press, 1964), 30.

<sup>15</sup>As seen earlier, Livingstone sought a harmonization between the two. Andrew Ross observed that Western-trained doctors still berated traditional healers, some 150 years on. Ross, “David Livingstone: The Man Behind the Mask,” 50-51.

<sup>16</sup>Macaulay, *Livingstone Anecdotes: A Sketch of the Career and Illustrations of the Character of David Livingstone, Missionary, Traveller, Philanthropist*, 36.

set up its [*sic*] church and a small hospital.”<sup>17</sup> Prior to 1922 proposals were at their infancy to have a mission station in Bechuanaland to be established by Pastor William H. Anderson, with the plans becoming firmer by way of locating a site in 1919.<sup>18</sup>

Dr. A. H. Kretchmar<sup>19</sup> started medical work (1922) in Bechuanaland,<sup>20</sup> and it was in the early 1950s that Dr. Jack Hay “started two dispensaries in the [Kalahari] desert for the [San], where they [came] in hundreds to hear the Word of God as the medicines [were] given to their bodies.”<sup>21</sup>

The Bangwaketse tribe of Bechuanaland, had its doors closed and barred to our work until the arrival of Dr. A. H. Kretchmar, who with his medical skill, was able to bring healing to the sick bodies of hundreds of members of that tribe. When the prejudice was thus broken down, practically every village in the tribe was thrown open to our missionaries.<sup>22</sup>

Clearly, medical work enabled the beginning of the gospel mission in Botswana.

Molefi reveals that the Dutch Reformed Church (DRC) opened its medical mission hospital institution in Mochudi in 1927, the LMS in Molepolole in 1934, while in 1933 the Lutherans and the Catholics began with clinics at Ramotswa and Kgale, respectively.<sup>23</sup> By 1938, the Adventist Church had its second hospital in Maun fully

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<sup>17</sup>Molefi, *A Medical History of Botswana: 1885-1996*, 17.

<sup>18</sup>W. B. White, “Selecting New Sites,” *The South African Missionary*, August 15, 1919, 3.

<sup>19</sup>J. H. Parkin, “Dawn in the Dark Continent,” *The Missionary Worker*, September 10, 1926, 6.

<sup>20</sup>Priscilla E. Willmore, “General Notes News,” *The African Division Outlook*, March 15, 1922, 6.

<sup>21</sup>Ralph S. Watts, “An Evening with the Southern African Division,” *The Advent Review and Sabbath Herald*, June 17, 1954, 315.

<sup>22</sup>William H. Branson, “Medical Work in Africa: Bechuanaland,” *Australasian Record*, October 30, 1928, 2-3.

<sup>23</sup>Molefi, *A Medical History of Botswana: 1885-1996*, 18, 20.

established and operational.<sup>24</sup> However, the Maun hospital was handed over to the Botswana Government because the Adventist Church did not have the financial resources to maintain the hospital.

In this second decade of the 2000s, there are several challenges that inherently affect medical missions in Botswana and the rest of southern African states. For a typical sub-Saharan African situation, “thousands of people die each day from malaria, tuberculosis, HIV/AIDS, and other preventable and treatable conditions. The dearth of delivery workers is partly responsible for this tragedy, and approaches based on the status quo won’t meet the region’s health needs quickly or effectively.”<sup>25</sup> This in itself raises the issues of community health education such as preventive health, nutrition, sanitation, and hygiene. What role can medical missions play to help alleviate the concerns raised?

Issues that affect medical missions in Botswana include the ever-increasing operational and capital needs of hospitals, plurality in the use of various medical systems available, that is, spiritual healing and traditional healing, and the overwhelming prevalence of HIV-AIDS that has drained the hospitals’ finances and human resources.

### **Statement of the Problem**

In a study on healing methods available to Africans, Othusitse Morekwa observes that there is an interchange and exchange among the following healing approaches:

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<sup>24</sup>Ibid., 23.

<sup>25</sup>Michael D. Conway, Srishti Gupta, and Kamiar Khajavi, “Addressing Africa's Health's Workforce Crisis,” *McKinsey Quarterly* November (2007): 1-2, <http://www.mckinsey.it/storage/first/uploadfile/attach/139896/file/adaf07.pdf> (accessed October 30, 2000).

African Traditional Healing, Modern Medicine, and Christian Healing.<sup>26</sup> This qualitative study will attempt to explore the reasons why these parallel medical systems exist and find concurrent use by the communities they serve. Further, this study aims to help Christian medical missions decide to what extent and how they can engage with these parallel medical systems, especially the African Traditional methods and Spiritual Healing.

The Adventist Church has used medical work in missions all over the world because it has believed it to be complementary to the gospel message. As a core part of the church's mission philosophy, "the gospel ministry is an organization for the proclamation of the truth and the carrying forward of the work for the sick and well. This is the body, the medical missionary work is the arm, and Christ is the head over all."<sup>27</sup> Hence Adventist medical work is often referred to as the "right hand of the gospel"<sup>28</sup> and consequently, the right arm of the gospel ministry.

However, the issue that needs to be addressed is whether the current Adventist medical mission health-care delivery system is relevant to today's needs. Since times have changed, perhaps Adventist medical missions should not continue operating from the same model they used before. A new model of Adventist medical mission in Botswana will help give the institution new impetus for the role it plays in the country.

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<sup>26</sup>Othusitse Morekwa, "The Interchange, Exchange and Appropriation of Traditional Healing, Modern Medicine and Christian Healing in Africa" (Master's thesis, University of South Africa, 2004), 1.

<sup>27</sup>Ellen G. White, *Medical Ministry: A Treatise on Medical Missionary Work in the Gospel* (Boise, ID: Pacific Press, 1963), 237. White (1827-1915) was one of the pioneers and founders of the Adventist Church in the United States who had a significant influence on the Church through her visions and advice, specifically in the area of health. See T. Housel Jemison, *A Prophet among You* (Boise, ID: Pacific Press, 1955), 203.

<sup>28</sup>Ellen G. White, *Evangelism* (Washington, DC: Review and Herald, 1946), 515-516.

Finally, there is currently no systematized, documented history specifically dedicated to Adventist medical missions in Botswana, except for a tapestry of isolated articles, testimonies, and brief references. This qualitative research will help bring the history of Adventist medical mission as a body of knowledge into existence.

### **Statement of the Purpose**

The purpose of this qualitative research study is to conduct a missiological historical study of the origin and development of the Adventist medical mission in Botswana by analyzing and comparing the Adventist methods with those of other medical missions and medical systems such as traditional medicine and spiritual healing in order to develop guidelines for a future alternative model for Adventist medical mission in Botswana and southern Africa.

In the face of parallel medical systems, this research will explore ways these systems could interact with one another. When the Adventist medical mission model has been developed, Adventist medical mission should be seen to provide first choice service by clients.

The data collection process will combine documents and texts, as well as interviews with various participants such as the village elders, traditional doctors, and medical doctors; these will provide historical information as well as data on the prevailing medical practices. Apart from providing information towards developing a model for Adventist medical mission, this research will also provide a documented history of Adventist medical missions in Botswana.

### **Research Questions**

The research questions that directed this study were:

1. What is the history of Adventist medical mission in Botswana?
2. Why do parallel medical systems exist?
3. How can Adventist medical mission engage indigenous medicine?
4. What alternative model can the Adventist medical mission in Botswana use?

### **Justification of the Study**

Missionary work by Adventists in Botswana effectively began in 1921. However, no research has been done to document the history of Adventist mission in the territory. There are numerous articles or short sections of books alluding to Adventist medical mission in Botswana. There is, however, no comprehensive scholarly research on Adventist medical missions and, as a consequence, no detailed record of missionary methods that were employed by the Adventist Church during those formative years. Therefore, there is no comprehensive research on Adventist Church mission work in Botswana. For this reason it is not known in detail what missionary strategies the church employed during those developmental years.

The results of this study will be potentially beneficial to the Adventist Church both in Botswana and beyond. Apart from making historical data relating to Adventist medical missions available, Botswana Adventists will have the opportunity to learn about the challenges that were faced by the pioneers of their faith, and come to appreciate the mission methods that were used as a basis for the growth of their church.

In addition, a study of past and present medical missions in Botswana will potentially help the church in the second decade of the twenty-first century to make informed decisions on the types of approaches needed for further development of the gospel work. David E. van Reken points out that

modern medical institutions are costly and require skilled personnel. As missions make this kind of investment, it is important that they have a very clear idea of how the medical work fits into the overall ministry of the mission and the local church. Unless the role of the hospital in the overall context of the mission and the church is understood by all concerned, there is ample room for frustration and failure.<sup>29</sup>

Thus, this calls for the development of an Adventist medical mission model that will be relevant to the overall Church mission in the early decades of the twenty-first century. Nevertheless, it is the biblical and theological foundation for mission that ultimately must drive the endeavors of Adventist medical mission.

### **Scope and Delimitations**

This study focuses on the medical mission approaches in Botswana. It does not deal extensively with the methods outside of southern Africa, even though some references might be used for illustrative purposes. The study does not examine the professional practice of medicine or appraise its efficiency in its technical form. The study is not a theological treatise of medical mission either. However, it does lay the foundation upon which such a much-needed theological study may be developed and constructed.

The research, rather, probes into the mission purpose, function, and achievement of Adventist medical mission in Botswana from 1921 to 2014, with consideration of the implications for a method in which “medical mission work is [truly] preventive, curative, redemptive, and constructive.”<sup>30</sup>

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<sup>29</sup>David E van Reken, *Mission and Ministry: Christian Medical Practice in Today's Changing World Cultures, A Billy Graham Center Monograph* (Wheaton, IL: Billy Graham Center, 1987), 38.

<sup>30</sup>Walter R. Lambuth, *Medical Missions: The Twofold Task* (New York: Student Volunteer Movement for Missions, 1920), 54. The term ‘holistic’ in this dissertation will be used throughout instead of ‘wholistic.’

## **Limitations**

A number of caveats need to be noted regarding the present study. First, the available time for the summer research was limited—less than three months. Although I arrived on time in Botswana, I found that the Office of the President had not yet processed the Permit to Research. Two issues caused this: (1) the research permit could not be initiated until the arrival of the researcher into the country and (2) the bureaucratic process. Arriving earlier would most likely have given different outcomes.

Extenuating circumstances also exacerbated matters. The passing of my mother, Olefetswe Gaulefufa Gabasiane, and a month later, my father-in-law, Mr. Freddy Gobo Ndlovu, shortened the time I had allocated for the research. Cultural funerals in Botswana take a lot of time and can demand a lot of involvement. On the other hand, the Government Research Permit took a long time to be released, partly because of red tape, thereby costing me additional time.

Limited time affected my field research in two major ways: (1) it reduced the number of interviews that I could take, and (2) I could not visit the Adventist Church archives in Zimbabwe and South Africa. In fact, on my way to South Africa, I had to disembark the bus in Zeerust (South Africa) when I received the news about the loss of my father-in-law.

Second, I had planned to study at least three institutional Christian medical missions: the Bamalete Lutheran Hospital (BLH), the Deborah Retief Memorial (DRMH) operated by the Dutch Reformed Church (DRC), and the Kanye Seventh-day Adventist Hospital (KSDAH). However, when I arrived in Botswana, I found that the government had already taken over the DRMH and this made contact with the former church



administrators difficult. So I was only able to study the only two extant Christian medical missions—the BLH and KSDAH.

Third, securing interviews with both traditional doctors and prophet-healers did not come easy. Most of these practitioners were reluctant to give an interview, citing fear for making statements that might incriminate them. Others were adamant that they needed to protect their work, alleging that educated Africans doing research colluded with Europeans to steal indigenous knowledge. They did not want to be part of a process that impoverished them further, while it enriched the already wealthy. In the end, I was able to interview thirteen traditional healers.

Therefore, the number of interviews I conducted was limited. However, the research would have been enriched had the interview protocol included interviewing Adventist and non-Adventist patients who practiced medical pluralism. This would have provided phenomenological insights concerning those clients, thus revealing first-hand information as to why they practiced medical pluralism. Similar arguments could be made about Birth Attendants, who were not interviewed either.

Finally, though not least, an important focus group that this research left out was the San people. Though they would have required a longitudinal study, research would have yielded interesting results on their worldview, particularly their healing systems as they seldom visit clinics and health posts because of their nomadic lives.

### **Ethical Considerations**

The research was guided by ethical stipulations of the Andrews University Institutional Review Board (IRB). Since the research included interviews, there needed to be safeguards to reduce the risk to the human subjects. Therefore, the participants

signed a consent form after I had explained to them about ethical considerations including, free participation, freedom to opt out of the interview at any time, and the guarantee of confidentiality. Thus, pseudonyms were used for those participants who requested anonymity, such as the traditional doctors and prophet-healers.

### **Self as the Research Instrument**

In every qualitative research, the researcher needs to have some degree of self-consciousness in order to have an understanding of the self that might influence research outcomes. This important phenomenon, known as reflexivity, “is a qualitative research strategy that addresses our subjectivity as researchers related to people and events that we encounter in the field.”<sup>31</sup> Therefore, I will describe some of my life experiences in relation to the topic of this study.

I was born and raised in Zimbabwe, where my parents—Olefetswe and Solomon Bagwasi Gabasiane (both deceased)—had migrated from Botswana to work there. Upon retirement, my parents settled in a remote rural area that was distant from hospitals. When sickness struck, my parents always prayed for healing, but they also used some natural remedies, including herbs.

However, most of the people in the neighborhood lived in fear because they believed in witchcraft and evil spirits. For protection, they consulted traditional doctors who required them to slaughter black oxen as sacrifices to appease the spirits.

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<sup>31</sup>A. Loree Primeau, “Reflections on Self in Qualitative Research: Stories of Family,” *American Journal of Occupational Therapy* 57 1 (2003): 9.

My parents refused to engage the traditional doctors save for the herbalist, and trusted in God's protection through prayer. However, several family friends urged them to reinforce their protection by consulting traditional doctors, but they refused.

One day, some family "friends" brought raw portions of meat as a gift to my parents. Since my father was running a butchery business, he wondered why the gift came in the form of something that he already had in abundance. So he directed his daughters to cook the meat as though it was going to be consumed by the family, but sternly cautioned them never to sample or taste it. The obedient girls did as instructed.

That evening, Father gathered us and told us he was feeding the stew to his beloved dogs. Jealous for the dogs, I could not understand why the waste. The next morning my father woke us up to witness an unforgettable sight: three dog carcasses lay in different areas of our yards. Father's words were, "Some people are not happy with the success of our business, so out of jealousy, they would rather have us dead." He cautioned us not to ingest food from anyone other than family members. Father further told us that the only way we could be protected from the threats of life was to pray and trust in God.

My mother was a devoted Christian. However, she was a renowned birth attendant who was called to serve in places near and far, yet she had never received any formal training like nurses do. When the family moved to Botswana in 1974, we settled in Mahalapye village where there was a government hospital. Mother switched churches from the LMS to join an African Independent Church (AIC). She began to have visions and her midwifery became a huge no-fee service to the community to the extent that reportedly she was sometimes called to the hospital to help with complicated deliveries.

Towards the close of her life, she embraced the Adventist faith and ceased her midwifery services when she became an Adventist. About the same time her visions also ceased.

When I had just graduated with an Honors Bachelor of Science Mining Engineering degree from the Camborne School of Mines (University of Exeter), I was appointed as a mining engineer by the world's richest diamond mine, Jwaneng. One of the crewmembers in my shift asked me if I had been to the "great doctor." Sensing the import of the question, I acknowledged so. Excited, the gentleman asked me who this doctor was because he needed a very strong medicine for protection. I pointed up towards heaven and said, "Jesus is my Greatest Physician." The man was disappointed and cautioned me that I would never have promotions in the mine, let alone survive mine accidents if I did not supplement the power of Jesus with that of some great doctor.

Later on, after receiving a Bachelor of Theology at Solusi University, I was appointed as Chaplain of Kanye Seventh-day Adventist Hospital (KSDAH). In my chaplaincy at the hospital, doctors, nurses, and laboratory technicians complained to me that patients were complicating matters for themselves by taking medications from the hospital, as well as those from the traditional doctors and sometimes from the AIC's spiritual healing prophet-healers. The hospital could only caution the patients about the dangers of doing so.

Since I was doubling up as church overseer/pastor for a nearby church, I also noticed that there were some Adventist members who consulted all three forms of health care: (1) hospitals during the day, (2) traditional doctors, and (3) prophet-healers under the cover of darkness. An Adventist member who had become a traditional doctor confirmed this to me later in 2009 when I was doing field research in Botswana. Before

interviewing him, he said to me, “Pastor, I must congratulate you for coming to me in broad daylight unlike some of your church members who come at night even though I tell them I am also a herbalist, which they should have no fear for.”

Certainly, these and many other experiences built in me a strong interest in the topic of this dissertation, but it is my awareness of them that will help me understand the level of my subjectivity in this whole research.

### **Methodology**

This research was historical and thus qualitative in its nature. It examined written and oral sources for research and data collection. This was most likely the first Adventist research to be carried out in Botswana, as the University of Botswana Library Archives, the Botswana National Archives, and several online academic searches did not provide much information about Adventist medical work. Therefore, I used a lot of primary sources in the form of both published and unpublished documents.

However, the primary sources on the history and progress of Adventist medical missions in Botswana are limited. A few books have been written both on the general history of Botswana vis-à-vis Christian missions and the Adventist missions in Botswana. Other literary sources are available as archival materials that include the Adventist Church journals, articles, and Mission Board minutes from the General Conference of the Seventh-day Adventist Church and its ancillary offices. The aforesaid Adventist archival material can mostly be accessed online,<sup>32</sup> even though some hard copies can be found in

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<sup>32</sup>For archival online sources see General Conference of the Seventh-day Adventists, “Adventist Archives,” <http://documents.adventistarchives.org/default.aspx> (accessed December 28, 2010).

the main libraries and centers of Adventist research worldwide.<sup>33</sup> I visited the General Conference in Washington, D.C., to enhance my archival data collection.

Other valuable unpublished sources that were used include local church board minutes in Botswana, available correspondence, letters, diaries, and memoirs from various missionaries and their surviving spouses and families.<sup>34</sup> Unfortunately, there were no unpublished church or hospital sources available in Botswana; KSDAH said they had dumped en masse all of their “very old” papers in the previous year. Furthermore, archival sources were accessed, such as the national and church archives in Botswana.<sup>35</sup>

In order to fill in the gaps in the published and unpublished written sources, this research also utilized oral history<sup>36</sup> in which key informants and focus groups were identified and interviewed in order to collect oral data. Key informants included village leaders, elders in the villages, traditional doctors, local medical and missionary doctors,

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<sup>33</sup>See Ellen G. White Estate, “How to Contact Ellen G. White Estate Worldwide Research Centers,” <http://www.whiteestate.org/about/estate.asp#research> (accessed November 1, 2006).

<sup>34</sup>For local Botswana church board minutes, the early churches of Kanye, Manyana, Moshupa, Kgalagadi, Francistown, and Maun were consulted. Donald A. Ritchie states that “scholars have accepted correspondence, diaries, and autobiographies as legitimate documentation, although their authors may be biased or incorrect,” thus, “oral history is as reliable or unreliable as other research sources. No single piece of data of any sort should be trusted completely, and all sources need to be tested against the other evidence.” Donald A. Ritchie, *Doing Oral History: A Practical Guide—Using Interviews to Uncover the Past and Preserve It for the Future* (Oxford: Oxford University, 2003), 26.

<sup>35</sup>For reasons already explained, I was not able to visit the archives in South Africa and Zimbabwe. However, I was able to spend significant time at the Botswana National Archives and the University of Botswana special collection “Botswana” section.

<sup>36</sup>Barbara W Sommer and Mary Kay Quinlan, *The Oral History Manual* (New York: Altamira Press, 2002), 5.

hospital chaplains, pastors, and local and missionary retirees.

However, before this process, permission was sought from the Institutional Review Board, as well as the research permit from the Republics of Botswana. Further permission was sought from local institutions such as hospitals for interviews, and national archives for document searches. The audiotaped, in-depth, semi-structured interviews lasted about forty-five to sixty minutes, and were then transcribed. The interviews were mostly with individuals on a one-on-one basis; a few others were interviewed by phone.

In the field, I was able to do face-to-face interviews with (1) the deputy director of the MOH, (2) the retired director of the Botswana Health Services (BHS), who was then running his own pediatric clinic and who happened to be Adventist, (3) the former director of BAMS, who also was running his own general clinic, (4) the director of BAMS, (5) the medical directors of BLH and KSDAH, (6) principal or senior nurses, (7) retired or current chaplains and missionaries, (8) village elders and head people, (9) traditional doctors, and (10) AIC prophet-healers. In total I interviewed twenty-three subjects: eleven females and twelve males, including two telephone interviews.

To lay the foundation for this research on Christian medical missions, a biblical and historical analysis of Christian mission models is made, including an Adventist medical mission model as espoused in the writings of Ellen G. White. The history of medical mission from the Early Church on will reveal its rationale and application.

A descriptive historical synopsis of the development of other Christian medical missions is also presented so that comparisons can be made between their work and Adventist medical mission in Botswana. This process will help to uncover the

weaknesses and strengths of Adventist medical mission in the light of other Christian medical missions.

This dissertation will also study indigenous African medical models, especially Traditional and Spiritual healing methods for the purposes of finding possible points of engagement between the two systems. Together with the study of biblical models from the Old and New Testaments, these data will be taken into account in the development of guidelines for an alternative model for medical mission in Botswana that will serve as a guideline for future medical missions for this country and southern Africa.

The analyses and interpretations of the data collected will then be triangulated so that the findings are more complete and validated.

### **Summary**

The purpose of this qualitative missiological study is two-fold. First it investigates the socio-history of Adventist medical mission in Botswana, thereby contributing to the body of knowledge on the subject. Second, by analyzing and comparing the plural medical systems in the country, which included government public health care, Christian medical missions, African Traditional Medicine (ATM), and AIC Spiritual Healing, the research will seek to discover reasons why Botswana often utilize all the systems throughout the course of their lifetime.

I will then develop guidelines for future Adventist medical missions in Botswana and beyond by suggesting an alternative model that will serve Africans more holistically.

Interspersed throughout the subsequent chapters, but usually at the end of each, this dissertation offers a conclusion that analyzes and emphasizes the missiological implications for Adventist medical missions.



## Chapter Outline

Chapter 2 considers the historical context of Christian and Adventist medical missions in Botswana. It discusses the historical and social background of Botswana: the cultural, socio-economic, and health-care settings. The chapter lays a good foundation to understanding the setting in which the parallel medical systems exist. By analyzing how pioneer medical missionaries dealt with cultural issues that affected Africans, this chapter gives insights into how Africans could appropriately be approached.

Chapter 3 explores the biblical and historical Christian medical mission paradigms from the Old and New Testament perspectives so that biblical principles can be drawn and applied to contemporary modern medical mission work and also inform a possible theology of Adventist medical mission. It surveys dynamics in Christian medical mission from the Early Church onwards. The chapter also briefly reviews the Adventist Church pioneer Ellen G. White's model of Adventist medical mission for application in this second decade of the twenty-first century.

Chapter 4 provides a wider scope for chapter 2 in that it describes the history and establishment of Christian medical missions in southern Africa, ending with a focus on Adventist medical mission in Botswana. It reviews how European colonialism influenced Christian medical missions in southern Africa. Implications for future medical missions will be drawn from past mission experiences.

Chapter 5 is a descriptive, yet analytic study of present medical models in Botswana including institutional Christian medical mission, AIC Spiritual healing, government public health care, and ATM approaches. The chapter looks at how each entity defines health and sickness, their diagnostic tools and methods, treatment

regimens, and their fundamental existential beliefs that inform their practice of medicine. From this study, I draw conclusions as to what constitutes holistic medicine.

Chapter 6 presents the challenges to Adventist medical missions, summarizes the findings, and considers the missiological implications for holistic approaches to Adventist medical mission. In the process, an alternative holistic Adventist medical mission model is suggested.

## CHAPTER 2

### HISTORICAL AND SOCIAL BACKGROUND OF BOTSWANA INCLUDING THE BEGINNING OF CHRISTIAN MISSION

#### **Historical Background**

Since the purpose of this dissertation is to conduct a missiological, historical study on the development of Adventist medical missions in Botswana, and to suggest an appropriate holistic mission model that is relevant especially for Africa, a comparative analysis of the health-care systems in the country—which include Adventist medical missions, African Traditional Medicine (ATM), and Christian Spiritual Healing (a.k.a. faith healing)—will be of importance.

This second chapter discusses the historical and social background of Botswana,<sup>1</sup> its mission beginnings, and cultural, economic, and health-care settings. This background knowledge is important to understand the sensitivity in developing a contemporary medical mission model.

As African Independent Churches (AICs) have played an important role in the faith and health of Botswana, their origins, development, and progress are also discussed. But eventually the focus will be mainly on the medical work supported by the Adventist Church.

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<sup>1</sup>The citizens of Botswana are called Batswana. A single citizen is a Motswana.

Since “the earliest southern Africans did not have a written language,”<sup>2</sup> establishing a reliable pre-colonial ethno-history of Botswana prior to the 1800s is difficult due to the lack of written documentation.<sup>3</sup> The main means of understanding the people’s history is to listen to oral traditions, at least until the arrival of missionaries.

Today, the majority of the inhabitants of southern Africa are Bantu, but the first people who lived in that territory were the San,<sup>4</sup> also known as Basarwa who are “the largest group of indigenous hunter-gatherers in Africa.”<sup>5</sup> Botswana historical scholars allege that the “oldest race in Botswana is that of . . . [San].”<sup>6</sup>

The San were supplanted by the peoples of the “central highveld [high altitude region] to the east of the Kalahari . . . dominated by the distinctive Sotho-Tswana lineage groups.”<sup>7</sup> It was specifically the Tswana who, at the onset of the Mfecane and Difaqane periods (eras), subdued and displaced the San.

The Mfecane/Difaqane period can be described as the crushing/scattering era because between 1816 and 1840 a series of wars helped to redefine the African political map of the region.<sup>8</sup> As a result of that turmoil, the Bakgaladi, Barolong, and other

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<sup>2</sup>Harry Stein, *Southern Africa* (New York: Franklin Watts, 1975), 12.

<sup>3</sup>John A. Wiseman, *Botswana*, vol. 150 (Oxford, England: CLIO Press, 1992), xv.

<sup>4</sup>Stein, *Southern Africa*, 23.

<sup>5</sup>Botswana Tourism Organization, “People and Culture,” [http://www.botswana-tourism.gov.bw/culture\\_and\\_his/people.html](http://www.botswana-tourism.gov.bw/culture_and_his/people.html) (accessed October 3, 2006).

<sup>6</sup>Anthony A. Sillery, *John Mackenzie of Bechuanaland/1835-1899: A Study in Humanitarian Imperialism* (Cape Town, South Africa: A. A. Balkema, 1971), 9.

<sup>7</sup>Kevin Shillington, *History of Africa* (New York: Martin's Press, 1989), 212.

<sup>8</sup>*Ibid.*, 258.

Tswana ethnic groups that lived in South Africa were pushed north into Bechuanaland,<sup>9</sup> until the Afrikaner expansion challenged them during this quest for land during their expansion.<sup>10</sup>

The interplay of both local and foreign political struggles influenced how European powers partitioned Africa. For example, at the behest of the Tswana chiefs, the Bechuanaland territory (Botswana) became a British protectorate in 1885 in order to preempt the expansionist drive of imperial Germany, the Union of South Africa, and the British South African Company.<sup>11</sup>

The British colonial government, under the “indirect rule” system, allowed the chiefs considerable powers over their own affairs.<sup>12</sup> It was under such discretion that the chiefs decided which Christian missions were allowed to serve in their territories. Since the Adventist Church arrived relatively late, they had to wait a long time before permission was granted for them to operate in certain assigned territories.

The Dutch settlers, also called Afrikaners, arrived at the Cape (South Africa) in 1652.<sup>13</sup> The Afrikaners soon embarked on a migration to the north. This northbound expansion—known as “the Great Trek”—was precipitated in 1803 by the arrival of the

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<sup>9</sup>Sillery, *John Mackenzie of Bechuanaland/1835-1899: A Study in Humanitarian Imperialism*, 7.

<sup>10</sup>David Livingstone, *Missionary Travels and Researches in South Africa* (New York: Harper & Brothers, 1859), 35.

<sup>11</sup>Niel Parsons, *King Khama, Emperor Joe, and the Great White King: Victorian Britain through African Eyes* (Chicago: The University of Chicago Press, 1998), 6, 62.

<sup>12</sup>Peter Fawcus and Alan Tilbury, *The Road to Independence* (Gaborone, Botswana: Pula Press and The Botswana Society, 2000), 37.

<sup>13</sup>Harold D. Nelson, *South Africa: A Country Study* (Washington, DC: The American Press, 1981), 6.

British who “began to govern the Cape settlement.”<sup>14</sup> Because the British promoted the abolition of slavery, “many [Afrikaners] . . . left the Cape Colony in the 1830s to acquire more grazing land and to escape what they thought was an unjust British rule.”<sup>15</sup> This search for land led inevitably to clashes between the Afrikaners and the Tswana.

Soon the British expanded their control of South Africa and also took control of colonial Bechuanaland in 1885. This control lasted for over 80 years, until September 30, 1966, when Botswana became independent.<sup>16</sup>

### **Cultural Background**

Living in large community settlements called *metse* or villages, the Tswana often had to move in search of water and grazing land.

The male-dominated *kgotla*—a semi-circle of tough logs—or the traditional court is where communal issues were discussed. However, these lower courts sent heavier matters of dispute to the main *kgotla* to be judged.

The Tswana owned triple homes, which are believed to be a result of people movements from their homes to farm lands and cattle posts during the rainy season and then back to their homes after the harvest.<sup>17</sup> Their life cycle was “a continual coming and going between towns, cattle posts, and farms.”<sup>18</sup>

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<sup>14</sup>Stein, *Southern Africa*, 23, 38.

<sup>15</sup>*Ibid.*, 38.

<sup>16</sup>Wiseman, *Botswana*, xxi.

<sup>17</sup>James Denbow and Pheny C. Thebe, *Culture and Customs of Botswana* (Westport, CT: Greenwood Press, 2006), 165.

<sup>18</sup>Alfred M. Merriweather, *Desert Doctor Remembers: The Autobiography of the Rev. Dr. Alfred Merriweather* (Gaborone, Botswana: Pula Press, 1999), 165.

The onset of urbanization added the fourth estate—a home in the city. This certainly posed a financial strain for a family who had to manage property in four separate areas, as well as for the government to provide health services to its people in all of these areas.

The peoples of Botswana are not a homogeneous group, but they are ethnically and racially diverse.<sup>19</sup> They include the Bantu, San, Europeans, and Asians. In fact, “there are more than thirty ethnic groups in Botswana, each . . . with distinct myths, rites of passage, regiments, origins and world view.”<sup>20</sup> Though the citizens of Botswana are known as Batswana, they are not all of the Tswana ethnic background.

The Tswana are divided into eight major tribes: Lete, Kgatla, Kwena, Ngwaketse, Ngwato, Rolong, Tawana, and Tlokwa. See Figure 1. However, there are also minor tribes that differ linguistically<sup>21</sup> such as the Herero, Kalanga, Kgalagadi, Mbukushu, Ndebele, and Yei.<sup>22</sup> Together with the Tswana, they comprise the Bantu people.

The Tswana had the greatest impact on all the other tribes.<sup>23</sup> There are other non-Tswana ethnic groups living in Botswana, such as the Kalahari people, and the White Afrikaans-speaking cattle pastoralists, who for three generations have lived in the area.<sup>24</sup>

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<sup>19</sup>Wiseman, *Botswana*, 3.

<sup>20</sup>Tjako Mpulubusi, “*Barile*”: *The Peopling of Botswana* (Gaborone, Botswana: The Government Printer, 1995), 2.

<sup>21</sup>Marjorie Froise, *World Christianity: Southern Africa—A Factual Portrait of the Christian Church in South Africa, Botswana, Lesotho, Namibia, and Swaziland*, ed. Edward R. Dayton, World Christianity Series (Monrovia, CA: MARC, 1989), 8-9.

<sup>22</sup>Wiseman, *Botswana*, xxi.

<sup>23</sup>Anthony A. Sillery, *Botswana: A Short Political History* (London: Methuen, 1974), 8.

<sup>24</sup>Margo Russell and Martin Russell, *Afrikaners of the Kalahari: White Minority in a Black State* (London: Cambridge University Press, 1979), 1.

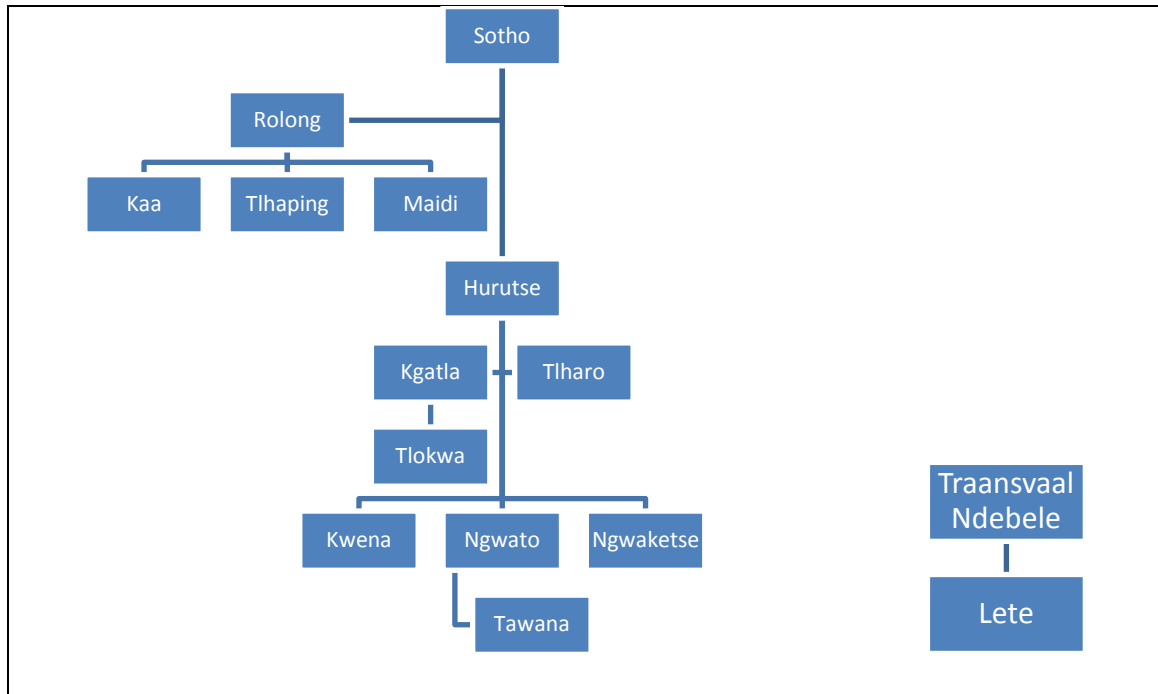


Figure 1. Principal Tswana traditional tribes and their offshoots.  
 Source: Anthony A. Sillery, *John Mackenzie of Bechuanaland /1835-1899: A Study in Humanitarian Imperialism*, Cape Town, South African: A. A. Balkema, 1971, 14.

Botswana has also immigrants from Europe and Asia. Most of the Caucasians came from Britain and the Netherlands, while the Asians came mainly from India. The Afrikaners, together with the Britons and Indians, can be traced back to the original settlers in South Africa who migrated to Botswana at the turn of the nineteenth century.<sup>25</sup>

The people of the mixed races were originally offspring of the Khoi, San, Whites, and Blacks who were brought to the Western Cape as slaves, while the Indians hailed from the Indian subcontinent.<sup>26</sup>

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<sup>25</sup>Wiseman, *Botswana*, xxii.

<sup>26</sup>Irving Kaplan and Harold D. Nelson, "The Society and Its Environment," in *South Africa: A Country Study*, ed. Harold D. Nelson, Area Handbook Series (Washington, DC: American University, 1981), 65-102.



## Social Background

The Botswana population is 2,024,904.<sup>27</sup> The annual population growth rate between 2001 and 2011 was 1.9 percent. This is significantly lower than the previous decennial censuses between 1971-2001, when the growth rate declined from 4.6 to 2.4 percent.<sup>28</sup> Although low fertility rates explain this phenomenon,<sup>29</sup> a more serious reason is the prevalence of HIV/AIDS, which stood at 17.1 percent of the population in 2010.<sup>30</sup> This fact threatens the health of the nation and causes a huge medical challenge in the country.

Botswana had a male vs. female ratio of 0.94 in 2001.<sup>31</sup> This ratio is significant in two ways: First, women are disadvantaged in the job market and “seven out of every ten Botswana live in households whose heads have no spouses and 60 per cent of these households are headed by females,”<sup>32</sup> making it hard for such households to improve the health of their families. Second, HIV/AIDS statistics show that more females die of the

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<sup>27</sup>Botswana Central Statistics Office, “2011 Botswana Population and Housing Census Alphabetical Index of Districts,” [http://www.cso.gov.bw/media/2011%20Census%20\\_Alphabetical%20Index%20of%20Districts.pdf](http://www.cso.gov.bw/media/2011%20Census%20_Alphabetical%20Index%20of%20Districts.pdf) (accessed November 12, 2012).

<sup>28</sup>Sakarea Makgapha, “Botswana Population Now Two Million,” *The Botswana Gazette*, October 10, 2011. For earlier years, see also Botswana Central Statistics Office, “History of Census Taking in Botswana,” <http://www.cso.gov.bw> (accessed June 21, 2007).

<sup>29</sup>Rodolfo Bulatao, “Population Projections for Botswana up to 2031,” World Bank, <http://www.cso.gov/WorldBank> (accessed June 22, 2007).

<sup>30</sup>UN Economic and Social Council, “Commission on Population and Development,” <http://www.un.org/News/Press/docs/2012/pop1003.doc.htm> (accessed November 13, 2012).

<sup>31</sup>Botswana Central Statistics Office, “2011 Botswana Population and Housing Census Alphabetical Index of Districts.”

<sup>32</sup>S. K. Gaisie, “Family Structure, Gender and Fertility in Botswana,” *Pula: Botswana Journal of African Studies* 14 2 (2000): 138.

disease than do men.<sup>33</sup> This suggests that females are more vulnerable than men.

Botswana is a youthful nation. The 0 to 35 years age bracket makes up the majority of its population.<sup>34</sup> This means that Botswana has a much-valued human capital resource that will sustain the country's labor needs.<sup>35</sup> A negative trend is that a large part of this age group is adversely affected by the HIV/AIDS epidemic,<sup>36</sup> notwithstanding the thousands of HIV/AIDS orphans who that need care.<sup>37</sup>

The HIV/AIDS pandemic is arguably the single biggest threat confronting this developing nation. This calls for a concerted effort by all, including Christian denominations, other religions, and Non-Government Organizations (NGOs) to address the epidemiological plight of the country proactively, and to deal with the underlying causes of HIV/AIDS that is caused by risky sexual behavior, poverty, illiteracy, and poor morality. This fact will become important in this dissertation when I will discuss the approach of Adventist medical mission.

### **Economic Context**

A discussion of Botswana's economic situation will illustrate the dire need of

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<sup>33</sup>USAID, "HIV/AIDS Health Profile," [http://www.usaid.gov/our\\_work/global\\_health/aids/Countries/africa/botswana.html](http://www.usaid.gov/our_work/global_health/aids/Countries/africa/botswana.html) (accessed February 9, 2009).

<sup>34</sup>U.S. Census Bureau, "Population Pyramids," <http://www.census.gov/gi-bin/ipc/idbpyry.pl?cty=BC&maxp=114149&maxa=80&ymin=300&yr=2007&.submit=Submit+Query> (accessed June 21, 2007).

<sup>35</sup>Sadasivan P. Nair, "Age Structural Transition in Botswana in the Context of HIV/AIDS," CIRCRED, <http://www.cicred.org/Eng/Seminars/Details/Seminars/Popwaves/PopwavesNair.pdf> (accessed June 26, 2007).

<sup>36</sup>Anna N. Majelantle, "Preliminary 2005/06 Labour Force Survey Results," *Stats Brief* 2, (2006): 1-2, [http://www.cso.gov.bw/html/labour.Stats\\_brief%20Nov2030%202006.pdf](http://www.cso.gov.bw/html/labour.Stats_brief%20Nov2030%202006.pdf) (accessed June 28, 2007).

<sup>37</sup>United Nations Children's Fund, "Basic Indicators—HIV/AIDS Statistics Botswana," [http://www.unicef.org/infobycountry/botswana\\_1907.html](http://www.unicef.org/infobycountry/botswana_1907.html) (accessed June 29, 2007); United Nations

public and private health-care providers. During the colonial era “there was a complete disregard for education, health, communications, manpower training, and water development.”<sup>38</sup> Combined with periodic droughts, lack of community and industrial development, the health and social situation worsened in the country.

The Tswana economy consisted mainly of cattle-raising and agriculture, which depended on erratic rainfall and existing poor soil;<sup>39</sup> this resulted in malnutrition and livestock disease that in turn led to high mortalities, especially among the young.

After 1844, Tswana migrant laborers flocked to the South African gold and diamond mines in search of jobs.<sup>40</sup> However, upon returning, the miners introduced new diseases,<sup>41</sup> which the country’s struggling health-care system could not cope with.

The economic situation in Botswana changed with the discovery of diamonds.<sup>42</sup> As a result, the government was able to invest massively over the last twenty-five years in social development, including the expanded free, primary health care and access to safe drinking water for 97 percent of the population.<sup>43</sup>

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Children's Fund, “Botswana Statistics: Basic Indicators,” [http://www.unicef.org/infobycountry/botswana\\_statistics.html](http://www.unicef.org/infobycountry/botswana_statistics.html) (accessed June 25, 2007).

<sup>38</sup>Serara Selelo-Khupe, *An Uneasy Walk to Quality: The Evolution of Black Nursing Education in the Republic of Botswana, 1922-1980* (Battle Creek, MI: W. K. Kellogg Foundation, 1993), xxxv.

<sup>39</sup>Anthony A. Sillery, *The Bechuanaland Protectorate* (Westport, CT: Greenwood Press, 1983), 15.

<sup>40</sup>Ibid.

<sup>41</sup>Selelo-Khupe, *An Uneasy Walk to Quality: The Evolution of Black Nursing Education in the Republic of Botswana, 1922-1980*, 17.

<sup>42</sup>Kristan Schoultz, “Welcome,” The United Nations in Botswana, [http://www.unbotswana.org/bw/the\\_un\\_in.html](http://www.unbotswana.org/bw/the_un_in.html) (accessed October 30, 2009).

<sup>43</sup>The United Nations System in Botswana, “Botswana: Toward National Prosperity—Common Country Assessment of the United Nations Agencies Working in Botswana,” [www.undg.org/archive\\_docs/933-Botswana\\_CCA\\_-\\_Botswana\\_2001.doc](http://www.undg.org/archive_docs/933-Botswana_CCA_-_Botswana_2001.doc) (accessed October 30, 2009).

“It is important to appreciate and recognize that health status in Botswana, until the advent of the HIV/AIDS epidemic, had been improving steadily and the vital health indicators [were] among the best in the region until the 1980s.”<sup>44</sup> Between 1971 and 1993 the mortality rate fell from 151 to 63 per 1,000 live births. The life expectancy rose from less than 50 in the late 1960s to 65 in 1992, whereas the under-five malnutrition rates declined from 25 percent in 1978 to 13 percent in 2000.<sup>45</sup>

However, these remarkable strides were eroded by the onset of the HIV/AIDS epidemic, which significantly affected the health and economy of the country. Tyrrell Duncan et al. fear that

[with] a substantial proportion of the population already affected with HIV, Botswana is clearly entering a period of human and economic catastrophe. In order to deal with this catastrophe and contain the spread of AIDS, government and the wider society face an enormous and urgent challenge to bring about change in sexual attitudes and practices.<sup>46</sup>

What role can the Adventist medical mission and other non-government organizations play to meet the HIV/AIDS challenge?

### **Health Care**

Since its independence (1966), Botswana’s public health care became one of the most important priorities of the country, especially in public health education,

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<sup>44</sup>World Health Organization, “Health Profile: WHO Country Cooperation Strategy--Botswana 2003-2007,” [http://www.who.int/countryfocus/cooperation\\_strategy/ccs\\_bwa\\_en.pdf](http://www.who.int/countryfocus/cooperation_strategy/ccs_bwa_en.pdf) (accessed October 22, 2009).

<sup>45</sup>The United Nations System in Botswana, “Botswana: Toward National Prosperity—Common Country Assessment of the United Nations Agencies Working in Botswana.”

<sup>46</sup> Tyrrell Duncan and et al., “Botswana: Social Development in a Resource-Rich Economy,” in *Development with a Human Face: Experiences in Social Achievement and Economic Growth*, ed. Santosh Mehrotra and Richard Jolly (Oxford, England: Clarendon Press, 1997), 126.

establishment of hospitals, clinics, and trained medical personnel.

Many of the early diseases had been introduced by European hunters and traders<sup>47</sup> as well as colonial policies, which enforced long-distance migration, increased labor demands, and the partial destruction of local forms of public health<sup>48</sup> (traditional medicine) and social taboos that were aimed at promoting health.

However, not all diseases came with the miners, as Sillery reports:

In June 1862, when [missionary] Mackenzie arrived at Shoshong . . . [he] found himself engaged in a campaign against smallpox and measles which were causing a high mortality among the people. Interestingly, the Ngwato had developed their own system of inoculation against smallpox. Exploiting this, Mackenzie improvised a serum for children from a mild form of the disease.<sup>49</sup>

In the twentieth century, other local diseases such as yellow fever, diphtheria,<sup>50</sup> leprosy,<sup>51</sup> smallpox,<sup>52</sup> sleeping sickness,<sup>53</sup> eye-diseases,<sup>54</sup> malaria,<sup>55</sup> and epilepsy

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<sup>47</sup>Selelo-Khupe, *An Uneasy Walk to Quality: The Evolution of Black Nursing Education in the Republic of Botswana, 1922-1980*, 17.

<sup>48</sup>Karen E. Flint, *Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948* (Scottsville, South Africa: University of Kwa-Zulu Press, 2008), 44. For disease through migrant labor see also Molefi, *A Medical History of Botswana: 1885-1996*, 54.

<sup>49</sup>Sillery, *The Bechuanaland Protectorate*, 29. It is significant for this dissertation that the Tswana had developed their traditional inoculation against smallpox.

<sup>50</sup>Fawcus and Tilbury, *The Road to Independence*, 41.

<sup>51</sup>"Hospital Maun Establishment by Seventh Day Adventist Mission, and Later Taken over by B P Government," 1934, MS S354/9/2, Fol. 6595/911, Botswana National Archives, Gaborone, Botswana.

<sup>52</sup>"Small Pox," 1930, MS S102/1-3, Botswana National Archives, Gaborone, Botswana.

<sup>53</sup>"Investigation of Sleeping Sickness, Ngamiland," 1935, MS S374/1-7, Botswana National Archives, Gaborone, Botswana.

<sup>54</sup>"Blind Africans in the High Commission Territories: Reports by Dr. Alexander Jokl, on Incidents of Eye-Diseases and Causes of Blindness in the Bechuanaland Protectorate," 1943-1945, MS S276/2/12, Botswana National Archives, Gaborone, Botswana.

<sup>55</sup>Thomas J. Larson, "The Ethno-Medicine of the Hambukushu in 1950," *Botswana Notes and Records* 18, (1986): 39, <http://www.jstor.org/stable/40979759>.

affected the people.<sup>56</sup> Many children suffered from acute pneumonia, bronchitis, measles, whooping cough, conjunctivitis, and skin diseases.<sup>57</sup>

### Traditional Health Care

Before the missionaries came to Botswana or any other part of sub-Saharan Africa and introduced Western medicine, people followed traditional forms of medicine.

African Traditional Medicine (ATM) as a

major African socio-cultural heritage, obviously in existence for several hundreds of years, was once believed to be primitive and wrongly challenged with animosity, especially by foreign religions, dating back to the colonial days in Africa and subsequently by the conventional or orthodox medical practitioners.<sup>58</sup>

The traditional forms of health care were deeply rooted in the African Traditional Religion (ATR), even to this day. The traditional health-care forms were holistic in nature, meaning that health was viewed beyond the physiological. They included spiritual, social, and ritual aspects of life. Setiloane explains:

The . . . word ‘*bolwetse*’ is . . . translated ‘illness’. . . ‘*Bolwetse*’ is certainly used to describe symptoms of physical disease requiring treatment with naturally occurring medicines, but also it describes the state of a man who is not himself ill, but whose family, stock and crops—indeed all his affairs—suffer misfortune through the action of ‘*badimo*’ [spirits] or sorcerers.<sup>59</sup>

Thorpe further adds that “[in] traditional societies . . . the sufferer is treated in a

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<sup>56</sup>Merriweather, *Desert Doctor Remembers: The Autobiography of the Rev. Dr. Alfred Merriweather*, 35.

<sup>57</sup>Alfred M. Merriweather and D. J. Arthur, *Hospital in the Desert: The Scottish Livingstone Hospital, Molepolole, Botswana* (Gaborone, Botswana: Botswana Press, 1976), 25.

<sup>58</sup>A. A. Elujoba, O. M. Odeleye, and C. M. Ogunyemi, “Traditional Medicine Development for Medical and Dental Primary Health Care Delivery System in Africa,” *African Journal of Traditional, Complementary and Alternative Medicines* 2, no. 1 (2005): 46, <http://www.bioline.org.br/request?tc05007> (accessed June 9, 2009).

<sup>59</sup>Gabriel M. Setiloane, *The Idea of God among the Sotho-Tswana* (Gaborone, Botswana: A. A. Balkema, 1975), 44.

holistic manner, as if the body, the psyche and, in fact, the whole society were suffering by extension.”<sup>60</sup> Thus to “balance” a traditional African life, evil spirits must be successfully warded off while good ones must be pacified. This is because “continuity and transmission of life depends upon maintaining a harmony between the living and their forebears who are now the ancestral spirits.”<sup>61</sup>

Historically, traditional healers had areas of specialization according to their heritage, training, or even calling. Selelo-Khupe describes *Dingaka tsa Setswana* (Tswana doctors) who are bone-thrower diviners (that is, who practice divination by throwing a set of bones onto the ground), *Dingaka tse dichochwa* (herbalists or healers who use plant medicine) who administer roots and herbs for healing purposes, and other specialists such as rainmakers, fracture setters, fertility restorers, and midwives.<sup>62</sup>

The role of females in traditional medicine is limited. Instead, they serve their communities as midwives and/or home-based nurses.<sup>63</sup> According to their custom, “a majority of TMs [Traditional Midwives] seem to concentrate on assisting biologically close relatives such as daughters and daughters-in-law in their deliveries—thus respecting the Tswana tradition of considering deliveries to be a ‘family affair.’”<sup>64</sup>

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<sup>60</sup>S. A. Thorpe, *African Traditional Religion: An Introduction* (Pretoria, South Africa: University of South Africa, 1991), 123.

<sup>61</sup>Aylward Shorter, “Eschatology in African Religions,” *Studia Missionalia* 32 (1983): 15.

<sup>62</sup>Selelo-Khupe, *An Uneasy Walk to Quality: The Evolution of Black Nursing Education in the Republic of Botswana, 1922-1980*, 2.

<sup>63</sup>Ibid., 3. Selelo-Khupe explains that the traditional midwifery was inclusive of antenatal and post-natal care to the mother, in addition to taking care of the sick at home as part of the women’s house-keeping duties.

<sup>64</sup>Sandra Anderson and Frants Staugård, *Traditional Medicine in Botswana: Traditional Midwives* (Gaborone, Botswana: Ipeleng Publishers, 1986), 79.

The traditional health-care system in Botswana has neither been phased out nor replaced by the Western medical-care system. The Tswana have continued to engage both systems,<sup>65</sup> a practice known as “medical pluralism,” which means that

some illnesses are considered ‘European’ and some ‘African’ and are brought to medical healers accordingly. Other illnesses are brought to Western medical doctors, traditional doctors, and church priests/healers for the same ailment or to as many healers as people can afford. Physical ailments and general misfortune are both considered treatable, and the latter is brought to the attention of traditional doctors/diviners and church healers who are likely to diagnose social causes—jealousies, malevolence, and selfish ambitions.<sup>66</sup>

Faith healers are another category of traditional healers who are also called spiritual healers. They are in charge of churches—often as prophets, priests, or pastors—especially in African Independent Churches (AICs). These churches historically broke away from traditional missionary churches. There are nearly 160 AICs in Botswana.<sup>67</sup>

In these churches

emphasis is placed on the need for faith in Jesus the healer. . . . Prayers are offered for the departed brothers and sisters. This is [a] significant departure from the teaching of CMS [Church Missionary Society] but one that comes naturally to the African as much of Traditional Religion is to do with the departed and interceding both for and through them.<sup>68</sup>

Western medicine, traditional medicine, and faith or spiritual healing form the

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<sup>65</sup>A possible explanation for this phenomena is that Africans, “armed with confidence that . . . medicines do not drive each other away, . . . combine traditional and modern health remedies when they are enduring a health crisis. Rose Mary Amenga-Etego, “The Interplay of Traditional and Modern Concepts of Health,” in *Reclaiming the Human Sciences and Humanities through African Perspectives*, ed. Helen Lauer and Kofi Anyidoho (Accra, Ghana: Sub-Saharan Publishers, 2012), 321.

<sup>66</sup>Melvin Ember and Carol R. Ember, “Botswana: Countries and Their Cultures,” in *Afghanistan to Czech Republic* (New York: Macmillan Reference USA, 2001), 144.

<sup>67</sup>Froise, *World Christianity: Southern Africa—A Factual Portrait of the Christian Church in South Africa, Botswana, Lesotho, Namibia, and Swaziland*, 17.

<sup>68</sup>Philip Tovey, *Inculturation of Christian Worship: Exploring the Eucharist* (Burlington, VT: Ashgate, 2004), 91.



milieu of the medical pluralism that exists in Botswana. What is striking is that for at least 80 percent of Africans who suffer from high fever and other common ailments, Traditional Medicine (TM) is the first-choice health care.<sup>69</sup>

### Christian Medical Mission

In Botswana, Christian medical missions and the government provide primary Western health-care.<sup>70</sup>

The main Christian mission health-care providers who have served Botswana are the Kanye Adventist Medical Mission (since 1922), the Deborah Retief Memorial Hospital (1927), the Bamalete Lutheran Hospital (1933), and the Molepolole Scottish Livingstone Hospital (1934).<sup>71</sup> Mission medical hospitals also took the initiative to start nursing training schools, with the Kanye Adventist Medical Mission hospital taking the lead in 1925.<sup>72</sup>

### Government/Public Health Care

The Botswana government public health-care system can be divided into two eras: colonial and post-independence (1966). This is significant since the approach and attitude in each period bore different consequences on public health. The government's

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<sup>69</sup>Elujoba et al., "Traditional Medicine Development for Medical and Dental Primary Health Care Delivery System in Africa," 46.

<sup>70</sup>However, there are private hospitals that offer excellent health services but they are beyond the reach of the ordinary citizen.

<sup>71</sup>Molefi, *A Medical History of Botswana: 1885-1996*, 18-20.

<sup>72</sup>Selelo-Khupe, *An Uneasy Walk to Quality: The Evolution of Black Nursing Education in the Republic of Botswana, 1922-1980*, 30.

provision of public health was at a bare minimum,<sup>73</sup> relying heavily on Christian medical services.

Early public health care initially was not designed to cater to all the citizens of Botswana. When the British annexed Botswana in 1885, they brought Western medicine for their own personal use, but not for Botswana.<sup>74</sup> It is clear that this initial health-care marginalized the African people. For all practical purposes, the colonial health-care system was for private use only.

However, in recognition of the importance of medical work carried out by medical missions, the colonial government offered to build hospitals for the missions.<sup>75</sup>

The government—which also had budgetary constraints—believed it was cost effective to let Christian missions operate medical institutions<sup>76</sup> because it cost less to run a Christian medical hospital than a government one since missionary medical staff accepted sacrificial remuneration.

A significant development was the establishment of government hospitals in Lobatse (Athlone Hospital) and Serowe (Sekgoma Memorial Hospital) in 1930 and 1931, respectively.<sup>77</sup> These mini hospitals were noteworthy because for the first time, health

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<sup>73</sup>Fawcus and Tilbury, *The Road to Independence*, 48.

<sup>74</sup>Selelo-Khupe, *An Uneasy Walk to Quality: The Evolution of Black Nursing Education in the Republic of Botswana, 1922-1980*, 9.

<sup>75</sup>“Hospital Maun: Question of Erection of General [Hospital in Maun],” 1933, MS S354/5, Fol. 6595, Botswana National Archives, Gaborone, Botswana.

<sup>76</sup>*Ibid.*

<sup>77</sup>Molefi, *A Medical History of Botswana: 1885-1996*, 19.

services were extended to Africans.<sup>78</sup> Unfortunately, the small medical staff of these hospitals could barely serve the vast eastern part of Botswana, let alone the northwest regions where the disease burden was higher.<sup>79</sup>

At independence, the county's public health system was "extremely limited. There were just five government hospitals [1954], with a total of 333 beds."<sup>80</sup> Thus the challenge to the new government was phenomenal. Assisted by the World Health Organization (WHO), the government continued to partially and incrementally fund mission hospitals, while at the same time building more public hospitals, especially clinics.<sup>81</sup>

The government in 1973/74 spent about £7.50 per capita on health-care for people living less than 5 miles from a hospital, while for 40% of the population living more than 25 miles from a hospital and 10 miles from a clinic, the government spent only £0.90 per capita, it attempted to redress the imbalance by expanding the mobile health service in the form of mobile clinics and a flying doctor service to visit especially remote areas.<sup>82</sup>

To meet the continuous needs, the government looked into other ways to improve access to public health. By the year 2000, it had established "687 mobile health stops, 314 health posts and 209 clinics . . . 14 Primary Hospitals and 14 District Hospitals . . .

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<sup>78</sup>Ibid.

<sup>79</sup>Ibid., 37.

<sup>80</sup>Fawcus and Tilbury, *The Road to Independence*, 41.

<sup>81</sup>Marjorie Froise, *World Christianity—Southern Africa: A Factual Portrait of the Christian Church in South Africa, Botswana, Lesotho, Namibia and Swaziland*, ed. Edward R. Dayton (Monrovia, CA: MARC, 1989), 10.

<sup>82</sup>Godfrey Walker, "Health Care in Botswana: A Study in Cost-Effectiveness," *Proceedings of the Royal Society of Medicine* 69, no. 12 (1976), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1864748/pdf/procrsmed00023-0082.pdf> (accessed September 30, 2009).

[with] two national referral hospitals.”<sup>83</sup> Botswana had also made significant strides in the public health-care services, making the load for medical missions lighter.

In order to understand the development of medical mission in Botswana, the next section will describe the context in which the Adventist Church began to work.

## **Mission Context**

### **Early Missionary Endeavor**

Mission and secular history for South Africa and Botswana are intertwined due to geographical proximity, and political and cultural ties.<sup>84</sup> Missionaries in South Africa defended Africans from white settlers who treated them as slaves and subjected them to hard labor.<sup>85</sup> As a result, the Afrikaners determined to thwart any expansion of missionary work to the Tswana territory in the north. This tactic slowed medical mission work in Botswana.

The London Missionary Society (LMS) was “the first British society to enter the South Africa field.”<sup>86</sup> The early LMS missionaries, such as Robert Moffat and Dr. David Livingstone,<sup>87</sup> became symbols of early missions in Botswana.<sup>88</sup> Robert Moffat started

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<sup>83</sup>Onalenna Stannie Seitio, “The Family Nurse Practitioner in Botswana: Issues and Challenges,” International Nursing Council, <http://international.aanp.org/pdf/Botswana.pdf> (accessed September 20, 2009).

<sup>84</sup>Johannes du Plessis, *A History of Christian Missions in South Africa* (Cape Town, South Africa: C. Struik, 1965), 122.

<sup>85</sup>Livingstone, *Missionary Travels and Researches in South Africa*, 35.

<sup>86</sup>This dissertation focuses on the Tswana of Botswana.

<sup>87</sup>du Plessis, *A History of Christian Missions in South Africa*, 7.

<sup>88</sup>G. B. A. Gerdener, *Recent Developments in the South African Mission Field* (Cape Town, South Africa: N. G. Kerk-Uitgewers, 1958), 51. This resulted in the Tswana residing in two different political domains: British Bechuanaland (South Africa) and Bechuanaland Protectorate (Botswana).

working among the Bathaping in Kuruman (South Africa) on May 17, 1821.<sup>89</sup> He served among the Tswana that resided both in British Bechuanaland (South Africa) and Bechuanaland Protectorate (Botswana). Moffat translated the Bible into Setswana and initiated communal gardens.<sup>90</sup> Having established Kuruman, the missionary extended his mission further north to Botswana.

Dr. Livingstone sought new sites beyond Kuruman,<sup>91</sup> where in 1843, he established his first mission station among the Bakgatla at Mabotsa.<sup>92</sup> He then moved further north to Chonuane to serve among the Bakwena whose chief, Sechele, was receptive to the gospel.<sup>93</sup> However, an inadequate water supply and the constant Afrikaner threat to the Bakwena forced the villagers to move.<sup>94</sup> Dr. Livingstone had to follow. When the Afrikaners attacked and ruined the missionary's base at Kolobeng, including the mission school, they forced him to move further north to the distant Linyathi to work among the Makololo.<sup>95</sup>

Dr. Livingstone's strategy was to explore the region beyond Kuruman, and then

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<sup>89</sup>Northcott, *Robert Moffat: Pioneer in Africa 1817-1870*, 83.

<sup>90</sup>Peter Hinchliff, *The Church in South Africa*, ed. V. H. H. Green, Church History Outlines (London: S.P.C.K for the Church Historical Society, 1968), 52.

<sup>91</sup>Robert I. Rotberg, *Christian Missionaries and the Creation of Northern Rhodesia 1880-1924* (New York: Princeton University Press, 1965), 3.

<sup>92</sup>Hinchliff, *The Church in South Africa*, 43.

<sup>93</sup>William Garden, *The Personal Life of David Livingstone* (New York: Negro University Press, 1969), 92-95. See also William Walters, *Life and Labours of Robert Moffat, D.D., Missionary in South Africa, with Additional Chapters on Christian Missions in Africa and Throughout the World* (London: Walter Scott, 1885), 155.

<sup>94</sup>H. G. Adams, *David Livingstone: The Weaver Boy Who Became a Missionary* (London: Hodder and Stoughton, 1882), 31.

<sup>95</sup>James I. Macnair, *Livingstone's Travels* (New York: Macmillan Company, 1954), 48.

have follow-up missionaries set up mission stations. Consequently, the LMS established more stations in Botswana so that “by 1880 the London Missionary Society . . . was well established among the Ngwato (1862), Kwena (1866), Ngwaketse (1871) and Tawana (1878).”<sup>96</sup>

There were other mission societies that soon were established, though for a short time.<sup>97</sup> For example, Litenyana, one of Chief Sechele’s villages of Kanye, was under the care of the (German) Hanoverian Society.<sup>98</sup> Other mission societies that established work in Botswana include the Methodist Church (1822), Dutch Reformed Church (1830), Evangelical Lutheran Church (1857), Roman Catholic Church (1956), and the Seventh-day Adventist Church (1921), which “over the next decades emerged as the second largest of the churches produced by the missionary endeavor.”<sup>99</sup>

In those early days missionaries often became political advisors to the paramount chiefs. For example, John Mackenzie and William C. Willoughby were LMS missionaries who helped the Tswana negotiate for British protectorate status. Mackenzie was instrumental in arranging for British Protection (1885) for both the Tswana in the

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<sup>96</sup>Leny Lagerwerf, *They Pray for You . . . Independent Churches and Women in Botswana*, vol. 6 (Leiden, The Netherlands: IIMO, 1982), 23.

<sup>97</sup>Bengt Sundkler and Christopher Steed, *A History of the Church in Africa* (Cambridge, England: Cambridge University Press, 2000), 92. Hole describes how one non-LMS missionary institution started its work among the Bamangwato, “Towards the end of 1859, there arrived a Mr. Schulenburg, a Hanoverian minister of the Lutheran persuasion, who built himself a house and a school and started classes for religious instruction. In the following May Khama was baptized by him, and a little later married, with Protestant rites, to Tshukuru’s daughter, herself a convert to the faith.” Hugh Marshall Hole, *The Passing of the Black Kings* (New York: Negro Universities Press, 1969), 71-72.

<sup>98</sup>Walters, *Life and Labours of Robert Moffat, D.D., Missionary in South Africa, with Additional Chapters on Christian Missions in Africa and Throughout the World*, 163.

<sup>99</sup>James N. Amanze and Thabo T. Fako, “Botswana,” *Religions of the World—A Comprehensive Encyclopedia of Believers and Practice* (Santa Barbara, CA: ABC-CLIO, 2002), 158.

British Bechuanaland and Bechuanaland Protectorate.<sup>100</sup>

In 1895, “Chiefs Kgama, Bathoen, and Sebele, accompanied by Mr. W. C. Willoughby . . . as interpreter . . . [went to England] to protest in person to the Secretary of State,”<sup>101</sup> purportedly to “prevent [the] transfer of the [Bechuanaland Protectorate] administration to Cecil Rhodes’s British South African Company.”<sup>102</sup> The chiefs and their missionary were successful in their plea, and no transfers of land or authority were made.

On the ecclesiastical front, a number of African Church leaders soon broke away from the “Western-oriented” churches and they started their own “African-oriented” congregations. The understanding of such movements will be of importance for the development of medical pluralism.

#### African Independent Churches

As Batswana embraced Christianity, many felt that some cultural and traditional aspects were missing in their faith experience. This led to secessions from the traditional mission churches, giving rise to African Independent Churches (AICs). AICs do play significant socio-cultural roles in the spiritual and healing processes. In addition, AICs proliferate incessantly, fast becoming the religion of the people.

Some scholars on African religion use the alternative term “African Initiatives in

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<sup>100</sup>Sillery, *The Bechuanaland Protectorate*, 54-56.

<sup>101</sup>*Ibid.*, 67.

<sup>102</sup>Lagerwerf, *‘They Pray for You . . .’ Independent Churches and Women in Botswana*, 24.

Christianity,”<sup>103</sup> explaining that “these [were] churches founded by Africans for Africans . . . so often referred to as ‘independent’ or ‘indigenous’ churches, to distinguish them from the ‘historic’ or ‘mission-founded’ churches.”<sup>104</sup> H. W. Turner defines an AIC as “a church which has been founded in Africa, by Africans and primarily for Africans.”<sup>105</sup>

Michiel Casparus Kitshoff adds:

They reflect the soul of [a] people seeking ecclesiastical independence, . . . desiring to express their religious faith in an African-oriented manner, . . . seeking for holistic health, . . . desiring to be moved by the spirit as they understand and experience it, people who by self-help and mutual aid try to free themselves from their material misery, people who had sought a place to feel and call home and have found it in the AIC.<sup>106</sup>

This explains why most AICs are syncretistic because they draw their faith and practice freely from both Christianity and African Traditional Religion (ATR). Not surprisingly, their healing methods appeal to faith and prayer as well as to culture and ritual.

Confident of their European culture and religion, some Western missionaries failed to see the deep connection between African spirituality and its culture.<sup>107</sup> Their ethnocentric perspective had a negative impact upon the African mission work because

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<sup>103</sup>John S. Pobee and Gabriel Ositelu II, *African Initiatives in Christianity: The Growth, Gifts, and Diversities of Indigenous African Churches—A Challenge to the Ecumenical Movement* (Geneva, Switzerland: World Council of Churches, 1998), 76.

<sup>104</sup>Ibid.

<sup>105</sup>H. W. Turner, “A Typology of African Religious Movements,” *Journal of Religion in Africa* 1 (1967): 17.

<sup>106</sup>Mike Casparus Kitshoff, “Introduction,” in *African Independent Churches Today: Kaleidoscope of Afro-Christianity*, ed. Mike Casparus Kitshoff, African Studies (Lewiston, NY: Edwin Mellen Press, 1996), 2.

<sup>107</sup>Ibid., 3.



their religion was seen as alien and/or superficial to African adherents.<sup>108</sup> Since the local people yearned for political independence and self-determination, these African Christians also broke away from the Western churches often seen as colonial churches to form autonomous churches.<sup>109</sup>

Since “the history of the Christian church in Botswana is not widely known,”<sup>110</sup> this section will briefly outline the beginning, development, and impact of the Botswana’s AICs, especially in connection with health-care.

In most cases “Tswana rulers tended to permit only one denomination access to their domains.”<sup>111</sup> In 1879, the Bamangwato King Khama III denied several Catholic missionaries access to his domain reasoning that “if both religions, the Catholic and Protestant, are the same we obviously only need one of them. If they are different, then there will be strife between them and that could cause divisions among my subjects.”<sup>112</sup> It is likely that his allies, the LMS missionaries, prompted Khama III to develop such an approach.

Certain church-state relationships restricted certain mission society programs.

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<sup>108</sup>Kofi Abrefa Busia, “Has the Christian Faith Been Adequately Represented?,” *International Review of Mission* 50 1 (1961): 89.

<sup>109</sup>Tinyiko Sam Maluleke, “African Christian Theologies,” in *African Christianity: An African Story*, ed. Ogbu U. Kalu, Perspectives on Christianity (Pretoria, South Africa: University of Pretoria, 2005), 487.

<sup>110</sup>Don Rempel Boschman, “Religious Freedom in Botswana: The Cases of the Zion Christian Church and the Nazareth Church of Botswana,” in *African Independent Churches Today: Kaleidoscope of Afro-Christianity*, ed. Mike Casparus Kitshoff, African Studies (Lewiston, NY: Edwin Mellen Press, 1996), 37.

<sup>111</sup>Isaac Schapera, “Christianity and the Tswana,” *Journal of the Royal Anthropological Institute* 83 1 (1958): 1.

<sup>112</sup>Boschman, “Religious Freedom in Botswana: The Cases of the Zion Christian Church and the Nazareth Church of Botswana,” 39.

Since within the LMC territories it was difficult for African Christians to freely express their grievances, a separation from the main traditional church denomination was inevitable.

The first known AIC in Botswana was the King Edward Bangwaketse Free Church.<sup>113</sup> In 1902, Mothowagae Motlogelwa and a group of followers reportedly left the LMS church, when he was refused ordination.<sup>114</sup> Another significant development in the growth of AICs in Botswana was the establishment in 1937 of the Zion Christian Church (ZCC) at Mochudi village, which is currently one of the largest AICs countrywide, and which is also known for its faith-healing practices. A disagreement between the Dutch Reformed Church (DRC) and a politically motivated Bakgatla Chief led to secession to the main ZCC in South Africa.<sup>115</sup>

Currently, AICs have grown substantially, and neither the government nor the traditional mainline churches can ignore them any longer. “There are approximately 160 African Independent (AIC) [*sic*] Churches in Botswana. Of these groups about half are of apostolic tradition”<sup>116</sup> and comprise 30 percent of Christian churches in Botswana.<sup>117</sup>

This is significant and has become a challenge for mission-founded congregations to retain membership and maintain doctrinal loyalty within their churches, as they are

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<sup>113</sup>Sillery, *Botswana: A Short Political History*, 119.

<sup>114</sup>Boschman, “Religious Freedom in Botswana: The Cases of the Zion Christian Church and the Nazareth Church of Botswana,” 40-41.

<sup>115</sup>Lagerwerf, *They Pray for You . . . ' Independent Churches and Women in Botswana*, 35.

<sup>116</sup>Froise, *World Christianity: Southern Africa—A Factual Portrait of the Christian Church in South Africa, Botswana, Lesotho, Namibia, and Swaziland*, 17.

<sup>117</sup>*Ibid.*, 13.

constantly challenged by the AICs. These two ecclesiastical systems are constantly in tension with one another, especially in the areas of doctrine and healing. AIC practices of faith-healing have also challenged government and medical institutions during the HIV/AIDS pandemic.<sup>118</sup>

On the other hand, might there be medical and healing practices of AICs that could complement those of traditional and Western doctors?<sup>119</sup> This question is significant since Botswana have exposed themselves to medical pluralism, visiting both African traditional healers and the Western-trained doctors.

#### Botswana Union Mission of the Seventh-day Adventist Church

For the context of this study it is important to understand the social and cultural context of the Adventist Church—the pioneers of medical mission in Botswana. The Botswana Union Mission (BUM) is the national church administrative unit.<sup>120</sup>

Out of a total country population of 2,033,000, there are 31,781 Adventists, who constitute only 1.56%.<sup>121</sup> In 2001, Adventists were the second largest Protestant Church in Botswana, signifying continuous growth.<sup>122</sup>

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<sup>118</sup>For more detail, see Jorum G. Ndaba and D. J. Kruythoff, “Risky Healing Practices in Botswana Independent Churches,” abstract, U. S. National Library of Medicine, <http://gateway.nlm.nih.gov/MeetinAbstracts/102200213.html> (accessed July 7, 2007).

<sup>119</sup>See chapter 5 for more details on AICs and how they could complement traditional and Western medicine.

<sup>120</sup>The BUM, together with seven other unions in neighbouring countries, is accountable to the Southern Africa Indian Ocean Division (SID), which is headquartered in Pretoria, South Africa.

<sup>121</sup>General Conference of the Seventh-day Adventists, *Seventh-day Adventist Yearbook* (Washington, DC: Review and Herald, 2013), 334.

<sup>122</sup>*World Christian Encyclopedia: A Comparative Survey of Churches and Religions in the Modern World*, 2nd ed., s.v. “Botswana.”

The Adventist Church membership and geographic distribution seem to follow the national pattern, territorially. “The urbanization process in Botswana is primarily fueled by the influx of migrants from the rural areas rather than a natural increase in the existing urban population.”<sup>123</sup> Therefore, there is a higher concentration of Adventists in urban cities/towns and semi-urban villages than in rural areas.<sup>124</sup>

Membership and geographic distribution for the Adventist Church is significant because the church depends on the members’ tithe and freewill offering for sustenance.<sup>125</sup> However, the colossal and soaring hospital medical operating costs are far beyond church members’ contributions.

The Adventist Church’s role in social areas such as medical services, education, and HIV/AIDS interventions is notable. The church’s social responsibility comes through its medical, educational, and ecclesial institutions. Currently, it operates a number of medical institutions such as Kanye Seventh-day Adventist Hospital (KSDAH), Kanye College of Nursing,<sup>126</sup> Moshupa Adventist Clinic, and the Botswana Adventist Medical Services (BAMS).

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<sup>123</sup>Bayo Ijagbemi, “Perspectives on African Urbanisms: ‘New Methodologies’—Beyond a Baseline Survey: Development of a Sampling Technique for an Urbanization Study in Africa,” *Journal of Political Ecology* 10, no. 2 (2003): 57-58, [http://jpe.library.arizona.edu/volume\\_10/Ijagbemi2003.pdf](http://jpe.library.arizona.edu/volume_10/Ijagbemi2003.pdf) (accessed July 2, 2007). Though Ijagbemi’s observations do not directly refer to specific migratory patterns of Adventist members, it is reasonable to presume the same movements occurred since Adventists are part and parcel of the socio-structure and subject to the same needs and challenges faced by the rest of the citizenry.

<sup>124</sup>This is my observation based on my years of pastoral service in Botswana: 1996-2005.

<sup>125</sup>For details on the Adventist Church financial accrurement system, see General Conference of the Seventh-day Adventists, *Working Policy 2008-2009* (Hagerstown, MD: Review and Herald, 2009), 139.

<sup>126</sup>For more detail on the hospital and the college, see Saleem Faraq, “Modernization Completed at Botswana Hospital: Upgrading Keeps Pioneering Kanye Facility at the Forefront,” *Adventist Review*, October 27, 1998, 27.

KSDAH and other Christian medical private mission hospitals initially charged pay-for-service fees until they “agreed to a government request in 1975 to operate as district hospitals. They also agreed to charge [only] a token fee for their services as the government [agreed] to subsidize them.”<sup>127</sup> Thus began a long-term, largely mutual partnership between the state and the church-operated medical institutions. This relationship however created a dependency syndrome, which stymied their ideological and philosophical growth.

The Adventist Church has had a limited impact on Botswana society through its traditional school system.<sup>128</sup> Some schools were established, but they did not endure long, owing to financial constraints.<sup>129</sup> The church’s quest for schools was revived in 2003 when the Mogoditshane Adventist Primary School was founded.<sup>130</sup> “Before this project, [the] Adventist Church’s contribution to development in Botswana was mainly in the health sector through its hospital and Institute of Health Sciences built in Kanye in 1922.”<sup>131</sup>

HIV/AIDS has affected and claimed the lives of Christians, including Adventists. A study was carried out to determine “the knowledge, attitudes and practices of

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<sup>127</sup>Daisy Pholo, “Government Considering Concerns of Non-Industrial Class,” *Daily News* May 24 (2000), <http://www.gov.bw/cgi-bin/news.cgi?d=20000524> (accessed July 5, 2007).

<sup>128</sup>*SDA Encyclopedia*, 1976 ed., s.v. “Botswana.”

<sup>129</sup>Kenaope Kenaope, “A Church Growth Study and Strategy for the Botswana Seventh-day Adventist Church” (D.Min. dissertation, Andrews University, 2003), 28.

<sup>130</sup>Consistent with Adventist educational aims, the schools in Botswana are meant to provide holistic education that appeals to students’ mental, physical, and spiritual faculties.

<sup>131</sup>BOPA, “SDA Church Opens School in Mogoditshane,” *Daily News* November 24 (2004), <http://www.olddailynews.gov.bw/cgi-bin/news.cgi?d=20041124> (accessed October 2007).

[Adventist] Youth related to abstinence or condom use to prevent HIV/AIDS.”<sup>132</sup> In the study,

the majority of the participants feel abstinence . . . is a realistic prevention method and recommend it to be used by Christians. However, 50% . . . believe those who cannot abstain . . . be allowed to use condoms. Forty two percent admit to having used condoms at least once and only 20% are currently using condoms as opposed to 80% who are abstaining or not using them.<sup>133</sup>

It is evident that the church’s youth are vulnerable. If church youth find abstinence a challenge, what more of their secular peers? There is an inevitable clash between government and the church policies over condom usage by unmarried people.<sup>134</sup> Obviously, both parties need each other and must urgently enter into dialogue, if only to save lives.

To address the HIV/AIDS challenge, the Adventist Church took several steps, including: (1) staging periodic awareness marches, (2) conducting premarital and marriage seminars, and (3) organizing home-based care programs for HIV/AIDS patients. The church’s local conference in the south established an HIV/AIDS Counseling Center at its headquarters in Mogoditshane.<sup>135</sup>

### **Missiological Implications**

History has shown that African traditional medicine has been the primary health-

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<sup>132</sup>Poloko Kebaabetswe, “Christians Fight against HIV/AIDS: Conduct Versus Condom,” *Second National AIDS Conference* (2000), [http://www.aids.harvard.edu/conferences\\_events/2000/botswana\\_abstract.pdf](http://www.aids.harvard.edu/conferences_events/2000/botswana_abstract.pdf) (accessed February 15-18, 2000).

<sup>133</sup>Ibid.

<sup>134</sup>Maranyane Kgwanaamotho, 2012. “Hospital Gives Condoms to Married People Only,” *Mmegionline*, <http://www.mmegi.bw/index.php?sid=1&aid=143&dir=2012/October/Friday5> (accessed October 5, 2012).

<sup>135</sup>Strike Ben, interview by author, Gaborone, Botswana, June 15, 2009.

care method for African individuals and communities. The operation of this health-care system can be seen in how the Ngwato tribe has tried inoculating children against smallpox—albeit inadequately.

Unfortunately, most Western medicine practitioners found no value in this rudiment of knowledge. Instead, the missionaries and medical practitioners demonized the traditional healing system, labeling the practice evil. This was because, central to African traditional healing, was the reliance to a large extent on ancestral revelations for the diagnosis of disease. The result was that Western medicine failed in part to see the psycho-social-spiritual needs of Africans in treating them. Paul Hiebert identifies this phenomenon as the “flaw of the excluded middle,” in which the Western two-tiered view of reality (science and religion) has a cultural veil that hinders recognition of the existence of ghosts, ancestors, and spirits.<sup>136</sup>

The challenge for Christian mission, especially medical mission, is to find ways and means to bridge African traditional medicine and religion, by trying to develop a holistic approach to healing. This can be done if the holistic framework, which is culturally sensitive and biblically relevant, informs the Church’s theology of mission.

The African Independent Churches (AICs) have attempted to “correct” the “flaw of the excluded middle.” The AICs recognized that since missionary and government medical systems did not take into account socio-cultural and religious meanings of illness, they integrated allegiance to their traditional beliefs into medical treatment. This is part of the very reason why AICs broke away from mission-founded churches, in order

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<sup>136</sup>Paul G. Hiebert, *Anthropological Reflections on Missiological Issues* (Grand Rapids, MI: Baker Books, 1994), 196.

to enable them to integrate worship and healing in a culturally relevant way. In essence, both traditional and AICs health-care practices reinstated the “self-image and socio-cultural identity” of Africans.<sup>137</sup>

It is of significance for this study to see that among traditional *Batswana* the AIC health-care practices have tried to compensate for the flaw of the excluded middle. They have tried to deal not only with the medical, but also spiritual or social needs of people in their approach. Medical missions certainly did fall short of satisfying the unmet needs of Africans in their quest for holistic healing. This gives rise to a pertinent missiological question: “How do medical missions deal with the excluded middle?” Until this question is addressed, medical missions will end up indistinguishable from secular Western (government) medicine. Should that be the case, the former’s relevance and original purpose will be questionable.

Since Botswana has at least thirty distinct ethnic groups, a careful anthropological and cultural study is necessary to help health-care workers in mission as well as government services to provide cultural relevance and sensitivity interventions.

Developing a holistic theology of mission will help medical mission practitioners in how to deal with the issue of the excluded middle, such as in the areas of HIV/AIDS, sexual risk behavior, and distribution of condoms. The Adventist medical mission is a significant part of this wider society. Bringing about a change in sexual attitudes and practices may not be achieved solely by medical means. The moral aspect of the Adventist mission will be a very important tool in addressing the challenge of HIV/AIDS.

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<sup>137</sup>C. Anyinam, “Availability, Accessibility, Acceptability, and Adaptability: Four Attributes of African Ethno-Medicine,” *Social Science and Medicine* 25 (1987): 807.



Thus, understanding the health-care background of Botswana may help point to possible solutions to the health challenges the country faces.

Chapter 3 will look at the foundation of medical missions from the biblical and historical perspective. It will highlight how early Christian medical mission was culturally relevant, and how this could be relevant in building a contemporary model for Adventist medical mission. The chapter also discusses Adventist medical mission that was shaped by one of its pioneer leaders, Ellen G. White.

## CHAPTER 3

### BIBLICAL AND HISTORICAL MODELS OF CHRISTIAN MEDICAL MISSION

The previous chapter looked at the context of Christian and Adventist mission in Botswana. It brought out the need for a holistic approach to Adventist medical mission. In order to accomplish that, there is a need for the development of a relevant and focused theology of mission in Africa, with particular emphasis (in this case) on how to respond to the needs of the people who are deeply influenced by African Traditional Religions (ATRs) and African Traditional Medicine (ATM). Such theology needs to address issues of ancestors, spirits, and magic that are constantly shaping the life and practice of Africans.

This chapter will now attempt to explore a biblical and Christian medical mission paradigm from Old and New Testament perspectives and will try to apply it to modern medical mission work.

#### **Yahweh, Health, and Shalom in the Old Testament**

The Old Testament presents evidence that “there did exist a flourishing medical

practice in the Judaic-biblical background.”<sup>1</sup> Some regard the Bible as the first textbook of public health on personal and social hygiene.<sup>2</sup> God promised the Hebrews to put “none of the diseases” upon Israel that He “brought on the Egyptians for I am the Lord who heals you” (Exod 15:26). As Healer of Israel, God is in full control of diseases, having the power to “take away from you all sickness” (Deut 7:15a).

When the Israelites complained about the bitter water (Exod 15:22-25), “Yahweh intervened to sweeten the waters on their behalf. The episode is foundational to the theology of healing in the Old Testament, for through it, Yahweh revealed himself as healer (Hebrew *rope*).”<sup>3</sup> However, God’s promise to heal and protect Israel is conditional to her obedience to Him.<sup>4</sup> Even if they are disobedient, God remains their Healer—upon repentance.

Healing comes from God, whether through natural or supernatural means. As God heals Israel, this blessing must be passed on to other nations. In the calling of Abraham, God mandated Israel to bless other nations: “I will bless you and make your

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<sup>1</sup>Robert North, “Medicine and Healing in the Old Testament Background,” in *Medicine in the Biblical Background: And Other Essays on the Origins of Hebrew*, *Anelecta Biblica* (Rome, Italy: Editrice Pontificio Istituto Biblico, 2000), 9.

<sup>2</sup>Douglas Guthrie, *A History of Medicine* (London: Nelson, 1945), 30.

<sup>3</sup>Diane B. Stinton, “Jesus as Healer: Reflections on Religion and Health in East Africa Today,” in *Religion and Health in Africa: Reflections for Theology in the 21st Century*, ed. Adam K. A. Chepkwony, The Ecumenical Symposium of Eastern Africa Theologians (Eseat) (Nairobi: Paulines Publications in Africa, 2006), 14.

<sup>4</sup>John Wilkinson, *The Bible and Healing: A Medical and Theological Commentary* (Grand Rapids: Wm. B. Eerdmans, 1998), 55.

name great; and you shall be a blessing. I will bless those who bless you . . . and in you all the families of earth shall be blessed” (Gen 12:2-3). This text can be a fundamental building block for a Christian medical mission model.

In response to God’s love, Israel was supposed to share her knowledge of Yahweh and His laws with other nations. In the same way, medical missions’ task should involve bringing healing to the world communities, as well as the sharing of the good news of the kingdom of God. The result of such work would help bring eternal peace (or *shalom*).<sup>5</sup>

The prophet Isaiah describes the human condition as someone afflicted by sickness (Isa 1:5-6).<sup>6</sup> In response to this prophetic diagnostic, Paul Tillich recognizes health as the antidotal reality to disease:

The concept of health cannot be defined without relation to its opposite—disease. . . . Health is not health without the essential possibility and the existential reality of disease. In this sense, health is disease conquered, as eternally the positive is positive by conquering the negative. This is the deepest theological significance of medicine.<sup>7</sup>

While biomedicine’s etiology explains disease causation in pathogenic terms, the Old Testament describes it in terms of (dis)obedience to God’s laws. Throughout the OT—as well as the NT—it is a common perception among the Hebrews to say that disease is a consequence of the transgression of God’s laws (Ps 107:17, 19).<sup>8</sup> Repentance seemed to be a critical condition for the restoration and healing of a severed relationship with God.

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<sup>5</sup>Anton Elias Zoughbie, “Shalom in the Hebrew Bible Scripture: Semantic Study and Theological Implications” (PhD diss., Golden Gate Theological Seminary, 1994), 98-100.

<sup>6</sup>Douglas Webster, *The Healing Christ: Four Bible Studies* (London: Highway Press, 1963), 7.

<sup>7</sup>Paul Tillich, “The Meaning of Health 1961,” in *The Meaning of Health: Essays in Existentialism, Psychoanalysis, and Religion*, ed. Peter Lefevre (Chicago: Exploration Press, 1984), 173.

<sup>8</sup>Wilkinson, *The Bible and Healing: A Medical and Theological Commentary*, 55.

Obviously, there are also other reasons for sickness than personal disobedience to God.<sup>9</sup> D. S. Allister argues that

sometimes it is impossible to see any reason at all. But in every case the pastor, and the doctor if he believes in treating the whole person and is aware of the spiritual dimension, has the clear duty to help those to whom God may be speaking to hear, understand and obey his voice.<sup>10</sup>

Such a view makes it clear that humanity invariably needs spiritual healing as well as physical treatment. Sickness “cannot be adequately treated by material means alone. The place of religion in the healing of disease is becoming clearer . . . and groups of doctors and clergy are studying together the various aspects of human ills with which they are jointly concerned.”<sup>11</sup>

In this way, Christian medical mission plays an important role in providing holistic healing.<sup>12</sup> Every chaplain, doctor, nurse, or any other spiritual caregiver in Christian medical ministry needs to learn to point the ailing persons to God the Ultimate Healer, so that they come to experience *shalom*—that individual inner peace or wholeness, which only God could give.

People are constantly seeking wholeness in their lives. The word “wholeness” is

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<sup>9</sup>The term appears 397 and 89 times in the OT and NT, respectively. “Such heavy usage is a clear indication of how important a word it is—that it was a concept that permeated both Hebrew and early Christian thought.” Samuel J. Kottek, “Concepts of Disease in the Talmud,” *Korot* 9 1-2 (1985): 9.

<sup>10</sup>D. S. Allister, *Sickness & Healing*, Latimer Studies, vol. 11 (London: Latimer House, 1991), 17.

<sup>11</sup>Alfred H. P. Fox, *The Church's Ministry of Healing* (London: Longmans, 1959), 104.

<sup>12</sup>Richard Rice, “Toward a Theology of Wholeness: A Tentative Model of Whole Person Care,” in *Spirituality, Health, and Wholeness: An Introductory Guide for Health Care Professionals*, ed. Siroj Sorajjakool and Henry Lamberton (Binghamton, NY: Haworth Press, 2004), 17.

usually associated with the term “*shalom*.”<sup>13</sup> Jonathan P. Sisson, in reference to “the lament in Psalm 38:4,” points out that “the petitioner complains: ‘There is no soundness (*èn-salôm*) in my bones’ (v 4b), by which a state of ill health is certainly meant. When the reason for this condition is cited—‘because of my sins’ (v 4b)—we recognize that the illness was understood as a result of a violation of the order of creation.”<sup>14</sup> Thus the human quest for healing from disease can be understood in the light of the same biblical term “*shalom*.”

Pattison defines “wholeness” as “reconciliation, peace, joy, the integration of opposites, and complete harmony of body, mind, and spirit, as well as unity within and between individuals and communities at all levels.”<sup>15</sup> However, the

primary objection to the prominent use of ‘wholeness’ as a leading concept in considering illness and healing is that it tends to trivialize, spiritualize and to make ethereal what appear . . . to be the real struggles and conflicts which surround and express themselves in illness and healing.<sup>16</sup>

For Pattison, illness and health need not be confined to the spiritual at the exclusion of the physical and environmental factors, but balance is needed for *shalom* to be achieved. It is this concept of “*shalom*” which describes “this sphere and this notion of a people living consistently with their primal experience of a life born of divine

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<sup>13</sup>Shalom Bible Study, “Shalom—A Biblical Survey: The Pentateuch,” <http://www.piut.org/shalombiblestudy.htm> (accessed December 26, 2008).

<sup>14</sup>Jonathan Paige Sisson, “Jeremiah and the Jerusalem Conception of Peace,” *Journal of Biblical Literature* 105 3 (1986): 432.

<sup>15</sup>Stephen Pattison, *Alive and Kicking: Towards a Practical Theology of Illness and Healing* (London: SCM Press, 1989), 76.

<sup>16</sup>*Ibid.*

righteousness and compassion.”<sup>17</sup> Further, according to Wagner Kuhn, love is the essence that brings holistic transformation of a human being.<sup>18</sup>

The concepts of healing, wholeness, and especially *shalom* are significant elements in the development of a biblical mission model of a health ministry. According to Rice, “a Christian theology of healing, health, and wholeness . . . regards the ultimate cause of illness as sin, the fundamental disorder that affects all of human existence, and views the attempt to overcome illness and restore life to its fullness [*shalom*] as one aspect of God’s saving work in the world.”<sup>19</sup> Therefore, *shalom* at its most critical can function as a theology of hope . . . , for it can be a resource against both despair and an overly eager settlement for an unfinished system.”<sup>20</sup>

The concept of *shalom* can be traced back to Eden when humanity lived serenely and tranquilly. This peace was felt when “God saw everything that He made, and indeed it was very good (Gen 1:31a). The Hebrew word *tôb* good has in this context at least a twofold connotation, aesthetic and ethical goodness.”<sup>21</sup> It is the ethical part that requires a human moral response to God’s offer of salvation and restoration.

However, the Edenic *shalom* was tainted by the emergence of sin (Gen 3). According to Joseph Michael Savage, “the fracturing of *shalom*/health in the Psalms and

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<sup>17</sup>Paul D. Hanson, “War and Peace in the Hebrew Bible,” *Interpretation* 38 4 (1984): 347.

<sup>18</sup>Wagner Kuhn, *Redemptions & Transformation through Relief and Development: Biblical, Historical, and Contemporary Perspective of God’s Holistic Gospel* (Benton Harbor, MI: Patterson Printing, 2013), 223.

<sup>19</sup>Rice, “Toward a Theology of Wholeness: A Tentative Model of Whole Person Care,” 16.

<sup>20</sup>Walter Brueggemann, *Peace* (St. Louis, MO: Chalice Press, 2001), 5.

<sup>21</sup>Richard J. Middleton, “Created in the Image of a Violent God? The Ethical Problem of the Conquest of Chaos in Biblical Creation Texts,” *Interpretation* 58 4 (2004): 353.

Jeremiah is primarily of a spiritual nature, and restoration can only be obtained through obedience to Yahweh's covenant."<sup>22</sup> Thus medical mission needs to be viewed as a tool to restore the original *shalom*.

According to Olyan, medical mission needs to lead people to peaceful relations with God (Isa 54:10), friendly relations between individuals (Jer 20:10; 38:22), as well as health and well-being (Gen 43:27; 1 Sam 17:18) of their bodies and, more generally, to completeness (Jer 13:19), as well as soundness and safety (Ps 38:4).<sup>23</sup>

*Shalom*, therefore, will lead humanity to be at peace with God and also with one another. It is also a state of individual and communal welfare and well-being. Thus health to the people must be considered in holistic—physical, mental, spiritual, social, environmental, and economic—terms. This can be achieved when medical mission and other branches of the church will cooperate with each other to fulfill God's mission of restoration of people who are afflicted by sin.

### **Implications to the African Perspective**

Such a concept could help bridge the Hebraic-Hellenistic-Western understanding of health and healing with the African worldview. How would the Scripture be interpreted in the African cultural context? This section will try to probe “whether there is any correlation between the biblical concept of God and the African concept of God [*vis-a-vis* health]; between what God has and is doing according to biblical record and

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<sup>22</sup>Joseph Michael Savage, “Shalom and Its Relationship to Health/Healing in the Hebrew Scriptures: A Contextual and Semantic Study of the Books of Psalms and Jeremiah” (PhD dissertation, Florida State University, 2001).

<sup>23</sup>Sisson, “Jeremiah and the Jerusalem Conception of Peace,” 432.



teaching, and what God has done and is doing in Africa according to African traditional beliefs.<sup>24</sup> This is an attempt to expose the African context of healing to those concepts aligned to the Hellenistic-Western passages of Scripture, that is, with a Western interpretation.

African traditional beliefs about God share common ground with Christian beliefs. In fact, “African teachings on God are very close to those of the Old Testament.”<sup>25</sup> To the Africans, God is also known as the Supreme Being who is the Source of all power. He is the “‘Creator God,’ responsible for the primal origins of the world, nature, and humanity. God is considered to be the ground of everything that exists.”<sup>26</sup> However, the African perspective is at variance in some points with the Christian tradition.

For example, Africans do not perceive God to be working directly in their affairs, viewing Him as more transcendent than immanent. That is, “the God of Africans is said to be detached from human affairs . . . *Deus remotus*.”<sup>27</sup> Africans believe their God has His own agents who work with human beings—ancestral spirits whose “presence . . . in any given community augments the African spiritual understanding of the community.”<sup>28</sup>

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<sup>24</sup>Francis Anekwe Oborji, “Revelation and Salvific Value of African Religion,” in *Towards a Christian Theology of African Religion*, ed. Justin Clemency Nabushwawo (Eldoret, Kenya: AMECEA Gaba Publications, 2005), 79.

<sup>25</sup>Charles Nyamiti, *African Tradition and the Christian God* (Eldoret, Kenya: Gaba Publications, 1977), 5.

<sup>26</sup>Edley J. Moodley, *Shembe, Ancestors, and Christ: A Christological Inquiry with Missiological Implications*, American Society of Missiology Monograph Series 2 (Eugene, OR: Pickwick Publications, 2008), 35.

<sup>27</sup>*Ibid.*

<sup>28</sup>Gwinyai H. Muzorewa, *The Origins and Development of African Theology* (Maryknoll, NY: Orbis Books, 1985), 12.

Ancestral spirits are believed to be the spirits of the dead. The Africans believe that their immediate dead are very much “alive” as spirits and are interested in their day-to-day lives.<sup>29</sup> Africans usually contact these “living dead”<sup>30</sup> for any messages to and from God. “The function of ‘*badimo*’ [ancestral spirits] is to ensure the good ordering of social relationships among the biological living, and the fertility and well-being of men, their crops and stocks. . . . Their attitude to the living is basically parental—protective, corrective and aimed at the welfare of the whole group.”<sup>31</sup>

Wellness and complete health to Africans must be understood in their original quest to restore the goodness, happiness, and providence that God had “at the beginning” set for them,<sup>32</sup> that is, before the disobedience of humanity “drove” God away to a distant abode. The Africans believe sickness is caused by a disharmony within the individual, neighbors, community, environment, nature, and the cosmos. Such disharmony affects their personal bodies, next of kin, livestock, farms, land, and so on. Their guardian spirit ancestors who may have been offended by their living descendants may also cause sickness.

Africans also believe that other spirit ancestors that are bent on evil may be the

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<sup>29</sup>One renowned African scholar calls these spirits “the living dead.” See John S. Mbiti, *Concepts of God in Africa* (London: SPCK, 1970), 179.

<sup>30</sup>For more detail on the “living dead,” see Joe M. Kapolyo, “The Human Condition through African Eyes: Traditional African Perspectives,” *Africa Journal of Evangelical Theology* 26 1 (2007): 32.

<sup>31</sup>Gabriel M. Setiloane, *The Image of God among the Sotho-Tswana* (Rotterdam, Netherlands: A. A. Balkema, 1976), 65.

<sup>32</sup>Muzorewa, *The Origins and Development of African Theology*, 15.

cause of their sickness.<sup>33</sup> These spirits work through the medium of witches and sorcerers to cast evil spells on targeted people. Displeased ancestors and other spirits are the main cause for fear in Africans.<sup>34</sup> The Supreme Being may also be the cause of calamities.<sup>35</sup>

In seeking healing, Africans look for protection from all the potential causations of any disharmony. They constantly have to check what is the pleasure of their guardian ancestral spirits—have they done well so far or have they offended them? If they have offended them, then what could they do to calm the spirits? Ancestors could reveal their wishes through dreams of a senior (or any) member of the family or clan. The family, in turn, could visit a traditional doctor who then will consult the spirit ancestors. Africans will then be obligated to offer sacrifices and offerings,

which are acts of restoring the ontological balance between God and man, the spirits and man, and the departed living. When this balance is upset, people “experience” misfortunes and sufferings, or fear that these will come upon them. . . . The departed, who are still remembered personally by someone in their family, are chiefly the recipients of sacrifices and offerings from the family group.<sup>36</sup>

Thus the “treatment of any illness is both a physical and a spiritual exercise. Unlike biomedicine, African systems of healing treat illness in a socio-cultural context where the spiritual plays an integral part.”<sup>37</sup> While the African approach to healing is

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<sup>33</sup>John S. Pobee, *Toward an African Theology* (Nashville, TN: Abingdon, 1979), 64. This is not good for the Africans because it is part of the reason they live in fear.

<sup>34</sup>Mbiti, *Concepts of God in Africa*, 179.

<sup>35</sup>Klaus Nürnberger, *The Living Dead and the Living God: Christ and the Ancestors in a Changing Africa* (Pietermaritzburg, South Africa: Cluster Publications, 2007), 31.

<sup>36</sup>Mbiti, *Concepts of God in Africa*, 179.

<sup>37</sup>Kapolyo, “The Human Condition through African Eyes: Traditional African Perspectives,” 36.

holistic, it is clear that the foundation upon which it is built is not biblical. Therefore the solution is to develop a theology of mission and healing that will consider all the aspects of human needs and concerns.

### **Jesus and Medical Mission**

Willard Swartley, in describing the Old Testament background to the New Testament word for *shalom*, says, “*Shalom (shalóni)*, the Hebrew word for *peace* has many dimensions of meaning: wholeness, completeness, well-being, peace, *justice*, salvation, and even prosperity.”<sup>38</sup> Thus, the concept of *shalom* in the New Testament resonates with that in the Old Testament.

Jesus was announced in the Old Testament as “the Prince of Peace” (Isa 9:6). Hence, Jesus is the “Prince of *Shalom*” for only He is capable of enacting *shalom* in its fullness. It is the same “‘Prince of Peace’ [that] will bring ‘endless peace’ and ‘establish and uphold it with justice and with righteousness . . . forevermore’” (Isa 9:6d-7).<sup>39</sup>

Jesus breathes out . . . his gift of peace. . . . Jesus sends the humble disciples out to radiate that very same creative peace to the world . . . to make their *each and every step* a step of peace.’ . . . *Shalom* is both gift and mission. . . . The disciples are sent out to leave the footprints of God’s peace everywhere they go.<sup>40</sup>

Jesus is central to the theme of *shalom* in the New Testament as much as Yahweh is in the Old Testament. “Jesus’ healing miracles must be seen clearly as bestowing the gift of *shalom*, wholeness, to those who lacked it, bringing not only physical health but

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<sup>38</sup>Willard M. Swartley, “The Relation of Justice/Righteousness to Shalom/Eirene,” *Ex Auditu* 22 (2006): 31.

<sup>39</sup>Ibid.

<sup>40</sup>Brian J. Pierce, “Prophets of the Shalom of God,” *The Living Pulpit*, December 2006, 4.

renewed membership in the society of YHWH.”<sup>41</sup> Medical mission in the New Testament era played a substantial part in the reconciliation of humanity to God. “We are sent as wounded prophets to breathe the *shalom* of God into the broken heart of our world.”<sup>42</sup>

Thus it is in this context that Christian medical mission needs to be perceived as an agency God uses in the restoration of *shalom* to the people of this world. Medical mission has a broader task than mere physiological healing of the sick; there is a close relationship between salvation and healing. Tillich explains,

When salvation has cosmic significance, healing is not only included in it, but *salvation can be described as the act of ‘cosmic healing.’* . . . In Matthew 9:22, the English translation of *sesoken se* (‘he saved thee,’ referring to the act of healing by Jesus) reads: ‘made thee whole.’ Salvation is basically and essentially healing, the re-establishment of a whole that was broken, disrupted, disintegrated.<sup>43</sup>

Salvation then is the ultimate restoration of God’s *shalom*. Medical mission therefore needs to participate in this act of “cosmic healing”—not just of personal physical healing, but extending to the “healing of the nations,” the poor, the unjustly treated, and the environment. In a pointed way, medical mission is a participant in the Church’s program “[in which] the healing ministry . . . embraces the whole man in all departments of his life.”<sup>44</sup>

Thus, “Christianity introduced a ‘revolutionary change’ in the outlook on disease

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<sup>41</sup>Stinton, “Jesus as Healer: Reflections on Religion and Health in East Africa Today,” 19.

<sup>42</sup>Ibid., 5.

<sup>43</sup>Tillich, “The Meaning of Health 1961,” 14.

<sup>44</sup>John Wilkinson, “Mission Charge to the Twelve and Modern Medical Missions,” *Scottish Journal of Theology* 27 3 (1974): 325.

by addressing itself, as ‘the religion of healing,’ especially to the weak and the sick.”<sup>45</sup> It needs to be Christianity’s aim to restore humanity fully in fulfillment of Jesus’ command since He “called His twelve disciples together and gave them power and authority over all demons, and to cure diseases. He sent them to preach the kingdom of God and to heal the sick” (Luke 9:1-2). Jesus sent His followers on a mission of *shalom*.

Medical mission scholars agree that Jesus inaugurated mission through His disciples. This “became the justification for the medical missionary movement which arose within the Protestant Church in the eighteenth and nineteenth centuries.”<sup>46</sup> John Wilkinson identifies a “group of imperatives usually known as the Mission Charge to the Twelve Disciples,”<sup>47</sup> in the synoptic Gospels (particularly from Matt 10:5-15): (1) go to the lost sheep of the house of Israel (vv. 5, 6), (2) preach as you go (v. 7), including a call to repentance (Mark: 6:12); (3) heal the sick (v. 8), (4) cleanse the lepers (v. 8), (5) cast out demons (v. 8).<sup>48</sup>

Though Wilkinson concludes that the group of imperatives had a local pre-resurrection application and does not see them applicable to modern medical mission, he admits that the “modern medical missions are just as certainly confined to a definite historical situation as the Mission Charge to the Twelve was.”<sup>49</sup> Because Jesus gave the ultimate “Mission Charge” after His resurrection—known as the Great Commission

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<sup>45</sup>Immanuel Jakobovits, *A Comparative and Historical Study of the Jewish Religious Attitude to Medicine and Its Practice* (New York: Bloch Publishing, 1975), 1.

<sup>46</sup>Wilkinson, “Mission Charge to the Twelve and Modern Medical Missions,” 313.

<sup>47</sup>Ibid.

<sup>48</sup>Ibid., 313-317.

<sup>49</sup>Ibid., 321.

(Matt 28:18-20)—medical mission can still make the claim for the charge to the Twelve.

Others also see a direct correlation between the “Mission Charge” and medical missions. For example, Harold Remus writes:

Jesus sends his followers out to heal. . . . There are numerous other Christian sources, beginning with the letters of Paul and continuing on into the Middle Ages, that constitute indirect sequels to Jesus’ healings in the New Testament gospels—responses . . . to the charge given to his earliest followers. These various sources make clear that early Christians viewed his healings as set forth in the gospels not as once-for-all manifestations of God’s power and life, but as something continuing, and to be continued.<sup>50</sup>

However, due to limitations that His followers have, medical mission requires teamwork, for instance, between the chaplain and the physician.

According to Dr. H. M. Scudder (19<sup>th</sup>-century medical missionary to India), medical work is (1) the union of preaching and healing that harmonizes with the example of Christ, (2) physical help which aids the reception of the spiritual message, and (3) a peculiar opportunity for manifesting Christian love.<sup>51</sup> Medical mission, then, is a harmonious blending of preaching and healing that will bring physical and spiritual salvation to the communities being served. The physician complements and co-works with the preacher, as both are equal witnesses for Christ.

It should be noted that the “Great Commission” by itself is not medical mission. The former is broader than the latter since healing does not come only through medical mission. “Physical healing is available to some in this life based on the power of God in Christ to heal, and it is the duty of Christian people who fall ill to seek healing through

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<sup>50</sup>Harold Remus, *Jesus as Healer: Understanding Jesus Today* (Cambridge, UK: Cambridge University Press, 1997), 96.

<sup>51</sup>Dodd, *The Gift of the Healer: The Story of Men and Medicine in the Overseas Mission of the Church*, 24-25.

means which are [biblical and] available whether those means are medical or non-medical, physical or spiritual.”<sup>52</sup>

Jesus arrives into first-century Palestine with a clear mission. He was named as Jesus because “He will save people from their sins (Matt 1:21).” At the beginning of His ministry He began to preach, “Repent: for the kingdom of God is at hand. (Matt 4:17).” Jesus’ ministry aimed at restoring God’s *shalom* in this world and the eternal world to come. Thus, Jesus had come to earth “that they might have life, and that they might have it more abundantly” (John 10:10b).

After the calling of the twelve disciples, “Jesus went about all Galilee, teaching in their synagogues, and preaching the gospel of the kingdom, and healing all manner of sickness and all manner of disease among the people” (John 4:23). Using the power of God, Jesus was an established Healer beyond the borders of Galilee whose “fame went throughout all Syria: and they brought to Him all the sick people who were afflicted with various diseases and torments, and those who were demon-possessed, epileptics, and paralytics, and He healed them” (v. 24).

John Pilch observes that “in western, scientifically-oriented cultures, therapies are etiological, that is, they focus on the causes of diseases: germs or viruses.”<sup>53</sup> He contrasts such cultures with those “that are not scientifically oriented, [where] therapies are symptomatic, that is, aimed at alleviating or managing the symptoms.”<sup>54</sup> Even though

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<sup>52</sup>John Wilkinson, “Physical Healing and the Atonement,” *The Evangelical Quarterly: An International Review of Bible and Theology* 63 2 (1991): 167.

<sup>53</sup>John J. Pilch, *Healing in the New Testament: Insights from Medical and Mediterranean Anthropology* (Minneapolis, MN: Augsburg Fortress Press, 2000), 13.

<sup>54</sup>Ibid.



during the time of Jesus the science of etiology was not known, there was a belief that disease was caused by individual sin or came as a divine initiative (John 9:1-3).

But was Jesus never concerned about scientific causes? When His disciples asked Him about the man born blind, “Rabbi, who sinned, this man or his parents?” Jesus replied that neither had, and furthermore, that was not the point (John 9:1-41). Pilch argues that “even in stories of demon-possession, the demon is not the cause but rather the manifestation of the misfortune, the symptom. Jesus’ exorcisms are thus symptomatic rather than etiological therapies.”<sup>55</sup>

However, Pilch’s position that Jesus was only concerned with symptoms and not causes is flawed.<sup>56</sup> First, Jesus has the power to heal any form of ailment, disease, or condition regardless of its etiology because “all authority has been given to Me in heaven and on earth” (Matt 28:18). Medical mission, as well as other agents of God’s mission, may claim this authority because Jesus “gave [the twelve disciples] power over unclean spirits, to cast them out, and to heal all kinds of sickness and all kinds of disease” (Matt 10:1).

Miraculous healings are a unique dimension Jesus used as one of His healing methods. Western medical practitioners generally do not have a place for this method.

However, Christian medical missions believe that God heals using His own power.

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<sup>55</sup>Ibid.

<sup>56</sup>While Jesus did not approach healing of any kind from a modern scientific perspective, some of the diseases he healed had an etiology that modern medicine could identify. Nevertheless, demonization has a different etiology than that which modern science accepts. When Jesus healed spiritually oppressed people, he was concerned with the spiritual etiology behind the symptoms. Merely helping victims to stop shouting or frothing at the mouth would have been an incomplete, non-holistic healing. Thus, Pilch is wrong to say Jesus cared only for symptoms, but is right to say Jesus did not care for scientifically verifiable etiology.

Second, if modern medical mission wants to treat the whole person it needs to address spiritual, demonic, and social etiology. Thus, demon possession and culture-bound fear treatments must give room for supernatural healing through prayer. In medical anthropological quarters such conditions are known as culture-bound or culture-specific syndrome, defined as “a combination of psychiatric and somatic symptoms that are considered to be a recognizable disorder only within a specific society or culture.”<sup>57</sup>

It would be important that chaplains and pastors help to infuse the medical missionary spirit in all health-care staff regardless of rank. Failure to do this would be a concession to the secularization of Christian medical practice. The secular “bio-medical specialists tend to ignore the sick person’s account of the [faith] experience and prefer to rely on laboratory tests for the ‘truth.’”<sup>58</sup>

When Jesus came to this earth, He found a broken world far from the ideals of *shalom*. He found imperfect beings under the weight of sickness, disease, injustice, prejudice, oppression by evil spirits or by fellow human beings, etc., as well as people who were slaves of sin and in a deplorable condition. All this brought sadness and stirred compassion in Him. Therefore the “healing ministry of Jesus was an expression of his compassion for those who were sick and afflicted.”<sup>59</sup>

The expression “the compassion of Jesus” has been widely used, albeit with little

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<sup>57</sup>Devika Dibya Choudhuri, Azara Santiago-Rivera, and Michael Tlanusta Garrett, *Counseling & Diversity* (Belmont, CA: Brooks/Cole, 2012), 46, 57.

<sup>58</sup>Pilch, *Healing in the New Testament: Insights from Medical and Mediterranean Anthropology*, 21.

<sup>59</sup>W. Meredith Long, *Health, Healing, and God’s Kingdom: New Pathways to Christian Health Ministry in Africa* (Wheaton, IL: Regnum Books International, 2000), 75.

understanding of its true depth. Further elucidation will help.

The verb *splanchnizomai* . . . is derived from the noun *splanchnon*, and is the strongest word for pity. In its plural form *splanchna*, this noun is used to denote inward parts of the body particularly the upper . . . organs such as the heart . . . which were the seat of emotions and the affections. The verb . . . means ‘to be moved in the inward parts’, that is, to feel sympathy, pity or compassion for a person in the deepest part of one’s being.<sup>60</sup>

In the NT, Jesus’ ministry was distinguished with compassion to His followers and others. “He was moved with compassion on them, because they fainted, and were scattered abroad, as sheep having no shepherd” (Matt 9:36).<sup>61</sup> H. J. M. Nouwen et al. explain that

the compassion that Jesus felt was obviously something quite different from superficial or passing feelings of sorrow or sympathy. Rather it extended to the most vulnerable part of his being. It is related to the Hebrew word for compassion, *rachamim*, which refers to the womb of Yahweh. Indeed, compassion is such a deep, central, and powerful emotion in Jesus that it can only be described as movement in the womb of God.<sup>62</sup>

Medical mission that is void of such compassion does not represent Christ, for “compassion gives birth to acts of mercy and grace. God’s kingdom broke into history not as a doctrine, but as an encounter between Jesus and those who came to Him for healing.”<sup>63</sup> The disciples of Jesus took His example of compassion and applied it in their later ministries to the sick and needy.

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<sup>60</sup>Wilkinson, *The Bible and Healing: A Medical and Theological Commentary*, 98.

<sup>61</sup>See also Matt 14:14 and Mark 1:41, 6:36.

<sup>62</sup>H. J. M. Nouwen, D. P. McNeil, and D.A. Morrison, *Compassion: A Reflection on the Christian Life* (New York: Doubleday, 1983), 16.

<sup>63</sup>Long, *Health, Healing, and God’s Kingdom: New Pathways to Christian Health Ministry in Africa*, 110.

## Implications to the African Perspective

A Supreme God is common to both the Christian and African tradition, but the name Jesus is alien to the latter. If Jesus were to ask tradition-oriented African scholars, “But who do you say that I am?” (Luke 9:20), most likely some would identify Jesus through the lens of their ancestors. For example, John S. Pobee links Jesus with ancestors:

In Akan society the Supreme Being and the ancestors provide sanctions for the good life and punish evil. . . . Our approach would be to look on Jesus as the Great and Greatest Ancestor. . . . He is superior to the other ancestors by virtue of being closest to God and as God. . . . He has authority over not only the world of men but also of all spirit beings, namely the cosmic powers and the ancestors.<sup>64</sup>

Pobee is contextualizing the image and person of Jesus as the Greatest Ancestor.<sup>65</sup> He however “is careful to stress that the Christian belief [is] that Christ is the preexistent agent of creation. This is the distinctively Christian claim which has no parallel in Akan [African] religion.”<sup>66</sup>

Traditional Africans will understand this message much better as it resonates with their worldview of spirit ancestors. However, the challenge comes when they begin to embrace Christianity. The biblical ancestors are not known to have consciousness after

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<sup>64</sup>Pobee, *Toward an African Theology*, 94. Pobee’s view that Jesus is the Greatest Ancestor superior to other ancestors echoes with how biblical characters viewed God in comparison to other gods. “Now I know that the Lord is greater than all the gods” (Deut 18:11); “For the Lord is . . . to be feared above all gods. For all the gods of the peoples are idols, but the Lord made the heavens” (1 Chr 16:25-26).

<sup>65</sup>Perhaps the questions that other scholars should ask is, “Does Pobee then accept the ‘lesser’ ancestors as God-recognized intermediaries?” While the biblical characters and texts say distinctly that God does not recognize the gods, can the same be said about the African spirit ancestors? African scholars are at variance on this issue with some answering in the affirmative and others in the negative. This question would make good research basis for further work outside this dissertation.

<sup>66</sup>Charles Nyamiti, “African Christologies Today,” in *Faces of Jesus in Africa*, ed. Robert J. Schreiter (Maryknoll, NY: Orbis, 1991), 7.

death. “For the living know that they will die; but the dead know nothing . . . for the memory of them is forgotten. Also their love, their hatred, and their envy have now perished; nevermore will they have a share in anything done under the sun” (Eccl 9:5-6).

In spite of this clear biblical text, Kwesi Dickson clearly assumes a consciousness of the African ancestors. He argues, “Christ was the perfect victim; by his death he merits, to use an African image, to be looked upon as Ancestor, the greatest of ancestors, who never ceases to be one of the ‘living dead,’ because there always will be people alive who knew him, whose lives were irreversibly affected by his life and work.”<sup>67</sup> An African ancestral Christology, which includes also a biblical understanding of the state of the dead, is thus needed to bring a balance between Christianity and African spirituality.<sup>68</sup>

I believe that Jesus Christ should be introduced to traditional Africans as the “Greatest Doctor” or Healer. Africans unswervingly seek the most powerful *nganga*<sup>69</sup> or *ngaka* (African traditional doctor) not only to heal them, but also to protect them from real, perceived, or potential harm and danger. Jesus needs to be presented as someone who possesses those qualities. He demonstrated that He could heal physical and also spiritual problems.

Jesus’ ability to exorcise evil spirits would certainly raise His acceptance in African traditional communities. The challenge is for Christian medical mission to use

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<sup>67</sup>Kwesi Dickson, *Theology in Africa* (Maryknoll, NY: Orbis, 1984), 197-198.

<sup>68</sup>This is important because Kwesi Dickson contradicts the biblical facts about the state of the dead. According to the Bible, the “living dead” neither exist nor do they have consciousness.

<sup>69</sup>For details on the healing and priesthood of the *nganga*, see John Parratt, *Reinventing Christianity: African Theology Today* (Grand Rapids, MI: William B. Eerdmans, 1995), 84-85.

that same power which Christ promised to give. Medical mission could achieve this by adopting a holistic approach to human sickness and suffering.

“The most prestigious task of the *nganga* consists of reconciling the social life of the village with the . . . water genies, water Ancestors, reconciling the village with the distant dead who have become active once more and who wander among the living.”<sup>70</sup> Presenting Jesus as the Water of Life (John 4:10) and the Living Water (John 7:38) will resonate with the African’s beliefs. Jesus Himself is not only a Healer, but also the Truth, Way, and Restorer of life (John 14:6). The African community would certainly embrace such a ‘*Nganga*’ for He has the complete solution to their problem.

Gabriel Setiloane however argues that African people who came to church via Christian health-care did not do so because they were coerced, but “because they have always understood that submitting one’s self to the healing practice of a ‘*ngaka*’ means also the acceptance and acknowledgement of ‘*badimo*’ and other spiritual powers who sponsor, support, [and] prosper his skill and prowess.”<sup>71</sup> He seems to imply that Jesus could be accepted as a *Nganga* within the corpus of other *ngangas*—something that could explain the reason why Africans consult multiple health systems that are available to them. However, the challenge to Christian mission is to present Jesus as a distinct Healer. It is only by offering a holistic approach that Christian medical missions could convince their African clients that Jesus is adequate to address their physical, psycho-social, and other needs.

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<sup>70</sup>Cece Kolie, “Jesus as Healer!,” in *Faces of Jesus in Africa*, ed. Robert J. Schreiter, Faith and Culture (Maryknoll, NY: Orbis, 1991), 136.

<sup>71</sup>Gabriel M. Setiloane, *The Image of God among the Sotho-Tswana* (Cape Town, South Africa: A. Balkema, 1975), 155-156.

Modern Christian hospitals need to refocus on their original purpose, which is to present Jesus as the Healer of the people, the Prince of *Shalom*. Kofi Appiah-Kubi rightly observes that

in the established churches, medical practice has become so specialized and secularized that the ordinary pastor has been radically excluded from the service for the sick; thus healing and worship have become separate. [Whereas] in the indigenous churches [which have reclaimed African roots] there is a reintegration of healing and worship.<sup>72</sup>

Rather than perpetuating the “flaw of the excluded middle,” when Jesus is presented to the African people as the sole and Greatest Doctor and Healer, they will look upon Him for worship, protection, and healing. It is important therefore in the development of a Christian medical model to take a look at the books of Luke and Acts and to see how they illustrate Jesus’ ministry of compassion to His followers.

### **Luke-Acts and Compassion**

Both Luke and Acts show how Jesus demonstrated to His immediate followers acts of compassion. He sent His disciples out with power and authority to preach the gospel and heal diseases (Luke 9:6; 10:9, 17), raise the dead, and to perform healings en masse (Acts).<sup>73</sup>

The disciples of Jesus and His subsequent followers had seen or heard how Jesus performed His compassionate ministry and were determined to follow suit. That they were empowered to carry out their compassionate work is seen in one of Peter’s healing acts. In Acts 3:2-7, Peter heals a “man who had been lame from his mother’s womb” (v.

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<sup>72</sup>Kofi Appiah-Kubi, “Indigenous African Christian Churches,” in *African Theology En Route*, ed. Kofie Appiah-Kubi and Sergio Torres (Maryknoll, NY: Orbis Books, 1979), 122.

<sup>73</sup>Allister, *Sickness & Healing*, 4.

2). Peter claims the power he had been promised and given by Jesus for he says, “In the name of Jesus Christ the Nazarene—walk!” (v. 6b). Paul also calls upon the same Name in order to heal a woman under the oppression of an evil spirit (Acts 16:18).

While onlookers gazed in amazement, Peter rebukes them, “Men of Israel, why do you gaze at us, as if by our own power or piety we had made him walk? The God of Abraham, Isaac, and Jacob, the God of our fathers, has glorified His servant Jesus” (Acts 3:12-13). Peter makes it clear that power and piety do not originate with him, but come from Jesus Christ. Hence, Allister observes that “there is a general insistence that the power to heal is that of Christ rather than his agent, and that faith is an important factor in the healing.”<sup>74</sup>

Here is a significant lesson for medical missions. It is Jesus who owns the medical mission. All healing and miracles are to be credited to Him. The compassion shown to patients and members of the community should draw the beneficiaries to Jesus and nobody else. “While humanity may be instrumental in the healing process, Christ is to be proclaimed as the ultimate Healer.”<sup>75</sup>

The disciples and followers of Jesus in the early church ministered not only to the sick, but also considerably to the poor.<sup>76</sup> While ministry to the poor might seem beyond

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<sup>74</sup>Ibid., 9.

<sup>75</sup>Gerrit Ter Haar, “Power and Powerlessness in Medical Mission,” *Missionalia* 18 1 (1990): 58.

<sup>76</sup>The disciple Thomas served among the poor in India. See Stephen Neill, *A History of Christian Missions* (London: Penguin Books, 1964), 33. Basil John Chrysostom, and Ambrose were among leaders who helped oversee the operation of hospices and hospitals that catered for the poor as well as the sick. Louis J. Swift, “Almsgiving,” *Encyclopedia of Early Christianity* 2nd ed. (New York: Garland Publishing, 1997), 38. While Ignatius gave advice on how to treat widows and slaves, Gregory of Nazianzus “developed a persuasive theology of why and how Christians should deal with their human and financial resources in helping the sick and the poor.” Frederick W. Norris, “Ethics,” *Encyclopedia of Early Christianity* 2nd ed. (New York: Garland Publishing, 1997), 390.



the scope of traditional medical mission, it was very much the concern of the disciples of Jesus who (like Him) wanted their communities to experience *shalom* (Acts 6:1-7; Rom 15:26; Gal 2:10; Jas 1:27; 2:14-17).

### **Historical Development of Medical Care**

The care for the sick and ailing has been the responsibility of Christians and others since the time of Jesus Christ. This practice differed from its counterpart classic Greek tradition. There were “various strains of Greek thought, which disparaged the body, regarding it as a prison of the soul, [whereas] the New Testament viewed the body as God’s creation, which would one day experience redemption and resurrection.”<sup>77</sup>

Christians believed the body deserved care, as was demonstrated in the care and healing of the sick. “Rooted in the ministry of Jesus himself, the concern for the physical sufferings of individuals has been understood throughout the centuries as part and parcel of the Christian witness.”<sup>78</sup> Historically, it was the Christian church that “introduced the most revolutionary and decisive change in the attitude of society toward the sick.”<sup>79</sup>

Christianity gave beyond medical care; the religion took its purest form in the midst of persecution by Roman imperial rulers:

Cyprian assembled his congregation, and exhorted them to love their enemies; whereupon all went to work; the rich with their money, the poor with their hands, and

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<sup>77</sup>Norris, “Ethics,” 390.

<sup>78</sup>Darrel W. Amundsen and Gary B. Ferngren, “The Early Christian Tradition,” in *Caring and Curing: Health and Medicine in the Western Religious Traditions*, ed. Ronald L. Numbers and Darrel W. Amundsen (New York: Macmillan Publishers, 1986), 46.

<sup>79</sup>Christoffer Grundmann, “Proclaiming the Gospel by Healing the Sick? Historical and Theological Annotations on Medical Mission,” *International Bulletin of Missionary Research* 14 3 (1990): 120.

rested not, till the dead were buried, the sick cared for, and the city saved from desolation.<sup>80</sup>

Thus were laid the *modus operandi* of Christian medical care that eventually led to the establishment of hospitals. As shall be seen later, “one of the most notable developments in Christianity in late antiquity was the growth and spread of monasticism,”<sup>81</sup> contributing to a great extent to Christian care, medicine, and healing.

However, apart from Christian health care, there were other parallel healing systems such as medical tradition, miracles, and magic<sup>82</sup> that at times ran against Christian values.

The forerunners of the medical tradition (modern medicine as it is known today) were two Graeco-Roman physicians: Hippocrates (460-350 B.C.) and Galen (A.D. 130-200).<sup>83</sup> It is significant that Christianity embraced and adopted some of the Hippocratic and Galenic methods of diagnosis and healing.

A common point shared by Hippocratic medicine and Christian health care was

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<sup>80</sup>Ibid.

<sup>81</sup>Phillip Schaff, *History of the Christian Church: Ante-Nicene Christianity A. D. 100-325*, vol. 2, Part 1 (Edinburgh: T. & T. Clark, 1884), 375-376.

<sup>82</sup>Amundsen and Ferngren, “The Early Christian Tradition,” 42. Kee gives the following definitions: “*Medicine* is a method of diagnosis of human ailments and prescription for them based on a combination of theory about and observation of the body, its functions, and malfunctions. Miracles embody the claim that healings can be accomplished through appeal to, and subsequent action by the gods, either directly or through a chosen intermediary agent. Magic is a technique, through word or act, by which a desired end is achieved, whether that end lies in the solution to the seeker’s problem or in damage to the enemy who has caused the problem.” Howard Clark Kee, “Introduction Definitions and Contexts for Healing,” in *Medicine, Miracle and Magic in New Testament Times*, Society for New Testament Studies Monograph Series (Cambridge: Cambridge University Press, 1986), 3.

<sup>83</sup>Kee, “Introduction Definitions and Contexts for Healing,” 3.

the ethic of the Hippocratic oath.<sup>84</sup> Amid charges of greed and lack of humanitarian concern, Hippocrates required physicians to help anyone—regardless of whether they could pay.<sup>85</sup> This was in line with Christian principles.<sup>86</sup>

The difference between Hippocratic medicine and early Christian care was that Christian doctors believed in miraculous healings and trusted in appealing to God—not gods—for that power.<sup>87</sup> Unfortunately, the practice of miraculous healing began to decline from A.D. 350 as the Church slowly shifted emphasis from this healing mode, as well as a tendency to require healings as proof of sanctity.<sup>88</sup>

“This Christian healing was not that of the doctors. It succeeded where they had failed; it was accessible to all; it was simple. It was a medicine of prayer and fasting, or of anointing and the laying on of hands.”<sup>89</sup> Thus while doctors and medicine are

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<sup>84</sup>The “ethic of the Hippocratic Oath” refers to the ethical codes that were binding to physicians who took vows to the oath, thus binding them to it. The oath included professional conduct in the areas of sex, preservation of life, equal treatment of all, and so on. For a full version of the English translation of the Hippocratic Oath, see *ibid.*

<sup>85</sup>Pierre M. Bellemare, “The Hippocratic Oath: Edelstein Revision,” in *Healing in Religion and Society from Hippocrates to the Puritans*, ed. Kevin J. Coyle and Steven C. Muir, Selected Studies in Religion and Society (Lewiston, NY: Edwin Mellen Press, 1999), 3.

<sup>86</sup>Incidentally, there also was compatibility between the Hippocratic medicine and the cult of Asclepius. “In the 5<sup>th</sup> Century B. C. while Hippocratic medicine flourished, the cult of Asclepius was established in Athens and soon thereafter in other Greek communities. There was no conflict between the two forms of medicine, which flourished side by side. In the centuries of imperial Rome the cult was widespread and very popular. A tide of mysticism swept the ancient world. Cybele, Dionysus, Osiris, Serapis, Mithras performed not only by Asclepius but miraculous cures also, and patients flocked to their temples. Chief competitor, however, was a new Syrian sect that had come with the promise of healing and redemption—Christianity.” Jerry Pattengale, “Benevolent Physicians in Late Antiquity,” in *The Light of Discovery: Studies in Honor of Edwin M. Yamauchi*, ed. John D. Wineland, The Evangelical Theological Society Monograph Series (Eugene, OR: Pickwick Publications, 2007), 131.

<sup>87</sup>Henry E. Sigerist, *Civilization and Disease* (Ithaca, NY: Cornell University Press, 1944), 138.

<sup>88</sup>Gary B. Ferngren, *Medicine & Health Care in Early Christianity* (Baltimore, MD: Johns Hopkins University Press, 2009), 65.

<sup>89</sup>Francis S. MacNutt, *The Healing Reawakening* (Grand Rapids, MI: Chosen Books, 2005), 111.

essential, the hope of healing should not be placed on these, but in the healing power of the Savior Jesus Christ.<sup>90</sup> Indeed this position is a powerful argument that recognizes God as the ultimate Healer, who responds to prayer for healing.

While traditional Hippocratic medicine had some commonality with Christian health care, a mystic rival to Christianity was a cult that had its own system of physicians exclusively dedicated to Asclepius (the Greek pagan high priest) and his god.<sup>91</sup> Inevitably, there was relentless conflict between the two systems of religious healing. To their advantage, the pagan cult had imperial support in their attempts to reproduce the benevolent actions of the Christians.<sup>92</sup> But this shows the value and efficacy of Christian practice.

Whereas the imperial-pagan axis initiated the establishment of state social welfare in the form of charitable entities, the weight of evidence suggests that Christians were the first to provide comprehensive (care for the sick, poor, widowed, orphaned, etc.) communal health care, albeit private.

For early Christians . . . hospital work was not so much a charitable gesture as [an] integral part of the life of the faithful; a way to fulfil [*sic*] the teachings of the Gospels, and to carry on Jesus' healing mission which [He] himself had handed on to his disciples. How better could a Christian demonstrate his faith than by helping the poor and the afflicted?<sup>93</sup>

Christian health care soon institutionalized through the agency of monasticism.

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<sup>90</sup>Vivian Nutton, *From Galen to Alexander: Aspects of Medicine and Medical Practice in Late Antiquity*, ed. John Scarborough, Symposium on Byzantine Medicine, Dumbarton Oaks Papers vol. 38 (Washington, DC: Dumbarton Oaks, 1984), 5.

<sup>91</sup>Ibid.

<sup>92</sup>Adolf Harnack, *The Expansion of Christianity in the First Three Centuries*, trans. James Moffat, Theological Translation Library, vol. 1 (New York: Williams & Norgate, 1904), 129

<sup>93</sup>Schaff, *History of the Christian Church: Ante-Nicene Christianity A. D. 100-325*, 376-377.

The beginning of Christian *xenodochia*—“originally place[s] for the comfort of strangers, both those who are travelling and those who are sick and require treatment”—(hospitals) can be traced to within a generation or two after Christianity became a legal religion.<sup>94</sup> Monasteries played a significant role in the development of Christian health care and the establishment of Christian hospitals.

When Christianity became the official religion of the Roman state it had to compromise with necessity by taking over the cultural heritage of the past. Christians became physicians and treated patients by applying the doctrines of pagan medical writers. Medical books were copied in Benedictine monasteries; hospitals were erected for the stranger, the poor and the sick.<sup>95</sup>

Thus monasteries became not only health centers, but also custodians of the medical knowledge and skills of the time. A parenthetical reference to monasticism may help in the understanding of its role in Christian medical mission.<sup>96</sup>

Howard Haggard states that after the fall of the Roman Empire, monasteries preserved medicine and also that the quality of medicine was poor as some monks merely

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<sup>94</sup>Brian Inglis, *A History of Medicine* (New York: World Publishing Company, 1965), 57-58.

<sup>95</sup>Amundsen and Ferngren, “The Early Christian Tradition,” 49.

<sup>96</sup>There were two types of monasticism: the Lavra and Coenobitic. See Sigerist, *Civilization and Disease*, 140. The Lavra or Laura had individual monastic cells clustered around a main opening; monks lived together in these cells either as hermits or as community and held common services. Andrew T. Crislip, *From Monastery to Hospital: Christian Monasticism & the Transformation of Health Care in Late Antiquity* (Ann Arbor, MI: University of Michigan Press, 2005), 4. Since these communities were living in isolation, they developed a system that initially took care of inmates, before opening up to the public. In due course, “hermits were reputed to have great wisdom and, frequently, miraculous powers to save souls and restore health, and so they attracted both transient pilgrims and more permanent disciples, who in turn attracted disciples of their own.” Frederick W. Norris, “Laura (Lavra),” *Encyclopedia of Early Christianity* (New York: Garland Publishing, 1997), 665. On the other hand, Coenobitic monasticism “takes its name from the Greek term for fellowship or community (*koinonia*). . . . In contrast to lavra monasticism, coenobitic monasticism was characterized by a high degree of centralized authority, a highly regulated monastic lifestyle, and physical boundary (that is, a wall) that separates the monastery from the world at large.” Crislip, *From Monastery to Hospital: Christian Monasticism & the Transformation of Health Care in Late Antiquity*, 6.

used simpler books with their recipes, herbs, and remedies for treating their patients.<sup>97</sup>

Though Haggard has a lower view of monastic medicine than does Daniel W. Amundsen,<sup>98</sup> he however acknowledges the monastic role in preserving medicine.<sup>99</sup> Religious orders (such as the Knights Hospitalers, Teutonic Knights, and Benedictines) were founded solely to care for the diseased and wounded during the Christian wars where they “did valiant work in the Holy Land, and [upon] returning home [to the West], established hospitals on the lines of march and in the towns where they stopped.”<sup>100</sup>

Considering that around A.D. 340 the monastic movement had already become powerful,<sup>101</sup> it is no surprise that the spread of Christian hospitals occurred from the same century onwards. Subsequent monastic or religious order hospitals, such as the one founded by Fabiola (A.D. 400), continued to serve the poor, sick, and sufferers in the streets<sup>102</sup> as part of their mandate to provide services to the communities.

One specialized health-care form provided by St. Basil hospital was the

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<sup>97</sup>Howard W. Haggard, *The Doctor in History* (London: Yale University Press, 1934), 135.

<sup>98</sup>Darrel W. Amundsen suggests that some health care in the infirmary, which was reserved for clerics, most likely did not have skilled physicians. It was, however, the “monasteries to which the sick most likely came were those known for their competent physicians.” Darrel W. Amundsen, “The Medieval Catholic Tradition,” in *Caring and Curing: Health and Medicine in the Western Religious Traditions*, ed. Ronald L. Numbers and Darrel W. Amundsen (New York: Macmillan Publishing, 1986), 84.

<sup>99</sup>Haggard, *The Doctor in History*, 138.

<sup>100</sup>*Ibid.*, 110.

<sup>101</sup>E. E. Kellett and F. H. Marseille, *Monasticism: Its Ideals and History and the Confessions of St. Augustine: Two Lectures by Adolf Harnack*, Harnack's *Monasticism and the Confessions of St. Augustine*, vol. 28 (New York: G. P. Putnam's Sons, 1901), 43.

<sup>102</sup>Fielding H. Garrison, *An Introduction to the History of Medicine: With Medical Chronology, Suggestions for Study and Bibliographic Data* (Philadelphia, PA: W. B. Saunders Company, 1929), 176-177.

“*keluphokomeion*” for leprosy patients.<sup>103</sup> Though a welcome development, it is alleged that the lepers were not only segregated, but also exclusively stigmatized.<sup>104</sup> Thus the inclusion of the lepers in the hospital of St. Basil was a major philanthropic breakthrough in the treatment of this marginalized sub-community.

Christian hospitals continued to spread until the beginning of the thirteenth century when they passed—by mutual agreement—from ecclesiastic authority to municipalities; by the fifteenth century, the construction of hospitals had reached its peak.<sup>105</sup>

There was a notable distinction between secular and Christian hospitals in that “the Romans had built slave and military hospitals for economic and political considerations. Further, the Church introduced the notion of hospitals as clear expressions of Christian charity.”<sup>106</sup> Thus Christianity pioneered compassionate services that included health care, contributing significantly to drawing and shaping the idea that civic community had some form of social obligation.

Certainly, lessons can be drawn from this section for medical mission work in Africa. Religious people, pastors, priests, and medical missionaries are custodians of

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<sup>103</sup>Crislip, *From Monastery to Hospital: Christian Monasticism & the Transformation of Health Care in Late Antiquity*, 135.

<sup>104</sup>*Ibid.*

<sup>105</sup>Garrison, *An Introduction to the History of Medicine: With Medical Chronology, Suggestions for Study and Bibliographic Data*, 179.

<sup>106</sup>David E van Reken, “Medical Missions and the Development of Health,” in *A New Agenda for Medical Missions: A Map International Monograph*, ed. Merrill D. Ewert (Brunswick, GA: MAP International, 1990), 19.

health and medical knowledge. But such knowledge has to be put into use in ways that are applicable to the physical, spiritual, social, cultural, and emotional needs of Africans. For example, the reservoir of knowledge that African traditional doctors have on effective plant medicine can be the basis of corroboration and dialogue between the two health systems. Early Christianity did not shy away from borrowing and adapting secular medicine. This historical fact should allow modern medical missions in Africa to work with the African traditional medical system in certain areas.

Western missionaries began modern medical missions in Asia. Peter Parker (1804-1888) is believed to have pioneered the work,<sup>107</sup> and is thus considered by some scholars as the founder of modern medical missions.<sup>108</sup>

However, there was slow progress in medical mission abroad due to an inadequate philosophy of medical missions. The view was that

the overseas missionary enterprise is strictly a preaching enterprise. Only ministers can do this properly. Doctors are needed to look after the health of these ministers, missionaries, and their families, but nothing more. Such doctors are auxiliaries but not real missionaries.<sup>109</sup>

When this narrow view was overcome, medical missionaries became an indispensable tool for spreading the gospel in foreign lands, especially in places where there was prejudice against Christianity. The progression of medical missions in

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<sup>107</sup>Grundmann, "Proclaiming the Gospel by Healing the Sick? Historical and Theological Annotations on Medical Mission," 122.

<sup>108</sup>G. V. Stevens and W. Fisher Markwick, eds., *The Life, Letters, and Journals of the Rev. and Hon. Peter Parker, M. D., Missionary, Physician, and Diplomatist, the Father of Medical Missions and Founder of the Ophthalmic Hospital in Canton* (Boston: Congregational Sunday-School and Publishing Society, 1896), 118.

<sup>109</sup>Dodd, *The Gift of the Healer: The Story of Men and Medicine in the Overseas Mission of the Church*, 24-25.



southern Africa will be discussed in the next chapter.

Ideally, Adventist medical missions have a holistic approach to health care. The guidance and foundation laid out by Ellen G. White needs to be revisited so that medical mission may refocus on the restoration of God's *shalom* in humanity.

### **Ellen G. White and Medical Mission**

Ellen G. White's views of medical missions are important to this dissertation because of her shaping influence on medical mission in the Adventist Church. White was a leading pioneer in the Seventh-day Adventist Church and was recognized not only as one of the Church's faith leaders, but also as one who was endowed with divinely revealed insights that she received through visions.

In May 1863 White received a vision—the Otsego vision—on health which not only related physical well-being to spiritual health, but also espoused the importance of a healthy diet and benefits of fresh air, sunshine, exercise, and pure water, among other things.<sup>110</sup> After the vision, Ellen White firmly advocated for abstinence from alcohol, tobacco, tea, coffee, and other health hazards not fit for human consumption.<sup>111</sup> She taught that the cause of much of the disease in the world was a result of disregarding the laws of health, which she said were divinely appointed.<sup>112</sup>

Ellen White also encouraged the use of natural remedies and taught the value of

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<sup>110</sup>Ellen G. White, "Questions and Answers," *Adventist Review and Sabbath Herald*, October 8, 1867, 260. For more detail, see also Ellen G. White, *Counsels on Diet and Foods* (Washington, DC: Review and Herald, 1946).

<sup>111</sup>Ellen G. White, "The Path of Progress," *Adventist Review and Sabbath Herald*, February 21, 1888, 113. However, the same source shows there were some physicians that already were teaching the same health message, which confirmed what Ellen White had been shown in the vision.

<sup>112</sup>White, *Medical Ministry: A Treatise on Medical Missionary Work in the Gospel*, 49.

hydrotherapy.<sup>113</sup> Further, writing during her times, she encouraged the use of plant medicine or herbs.

God has caused to grow out the ground, herbs for the use of man, and if we understand the nature of these roots and herbs, and make a right use of them, there would not be a necessary running for the doctor so frequently, and people would be in much better health than they are today.<sup>114</sup>

Thus began the Adventist health reform message. The rationale was that those who strived to better their lifestyles health-wise would have “the blessing of physical and mental vigor. They will have the moral power to engage in the warfare against Satan.”<sup>115</sup> Furthermore, White taught that health reform was one branch of the Church’s mission that was to prepare a people for the second coming of the Lord Jesus Christ.<sup>116</sup> So Ellen White linked healthful living to the third angel’s message of Rev 14:6-12: “God has shown me that health reform is . . . closely connected with the third angel’s message.”<sup>117</sup>

As a result, the tone was set for the Adventist Church to go out into the world with the dual ministry of the gospel and health—one suffused in the other. This was the onset of Adventist medical mission. Ellen White called for “medical mission . . . to be carried forward with an earnestness with which it has never yet been carried. This work is the door through which the truth [message] is to find entrance to the large cities, and

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<sup>113</sup>Ibid., 230-231.

<sup>114</sup>Ellen G. White, *The Place of Herbs in Rational Therapy*, vol. 144 (St. Helena, CA: “Elmshaven” Office, 1934), 14.

<sup>115</sup>Ellen G. White, *Temperance* (Boise, ID: Pacific Press, 1949), 145.

<sup>116</sup>Ellen G. White, *Counsels on Diet and Foods: A Compilation from the Writings of Ellen G. White* (Hagerstown, MD: Review and Herald, 1976), 69.

<sup>117</sup>Ellen G. White, *A Call to Medical Evangelism and Health Education: Being Selections from the Writings of Ellen G. White* (n.p.: Pacific Coast Conferences of Seventh-day Adventists, 1933), 27.

sanitariums [and hospitals] are to be established in many places.”<sup>118</sup>

It was indeed fitting for Ellen White to state that

the medical missionary work has never been presented to me in any other way than as bearing the same relation to the work as a whole as the arm does to the body. The gospel ministry is an organization for the proclamation of the truth and the carrying forward of the work for the sick and well. This is the body, the medical missionary work is the arm, and Christ is the head over all.<sup>119</sup>

Distinctly, it was through the influence of Ellen White that the early Adventist Church included medical missions as part of their gospel work. Though her principles of health were not exclusively original with her, they were fundamental in setting the pattern for Adventist healthful living, as well as the worldwide progression of the Church’s medical missions. Adventist missionaries set up various centers in a bid to minister to the sick physically and spiritually.

Ellen White further urged the church to carry out welfare ministry. She challenged the Adventist Church to social responsibility, even providing a rationale why the world always has its poor.

In the providence of God events have been so ordered that the poor are always with us, in order that there may be a constant exercise in the human heart of the attributes of mercy and love. Man is to cultivate the tenderness and compassion of Christ; he is not to separate himself from the sorrowing, the afflicted, the needy, and the distressed.<sup>120</sup>

At a global level, one of the visible responses of the Adventist Church to this

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<sup>118</sup>Ellen G. White, *Testimonies for the Church*, vol. 3 (Mountain View, CA: Pacific Press, 1948), 62. Accordingly, White valued the work of the minister of the gospel as much as the medical missionary (doctor).

<sup>119</sup>Ellen G. White, *Counsels on Health and Instructions to Medical Workers* (Boise, ID: Pacific Press, 1951), 392.

<sup>120</sup>Ellen G. White, *Welfare Ministry: Instruction in Christian Neighborhood Service* (Washington, DC: Review and Herald, 1952), 17.

challenge is through the Adventist Development and Relief Agency's (ADRA) humanitarian projects in more than 100 countries.<sup>121</sup>

Because of her contributions, Ellen White has helped the church to have this current position on its global mission:

Adventists are engaged in a mission to communicate to all peoples the everlasting gospel of God's love, leading them to accept Jesus as personal Savior and Lord, to unite with His remnant church, and to prepare for His soon return. This mission is advanced through many and varied methods of preaching, teaching, and healing. A worldwide infrastructure links local churches as part of a global faith community. The Church has also established numerous educational, publishing, and health-care institutions that perform a vital role in demonstrating and communicating the Church's focus on mission and witnessing to the gospel through service to others.<sup>122</sup>

Lowell C. Cooper explains that the terms “entering wedge” and “right arm” help to link the function and relationship of the ministry of the hand (helping, healing, and training) with the ministry of the Word (preaching, teaching, baptizing, and discipling) so that health care and community services should be understood in the context of the Church's mission to proclaim the gospel and prepare the world for the second coming of Jesus Christ.<sup>123</sup>

### **Missiological Implications**

I have presented the biblical and historical models of medical mission. As the

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<sup>121</sup>Lowell C. Cooper, “In the Name of Jesus: Reflecting the Dynamic Ministry of a Life Spent Teaching and Serving,” *Adventist World*, June 2010, 8.

<sup>122</sup>General Conference of the Seventh-day Adventists, “Official Statements Documents: Safeguarding Mission in Changing Social Environments,” <http://www.adventist.org/information/official-statements/documents/article/go/0/safeguarding-mission-in-changing-social-environments/> (accessed January 26, 2014).

<sup>123</sup>*Ibid.*

result of this analysis we saw that God's original purpose was to provide sustained health and *shalom* for His people. Jesus, while on earth, demonstrated that humanity needed full restoration in order to achieve the state of *shalom*. As the Exemplar medical missionary, He demonstrated unparalleled compassion; He restored broken people physically, socially, as well as spiritually. The disciples took Jesus' mission model not only to propagate the gospel, but also to heal the sick and care for the needy.

Thus far, there are at least two missiological implications for medical work in Africa. Christians and Africans believe in the Supreme God. Furthermore, though they have different underlying beliefs, both traditions see health care as a holistic approach, which means complete health is not limited to the physical, but to the spiritual as well.<sup>124</sup> This common ground provides an important basis for a dialogue between Christian medical mission and African healing systems.

While the early Christian church embraced secular medical practices, modern Christian medical mission could not see the value of African plant medicine. Since African herbal or plant medicine has been tested on humans, Christian medical missions could analyze these medicines in their hospital laboratories and further develop their efficacy.

But there are also important differences between Christianity and African Traditional Religion (ATR) that are worth noting. For example, Africans believe spirit ancestors mediate between them and their God while Christians have Jesus as their

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<sup>124</sup>However, the Christian Western medical system has been adversely affected by the enlightenment thought so much that Christian hospitals tend to focus more on the physical than the spiritual.

Mediator. This explains why Africans engage traditional healers as well as sorcerers.<sup>125</sup>

Practitioners of Western medicine largely do not consider the African worldview to be culturally relevant. This fact has led to the establishment of numerous AICs that offer contextual healing services to Africans. Not surprisingly, Africans continue to seek healing from Western-oriented hospitals, including Christian medical missions, as well as traditional doctors.

The readiness of Africans to accept God as Protector from evil and Jesus as the Great Physician cannot be doubted. Thus Africans can be taught how to pray and trust in God so that they can be protected from disease, evil spirits, and the fear of the unknown. Seemingly, prayer is becoming a lost art that needs to be revived in Christian medical missions. Further, a holistic healing approach that is biblically correct and culturally relevant needs to be developed in order to address the needs of Africans in their cultural context.<sup>126</sup>

Ellen G. White initiated Adventist health reform, urging the church to make use of medical mission as “the right arm” of the gospel. This is consistent with Christians from the apostolic era to the modern era that followed the Jesus model of medical missions. The Monastic era laid the basis for today’s institutionalized health care such as hospitals, while the modern era revitalized medical mission leading to the unprecedented

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<sup>125</sup>Dodd, *The Gift of the Healer: The Story of Men and Medicine in the Overseas Mission of the Church*, 24-25.

<sup>126</sup>Yuri N. Drumi points to “Luke’s philosophy of holism . . . his [Luke’s] theology ‘strikes a careful balance between physical and spiritual salvation; he offers home to men and women at all levels of their troubled existence.’” Yuri N. Drumi, “The Trauma of Stalinism Narrated in Varlam T. Shalamov’s *Kolymskie Rasskazy: Missiological Implications for Contemporary Russia*” (PhD dissertation, Andrews University, 2008), 200. See also Judith L. Hill, “Health, Sickness and Healing in the New Testament: A Brief Theology,” *Africa Journal of Evangelical Theology* 26 2 (2007): 151.

worldwide propagation of the gospel and health messages.

The holistic nature of Adventist medical mission is significant in two ways. First it pursues the biblical *shalom*, seeking the restoration of humanity in all aspects of life, the most important of which is restoring relationships with God. Hence a holistic approach entails providing people with spiritual, health, and social needs care. Second, Adventist medical mission to a large extent resonates with the African understanding of wholeness in health. For this reason, Adventist medical mission—carried out appropriately—has the efficacy and potential to fully address the health needs of Africans. It is interesting that as much as Africans value plant medicine, so did Ellen G. White, who encouraged the use of herbs, though pharmacy has made great strides since then.

The next chapter describes the history and establishment of Christian medical missions in southern Africa, including Adventist medical missions in Botswana. This is important for this dissertation because some missiological lessons can be drawn from past mission experiences, with implications for future medical mission.

## CHAPTER 4

### SOUTHERN AFRICA CHRISTIAN MEDICAL MISSION: 1870-1950

This chapter discusses Christian medical mission in southern Africa<sup>1</sup> which occurred concurrently with the European colonization of Africa. The first section establishes the challenges to medical mission followed by a historical overview of Christian medical mission in southern Africa.<sup>2</sup> The third section discusses the establishment of Adventist medical missions in the territory. The last section expressly covers Adventist medical mission in Botswana.

The local people in southern Africa are mainly Bantu and “it is among these people that missionary work has achieved its greatest results.”<sup>3</sup> However, medical missions to the Bantu were not without initial challenges.

#### **Challenges to Medical Missions**

There were various challenges to medical missions in southern Africa, ranging

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<sup>1</sup>Southern Africa in this context covers Botswana, Lesotho, Namibia, Malawi, Mozambique, South Africa, Swaziland, Zimbabwe, and Zambia.

<sup>2</sup>Except for Mozambique and Angola, missionary efforts in these territories had South Africa as their launching pad. Thus to be consistent with the “South African missionary unit,” the two former Portuguese possessions will not be considered in this paper. See Malawi, Zimbabwe, and Zambia will be discussed in this section because of the direct or indirect contributions of missions emanating from or through South Africa.

<sup>3</sup>Robert H. Glover, *The Progress of World-Wide Missions* (New York: George H. Doran, 1924), 232.



from the politics of slavery to rival traditional medical systems. Typically, some African tribes resisted the missionaries to protect their religion, culture, and tradition. However, medical missions served as a beachhead, which “proved to be the only way of gaining access to the lives and hearts of the people.”<sup>4</sup>

In the early eighteenth century, Moravian missionary pioneer Georg Schmidt served in South Africa where he fought for the rights of the enslaved Hotentots. As he sought to Christianize the Hotentot tribe, Schmidt was so vigorously opposed by the Dutch settlers that he “was summoned to answer to a court in Holland and never got the chance to return.”<sup>5</sup>

This state of affairs, built upon the premise of segregation and the elevation of White settlers as a superior race, led to a delayed establishment of medical mission for the Bantu people.<sup>6</sup>

The presence of missionary nurses and the training of indigenous personnel was a crucial complement to the already hard-pressed medical missionaries. In some territories, the nursing sisters had the responsibility of establishing medical clinics or even running a hospital for several years while awaiting the appointment of a medical doctor.<sup>7</sup>

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<sup>4</sup>Samuel W. W. Witty, *Medical Missions in Africa and the East* (London: Church Missionary Society, 1922), 5.

<sup>5</sup>Ellen C. Parsons, *Christus Liberator: An Outline Study of Africa* (London: Macmillan Company, 1905), 243. For more detail, see H. C. Bredekamp and J. L. Hattingh, “The Establishment of Christianity in the Early Period of Settlement, 1665-1804,” in *History of the Church in South Africa: A Document and Source Book*, ed. J. W. Hofmeyr, J. A. Millard, and C. J. J. Froneman, Studia Composita (Pretoria, South Africa: University of South Africa Press, 1991), 28-29.

<sup>6</sup>Horton J. Davies and R. W. Shepherd, *South African Missions: 1800-1950* (London: Thomas Nelson, 1954), 215.

<sup>7</sup>Michael Gelfand, *Christian Doctor and Nurse: The History of Medical Mission in South Africa from 1799-1976* (Pretoria, South Africa: Mariannhill Mission Press, 1984), 19.

While financial constraints accounted for the shortage of doctors, the prevailing underdeveloped philosophy of medical mission was also a contributing factor. The sending missionary societies in Europe seemed to undervalue medical missions. When early Scottish missionaries “asked the Glasgow Missionary Society to send them a medical missionary [a] reply was made that no one was available in Scotland, but that there was a medical missionary in [offshore] Madagascar who might look after both fields.”<sup>8</sup>

This led the South African government to establish its first public hospitals even before mission hospitals were established. However, medical missions had the burden of native health-care in the territories to the north while government hospitals catered mainly for the Whites.<sup>9</sup>

The prevailing philosophy of medical missions crippled the progress of medical work as “many Christian leaders . . . considered prayer at the time of sickness more beneficial than treating the patient medically as well.”<sup>10</sup> In other words, they did not consider medical work as important. Further, “many believed that faith and prayer was

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<sup>8</sup>Davies and Shepherd, *South African Missions: 1800-1950*, xxi.

<sup>9</sup>Martin Ballard suggests some ‘best scenario’ where the colonial governments cooperated with Christian medical missions, “since the imperial enterprise had never encompassed any vision for the building of medical and educational services for newly conquered countries, any advances in these areas would necessarily have to be delivered in partnership with mission agencies.” Martin Ballard, *White Men's God: The Extraordinary Story of Missionaries in Africa* (Oxford: Greenwood World, 2008), 243. In several cases, this was solely the burden of the medical missions, with the authorities merely facilitating the land rights for missionary usage. For example, in the year 1891 in Rhodesia (Zimbabwe), Cecil Rhodes, the British imperialist, offered Methodist pioneer Owen Watkins three farms with the promise of more upon proof of success on the current ones, with no obligatory financial support to the mission agency. See Davies and Shepherd, *South African Missions: 1800-1950*, 93-94.

<sup>10</sup>Gelfand, *Christian Doctor and Nurse: The History of Medical Mission in South Africa from 1799-1976*, 18.

sufficient to ensure native health. Medical missionaries were expected . . . to be first preachers, then medical men, if time remained for that.”<sup>11</sup>

Thus, the perception that elevated the preacher over the doctor impacted the role of medical missions negatively. However, this handicap came to a close when medical mission began to be viewed as complementary to the “ordained ministry.”<sup>12</sup>

Reminiscent of the conflicts the early Christian Church healers had with the medicine practitioners of the order of Aesculapius (see chapter 3), medical missionaries found themselves constantly in conflict with the revered and feared African traditional doctor.

The practice and belief system of the traditional doctor is discussed elsewhere in this dissertation. However, this section will briefly highlight how Christian medical missionaries approached this alternative medical system that had sustained Africans long before the introduction of Western medicine.

Consistent with the imperial philosophy of Christianization, commercialization, and civilization of Africans, many missionaries arrived in Africa with a similar frame of mind. Armed with the “advantages” of Western civilization—education, industry, and

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<sup>11</sup>James B. McCord and John Scott Douglas, *My Patients Were Zulus* (New York: Rinehart & Co, 1956), 25-26. The perception was that gospel ministers were doing more essential work than medical practitioners.

<sup>12</sup>First, Dr. H. M. Scudder Jr. wrote his Mission Board outlining his ideas on medical work in India and emphasizing its aspect as the “opening wedge” to gospel work. Second, soon after Scudder’s proposal, the ABCFM pronounced (1885) that “the work of the medical missionary has assumed increased importance during the last decades of our history. . . . The physician exerts a Christian influence only second to that of the ordained ministry. . . . A skillful and sympathetic ministry to the bodies of the sick and infirm in numerous instances opens the heart and conscience to the supreme gift of salvation. . . . This arm of our missionary service we shall increase, as Providence opens the way.” Third, in 1897 the “Prudential Committee . . . of the American Board decided that henceforth medical personnel in the service of the Board should have the status of ‘missionary,’ not ‘assistance missionary’ as had been the case for 87 years.

medicine—many colonists and missionaries presumed Africans needed a complete cultural and traditional reorientation. This approach led many medical missionaries to erroneously view the African belief system and medicine with disdain.<sup>13</sup>

Medical missionaries ignored the fact that Africans “had their own ideas about well-being. . . . Healing held a pivotal place in their conceptions of power . . . [thus] it was the site, *par excellence*, of mediation between the human and the divine.”<sup>14</sup> An African pastor lamented that earlier missionaries failed to appreciate Bantu religion, fearing the church has perpetuated the mistake.<sup>15</sup> As they were “trapped within an imperialist cultural ideal, the missionaries’ sense of superiority also left them indifferent to African religious ideas.”<sup>16</sup> As a result, Africans were apprehensive to anyone who slighted their religion, leading many to reject the new religion of Christianity.

Yet there were a few medical missionaries who were culturally sensitive. James B. McCord did not ridicule Zulu Chief Delewayo’s traditional doctor, hoping to create rapport and subsequently initiate dialogue.<sup>17</sup> David Livingstone took a step further; first

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Medical people were for the first time allowed to vote in affairs of the missions.” Dodd, *The Gift of the Healer: The Story of Men and Medicine in the Overseas Mission of the Church*, 24-25.

<sup>13</sup>The missionaries’ approach may not have been deliberate, after all, social sciences had not yet been developed then for them to have grasped concepts such as “worldview” and how to deal with it. In fact Marguerite Kraft posits that “a people’s concepts, basic presuppositions, and experiences affect the way the message of Christianity is heard and interpreted. [Thus] understanding the worldview is a necessary basis for effective hearer-oriented communication. It is the basis also for strategizing for presenting the Gospel as well as effectively nurturing the Christian.” Marguerite G. Kraft, *Worldview and the Communication of the Gospel: A Nigerian Case Study* (Pasadena, CA: William Carey Library, 1978), 4.

<sup>14</sup>John L. Comaroff and Jean Comaroff, *Of Revelation and Revolution: The Dialectics of Modernity on A Southern African Frontier*, vol. 2 (Chicago: The University of Chicago Press, 1997), 333.

<sup>15</sup>Gerdener, *Recent Developments in the South African Mission Field*, 11.

<sup>16</sup>Charles Villa-Vicencio, “Mission Christianity,” in *Living Faith in South Africa*, ed. Martin Prozesky and John de Gruchy (New York: St. Martin Press, 1995), 65.

<sup>17</sup>McCord and Douglas, *My Patients Were Zulus*, 67.

he learned about the traditional doctor's medicine, and then he adopted and applied some of it. In this way, Livingstone enhanced African acceptance of his medical mission.

This does not imply that McCord and Livingstone agreed wholesale with the regimen of the traditional doctor's practice, but it does suggest that by putting aside cultural superiority—thereby exercising cultural humility—they recognized certain values in some aspects of the traditional doctor's practice, especially botanic medicine.

Had medical mission acknowledged some of the effective local treatments and “supplemented Western medical knowledge with it, [then] this would have alleviated tensions and helped to plant a sound medical practice in the culture of the people.”<sup>18</sup> Surprisingly, this trend apparently has not changed since these entities are still working independently of each other.

### **Establishing Medical Missions in Southern Africa**

#### **South Africa**

A significant missionary development in South Africa was the establishment of the South African Mission Field in 1799.<sup>19</sup> The Mission Field partnered with foreign mission boards in several ways, including sending its own missionaries to accompany missionary inductees on their forward journey to the north.<sup>20</sup>

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<sup>18</sup>Peter Falk, *The Growth of the Church in Africa* (Grand Rapids, MI: Zondervan, 1979), 446-447.

<sup>19</sup>Villa-Vicencio, “Mission Christianity,” 48.

<sup>20</sup>South Africa was inundated with a plethora of foreign missions; “there must be very few Churches or societies anywhere in the world which have not entered the South Africa field,” and consequently, “at the beginning of the [twentieth] century voices were raised requesting that no further society should enter South Africa.” Gerdener, *Recent Developments in the South African Mission Field*, 23.

Henry Callaway, the “founder of the first mission hospital in South Africa,”<sup>21</sup> established the Lovedale Mission Institution that “became the first place in the country at which Africans could be fully trained as nurses.”<sup>22</sup> Gradually, more mission hospitals were founded in rural places: Zululand, Maputoland, and Swaziland—mostly by the Methodist Church of South Africa.<sup>23</sup> Notably, the Church trained and employed African nurses.

The Christian medical missions enjoyed financial support from the South African government from 1935 to 1973, known as the “Period of State Support.”<sup>24</sup> But, a sudden government take-over in 1970 marked the decline of medical missions in South Africa.<sup>25</sup>

In contrast, the situation was different for the rest of southern Africa, which was comparatively poor and increasingly depended on the goodwill of medical missions. Governments in that region seemed more interested in taking over rural schools than hospitals, leaving medical missions with a massive institutional financial burden.<sup>26</sup>

## Lesotho

“The [mission] churches’ approach to evangelizing the Basotho nation [Lesotho]

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<sup>21</sup>Gelfand, *Christian Doctor and Nurse: The History of Medical Mission in South Africa from 1799-1976*, 48.

<sup>22</sup>Hinchliff, *The Church in South Africa*, 88.

<sup>23</sup>Gerdener, *Recent Developments in the South African Mission Field*, 63.

<sup>24</sup>Gelfand, *Christian Doctor and Nurse: The History of Medical Mission in South Africa from 1799-1976*, 147-148.

<sup>25</sup>Joy Brain, “Moving from the Margins to the Mainstream: The Roman Catholic Church,” in *Christianity in South Africa: A Political, Social, and Cultural History*, ed. Richard Elphick and Rodney Davenport (Los Angeles, CA: University of California Press, 1997), 207.

<sup>26</sup>Adrian Hastings, *A History of African Christianity: 1950-1975*, ed. John et al Dunn, African Studies Series (London: Cambridge University Press, 1979), 189.

was through education and health-care, and through these institutional methods church membership grew rapidly.”<sup>27</sup> The Paris Evangelical Society (PES) began medical mission work in 1829,<sup>28</sup> but political and military difficulties grossly affected the work.<sup>29</sup> Despite missionary presence in Lesotho since 1833, the Methodist Church opened a hospital only in 1981; by then the PES had established two hospitals and health center that trained local workers to identify and serve the community’s health needs.<sup>30</sup>

The impact of mission health care is still strong in Lesotho. The “churches continue to play a vital role in the health-care system of the government. In 1981, 20 percent of the 114 doctors in the country worked in mission hospitals or clinics while 33 percent of all outpatients seen were at mission hospitals and clinics.”<sup>31</sup>

### Swaziland

In Swaziland, unfriendly tribal rulers who welcomed only Europeans who brought them gifts, especially guns and ammunition, stalled medical mission.<sup>32</sup> However, in the 1840s the Wesleyans managed to set up churches, schools, and health clinics. Other missions followed: the Anglicans, German Lutherans, and Dutch Reformed, and later in

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<sup>27</sup>Froise, *World Christianity: Southern Africa—A Factual Portrait of the Christian Church in South Africa, Botswana, Lesotho, Namibia, and Swaziland*, 29.

<sup>28</sup>Victor Ellenberger, *A Century of Mission Work in Basotholand (1833-1933): Centenary Jubilee of the Basotoland Mission--(1833-1933)* (Moriya, Lesotho: Sesuto Book Depot, 1938), 7.

<sup>29</sup>C. P. Groves, *The Planting of Christianity in Africa 1848-1878*, vol. 2 (London: Lutterworth Press, 1954), 147.

<sup>30</sup>Froise, *World Christianity: Southern Africa—A Factual Portrait of the Christian Church in South Africa, Botswana, Lesotho, Namibia, and Swaziland*, 34.

<sup>31</sup>*Ibid.*, 40.

<sup>32</sup>Falk, *The Growth of the Church in Africa*, 178.

the 1900s, the Roman Catholics, and the American Nazarenes Mission.<sup>33</sup>

Dr. David Hynd established the Raleigh Fitkin Memorial Hospital in 1925,<sup>34</sup> including the Umbeluzi Leprosy Hospital, with the help of funds from the Colonial Development and Welfare Fund.<sup>35</sup> Several missions' agencies including Good Shepherd, Catholics, Seventh-day Adventists, and Church of Nazarene operate hospitals and dispensaries in Swaziland.<sup>36</sup>

### Namibia

Namibia was a colony of Germany beginning in 1884,<sup>37</sup> thus its mission history was in part shaped by German mission societies.

However, various subsequent mission societies contributed to the health sector in Namibia, including the Finnish (1902-1910), Rhenish, and Anglican Missionary Societies.<sup>38</sup> By 1986, the Lutheran Medical Mission had twelve hospitals and twenty-one clinics, while the Roman Catholic Church had eleven hospitals.<sup>39</sup>

Though Namibia came under the rule of the South African government in 1920, it

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<sup>33</sup>Alan R. Booth, *Swaziland: Tradition and Change in a Southern African Kingdom*, ed. Larry W. Bowman, Profiles: Nations of Contemporary Africa (Boulder, CO: Westview Press, 1983), 50-51.

<sup>34</sup>Gerdener, *Recent Developments in the South African Mission Field*, 240.

<sup>35</sup>Dudley Barker, *Swaziland* (London: Her Majesty's Stationery Office, 1965), 101.

<sup>36</sup>Froise, *World Christianity: Southern Africa—A Factual Portrait of the Christian Church in South Africa, Botswana, Lesotho, Namibia, and Swaziland*, 121.

<sup>37</sup>Republic of South Africa, *South West Africa Survey 1967* (Pretoria, South Africa: Department of Foreign Affairs of the Republic of South Africa, 1967), 26. Later, Namibia was mandated to South Africa.

<sup>38</sup>*Ibid.*, 122.

<sup>39</sup>Froise, *World Christianity: Southern Africa—A Factual Portrait of the Christian Church in South Africa, Botswana, Lesotho, Namibia, and Swaziland*, 56.



was only from April 1966 that the latter began to heavily subsidize mission hospitals, also providing free medication.<sup>40</sup> This helped Africans to have more access to health-care.

The trend was that Namibia, South Africa, and Zimbabwe—all with White-controlled governments—had access to resources to finance public health, which served mostly White communities. In stark contrast, the rest of the southern African countries relied on medical missions, which, no doubt, struggled for financial resources.

### Zimbabwe

The London Missionary Society (LMS) was the first pioneer and primary missionary body to start mission work in Zimbabwe at Inyati (1859) and Hope Fountain (1870).<sup>41</sup> Later, missions that followed were Jesuits (1879),<sup>42</sup> Anglicans (1890), Dutch Reformed (1891), Wesleyan Methodist (1891), Salvation Army (1890), and the American Board of Commissioners for Foreign Missions (1893).<sup>43</sup>

Medical missions began in Zimbabwe in the 1890s with the American Congregational Church's permanent African medical mission when they opened the Mt.

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<sup>40</sup>Republic of South Africa, *South West Africa Survey 1967*, 28, 122.

<sup>41</sup>W. A. Elliot, *Gold from the Quartz* (London: Simpkin, Marshall, Hamilton, Kent and Company, 1910), 48, 125.

<sup>42</sup>Chengetai J. M. Zvobgo, *A History of Christian Missions in Zimbabwe: 1890-1939* (Gweru, Zimbabwe: Mambo Press, 1996), 1.

<sup>43</sup>*Ibid.*, 3-6. Zvobgo notes two important points here: the first is that most of these missionaries came along with or just after the White settlers' Pioneer Columns of Cecil John Rhodes, and the second is that the missionaries were granted large tracts of land, in addition to grants of monies to help them establish their mission stations. When the time for medical missions came, it was predictable that they also would probably receive some financial assistance from the Administration of the colony or the government.

Selinda mission dispensary, followed by a small mission hospital in Chikore (1900).<sup>44</sup>

Medical missions by various missionary societies established Morgenster Mission Hospital (1894), a leper settlement (1899), and the Dutch Reformed Church Gutu Mission Hospital (1929).<sup>45</sup>

Due to “appeals from various missionary societies for financial support, the Government decided [in 1928] to give grants for the first time to missionary societies engaged in medical work among Africans.”<sup>46</sup> Though Zimbabwe was part of a loose federation<sup>47</sup> that from 1953-1964 included Malawi<sup>48</sup> and Zambia, none of the latter two countries benefitted from government grants on this scale.

## Malawi

By 1875, the Universities Mission to Central Africa, Established Church of Scotland, and Free Church of Scotland had sent missionaries to Malawi, while the Dutch Reformed Church [DRC], Zambezi Industrial Mission, and Nyasa Baptist Mission followed later.<sup>49</sup> As often was the case in other territories, gospel missionaries preceded

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<sup>44</sup>Michael Gelfand, “Medicine and the Christian Churches in Rhodesia, 1857-1930,” in *Christianity South of the Zambezi*, ed. A. J. Dachs (Gwelo: Mambo Press, 1973), 115. See also Michael Gelfand, *A Service to the Sick* (Gwelo: Mambo Press, 1976), 100.

<sup>45</sup>Zvobgo, *A History of Christian Missions in Zimbabwe: 1890-1939*, 202-210, 288-310.

<sup>46</sup>*Ibid.*, 286.

<sup>47</sup>The Federation of Rhodesia (Zimbabwe and Zambia) and Nyasaland (Malawi); see Andrew C. Ross, *Blantyre Mission and the Making of Modern Malawi: Kachere Monograph No. 1*, ed. J. C. Chakanza et al., Kachere Series (Blantyre, Malawi: Christian Literature Association in Malawi, 1996), 11.

<sup>48</sup>Malawi became a British Protectorate in 1891. See Falk, *The Growth of the Church in Africa*, 189-191.

<sup>49</sup>Jaspine D. C. Bilima, “The Seventh-day Adventist Church in Malawi: 1900-1980” (DMin dissertation, Andrews University, 1987), 18.

medical missionaries in Malawi, except David Livingstone who was more of an explorer who opened the way for mission and commerce. “The Malawi missionaries were in control of all health and educational matters for nearly twenty-four years. They were so influential that mail was transported in mission boats. They were regarded almost as being the ‘virtual’ government.”<sup>50</sup>

Significantly, Malawi mission stations offered a more holistic approach to mission than other territories thus far discussed. “The work of the Livingstonia Mission established the pattern in Malawi that most mission societies would later take in medical, educational, industrial, and evangelistic approaches.”<sup>51</sup> This is significant to mission because the Africans were empowered as well as helped medically and spiritually. The Livingstonia Mission became a ‘mentor’ to other missions in that newly arrived missionaries from other societies received logistic help and cooperation from this mission.

For example, “the Dutch Reformed Church of South Africa began a ministry in Malawi in 1888 in collaboration with the Livingstonia Mission.”<sup>52</sup> Taking its cues from the Livingstonia Mission, the DRC established schools, medical institutions, and agricultural and other industries south of the Blandawe district.<sup>53</sup>

Notably, Malawi seems to be the first mission territory outside of South Africa

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<sup>50</sup>Thabo T. Fako, “Historical Processes and African Health Systems: The Case of Botswana 1800-1966” (PhD dissertation, University of Wisconsin-Madison, 1984), 88-89.

<sup>51</sup>Bilima, “The Seventh-day Adventist Church in Malawi: 1900-1980,” 21.

<sup>52</sup>Falk, *The Growth of the Church in Africa*, 212.

<sup>53</sup>Kenneth Scott Latourette, *The Great Century: The Americas, Australasia, and Africa*, vol. 5 (New York: Harper and Row, 1943), 396.

where Livingstone's ideal of providing Africans with Christianity and commerce was encouraged. In addition, Malawi and Zimbabwean missions significantly contributed to opening new work in Zambia. This signified a growing strength of medical missions.

### Zambia

Early missions in Zambia (Northern Rhodesia) were initiated partly from Zimbabwe, but chiefly from Malawi.<sup>54</sup> This was a positive indication of maturation of local missions. In the same vein, the Paris Mission Society—a mission from Lesotho—became one of the most prominent in the evangelization of the African peoples in Zambia. Nevertheless,

the development of the Christian faith suffered . . . as the missionary centers were either outside the country: Methodists and Jesuits in Zimbabwe, Presbyterians and Anglicans in Malawi, or in a frontier position: the Paris Mission in the extreme west and the White Fathers in the extreme north.<sup>55</sup>

Mission work in Zambia followed the pattern of Malawi and Zimbabwe, thus the discussion of medical work in this country will be brief. “The [mission] societies in Zambia generally adopted the traditional methods of establishing schools and helping the sick in addition to proclaiming the gospel. . . . [Hence] the people were benefitted through educational and medical services.”<sup>56</sup>

Medical missions continued to face a host of challenges. In one incident, Dr. Walter Fisher of the Christian Missions in Many Lands had a spat with Chief Sakawumba

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<sup>54</sup>John Baur, *2000 Years of Christianity in Africa: An African History 62-1992* (Nairobi, Kenya: Paulines Publications Africa, 1994), 206.

<sup>55</sup>*Ibid.*, 432.

<sup>56</sup>Falk, *The Growth of the Church in Africa*, 203.

of the Luvale tribe by the Zambezi river in Angola; he thus decided to move his station across the border to Kalene in Zambia and worked among the Lunda tribe.<sup>57</sup>

Medical mission was more advanced in Namibia, South Africa, and Zimbabwe simply because the White minority governments heavily sponsored health care. Besides, those health services were largely for the benefit of the White people. In contrast, the rest of the southern African countries had to rely on medical missions that struggled financially. The Livingstonia Mission was exemplary—at a macro level—in that it offered a holistic approach to mission, offering physical and spiritual health as well as empowering the Africans with education and vocational training.

The next section examines Adventist medical mission work in the same territories of southern Africa. Overall, Adventist medical missions in the region came at the turn of the century.

### **Southern Africa Adventist Medical Mission**

#### **South Africa: European Patronage**

Adventist Medical Mission in southern Africa also pioneered its work in and from South Africa to the north. However, the Adventists did not start with medical clinics or hospitals; instead they started with a system of health treatment centers known as sanitariums, which offered treatments in the form of hydrotherapy, diet, exercises, rest, and massages as well as helping clients to have a positive outlook based on faith in

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<sup>57</sup>Reportedly, the doctor had been instructed by Chief Sakawumba to drown two of his African male smallpox patients, but the latter refused and instead chose to relocate. See Walima Kalusa, “Disease and the Remaking of Missionary Medicine in Colonia Northwestern Zambia: A Case Study of the Mwinilunga District, 1902-1964” (PhD dissertation, Johns Hopkins University, 2003), 1-2.

God.<sup>58</sup> The rationale behind this approach was that the human body needed complete restoration, both physical and spiritual. This signaled the early stages of holistic approaches to healing.

This early system of healing and medical mission work in South Africa began under European patronage.<sup>59</sup> In 1895, the first sanitarium superintended by an American physician, Dr. Kate Lindsay, was established in Cape Town.<sup>60</sup> Other medical and health institutions opened up in different places such as Stellenbosch, Pietermaritzburg, Durban, East London, Port Elizabeth, and Bloemfontein, operated by the Adventist Church or private Adventist members.<sup>61</sup> An added important feature of the Cape Sanitarium was that it served as a “haven of peace for the missionaries who arrived from the north seeking to rebuild their health [or recuperate] after arduous years in the tropics.”<sup>62</sup>

Financial limitations led to the demise of most of the sanitariums. “By 1930, however, the Cape Sanitarium was reduced to a nursing home, and the emphasis on

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<sup>58</sup>Francois Swanepoel, “The Origin and Early History of the Seventh-day Adventist Church in South Africa, 1886-1920” (MA thesis, University of South Africa, 1972), 156-157.

<sup>59</sup>Arthur Whitefield Spalding explains, “The work in South Africa naturally divided itself into two concerns: first with the white people . . .; the second, with the native peoples who had yet to be Christianized.” Arthur Whitefield Spalding, *Christ's Last Legion: A Second Volume of a History of Seventh-day Adventists Covering the Years 1901-1948*, vol. 2 (Washington, DC: Review and Herald, 1949), 371.

<sup>60</sup>Arthur Whitefield Spalding, *Origin and History of Seventh-day Adventists: A Revision of the Books Captains of the Host and Christ's Last Legion*, vol. 4 (Washington, DC: Review and Herald, 1962), 10-11.

<sup>61</sup>Swanepoel, “The Origin and Early History of the Seventh-day Adventist Church in South Africa, 1886-1920,” 164.

<sup>62</sup>Muriel E. Chapman, “Missionary Nursing in South Africa, 2009,” Fld 4, Box 2, Muriel E. Chapman Collection, Center for Adventist Research, Andrews University, Berrien Springs, MI.

medical service was transferred to the native missions.”<sup>63</sup> The Adventist medical service to Whites in South African thus came to an end<sup>64</sup> for several reasons, including the (1) high cost of operating well-equipped medical institutions for Whites, (2) adequacy of government hospitals for Whites, and (3) pressing plight of African health needs.

It took a long while till Adventist medical missions were extended to native South Africans. The South African government also “virtually forgot the medical needs of the black people living in tribal lands.”<sup>65</sup> However, medical missions to the northern frontier began about the mid-1890s.<sup>66</sup>

### Adventist Medical Missions to Africans

#### **Zimbabwe**

Simultaneous to the establishment of sanitariums in South Africa, Adventists sent their first missionaries into the interior of southern Africa. “The native work was first begun by the opening of Solusi Mission . . . [in] Matebeleland [a province in Zimbabwe], in 1894.”<sup>67</sup> It was tragic when Dr. A. S. Carmichael, who was part of the missionary team, became the first of several missionaries to succumb to malaria.<sup>68</sup> However, Dr. H.

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<sup>63</sup>Spalding, *Origin and History of Seventh-day Adventists: A Revision of the Books Captains of the Host and Christ's Last Legion*, 11.

<sup>64</sup>Swanepoel, “The Origin and Early History of the Seventh-day Adventist Church in South Africa, 1886-1920,” 167.

<sup>65</sup>Gelfand, *Christian Doctor and Nurse: The History of Medical Mission in South Africa from 1799-1976*, 23.

<sup>66</sup>Arthur Whitefield Spalding, *Captains of the Host: First Volume of a History for Seventh-day Adventists Covering the Years 1845-1900*, vol. 1 (Washington, DC: Review and Herald, 1949), 611.

<sup>67</sup>Ibid.

<sup>68</sup>William H. Anderson, “Early Experiences: Our First Mission Station in a Heathen Land,” *The Advent Review and Sabbath Herald*, July 30, 1929, 17.

A. Green soon joined the mission and began serving Africans surrounding the mission and the White settlers who had begun to settle on the farms in the vicinity.<sup>69</sup>

Though the Adventist Church in Zimbabwe does not currently have a full-fledged hospital, the medical work began with the setting up of the Solusi Clinic and several other clinics or dispensaries in the country. However, education was the main agency as schools were established first. F. B. Armitage opened a mission station called Somabula in 1901 that was later known as the Lower Gwelo Mission.<sup>70</sup> In this mission, a school was established that eventually developed into a teacher training institution. By 1952, the medical clinic that served the school and the community also developed further to a little sixteen-bed hospital.<sup>71</sup>

Subsequently, Inyazura Mission and a host of other mission stations were established, but none of them had medical work at a level higher than a clinic or dispensary. Most of these stations had to do without a medical doctor, placing a lot of strain on the lead nurse.<sup>72</sup> Nevertheless, lack of resources affected the work in the territory, hampering the planned work further north in Zambia.

## **Zambia**

Adventist medical mission to Zambia was a direct extension of work from the Solusi Mission. William H. Anderson ventured north across the Zambezi River into

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<sup>69</sup>William H. Anderson, *On the Trail of Livingstone* (Mountain View, CA: Pacific Press, 1919), 138-141

<sup>70</sup>*SDA Encyclopedia*, 1976 ed., s.v. "Rhodesia: Development of SDA Work."

<sup>71</sup>Chapman, "Missionary Nursing in South Africa."

<sup>72</sup>E. C. Borger, "Opportunities in the Zambesi Union," *The Advent Review and Sabbath Herald*, June 27, 1929, 19-20.



Zambia about 1906 to establish the famed Rusangu Mission.<sup>73</sup> In 1916 S. M.

Konigmacher opened the Mosufu Mission close to the Belgian Congo, but within Zambia.<sup>74</sup>

Other missions that followed such as the Chimpempe Mission (1921) in the northeast section of Zambia had rudimentary medical outstations in the form of simple treatment centers or dispensaries. The maturation of Adventist medical work in Zambia came with the establishment of hospitals such as the Mwami Mission Hospital and Leprosarium (1925) in the northeast toward Nyasaland (Malawi) and the Yuka Hospital and Leprosarium (1955) in the Kalabo district.<sup>75</sup>

Comparatively, Zambia had more Adventist hospitals than Zimbabwe. While medical missions in Zambia were initiated from Zimbabwe, Malawi was responsible for the Mwami Mission Hospital and Leprosarium.

## **Malawi**

In Malawi, “although Malamulo Mission was established in 1902, it was more than a decade before medical work was begun.”<sup>76</sup> Prior, the Nyasaland Mission had been known as the “Plainfield Mission,” formerly a Seventh-day Baptist institution that Adventists purchased. It was later renamed “Malamulo Mission,” that is, the Mission of

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<sup>73</sup>William H. Anderson, *On the Trail of Livingstone* (Mountain View, CA: Pacific Press, 1919), 263.

<sup>74</sup>William H. Branson, *Missionary Adventures in Africa* (Washington, DC: Review and Herald, 1925), 121.

<sup>75</sup>*SDA Encyclopedia*, 1976 ed., s.v. “Mwami Hospital.” See also *ibid.*, s.v. “Zambia.”

<sup>76</sup>Muriel E. Chapman, *Mission of Love: A Century of Seventh-day Adventist Nursing* (Portland, OR: Association of Seventh-day Adventist Nursing, 2000), 261.

the Commandments.<sup>77</sup> At this mission, a hospital and leprosy treatment center were established—the Malamulo Hospital and Leprosarium—in 1926.<sup>78</sup>

Medical work spread fast in Malawi, though beset by many challenges. The Blantyre Medical Mission work was established not long after Malamulo. In 1908, S. M. Konigmacher and his wife were sent to Matandani to establish a mission station about a hundred miles north of Malamulo. As professional nurses, they immediately began simple treatments. In 1915, nurse Irene Fourie arrived to help in what had become a modest hospital building, but staff shortage and limited funds reduced the hospital to a dispensary.”<sup>79</sup> However, several other dispensaries were established elsewhere including Thekerani and Luwazi.<sup>80</sup>

There were some significant developments that came about as a result of medical mission in Malawi. First, Matandani grew to be an important instructional industrial center for Africans. Second, the training of African para-medical or first-aid missionaries was started, necessitated by a dire need for professional medical personnel. Such skilled and essential workers were urgently needed throughout the country.

Most of our native teachers at the main station [Malamulo] receive a little training in medical work. They spend a few weeks in the hospital, and learn when and how to administer simple medicines, give simpler treatments, and dress wounds. . . . They find this training of great value to them when they go out to teach in the village

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<sup>77</sup>Branson, *Missionary Adventures in Africa*, 35.

<sup>78</sup>W. L. Emmerson, “Malamulo Mission Jubilee,” *British Adventist Messenger* 57 14 (1952): 10-11.

<sup>79</sup>Branson, *Missionary Adventures in Africa*, 37.

<sup>80</sup>E. G. Marcus, “The Medical Work of the South East African Union,” *The Southern African Division Outlook*, February 15, 1934, 4.

schools. It also helps to break down prejudice, and lets the people know that the teacher is there to try to help them.<sup>81</sup>

This certainly had an impact on the medical work among the African people. After government accreditation in 1935, students who completed the three-year course graduated as medical assistants.<sup>82</sup>

Third, was the training of hospital assistants for young Africans, which was carried out in the same hospital. “The term ‘hospital assistant’ is used because the student has preparation not only in nursing but also in giving service in diagnosing, prescribing, and dispensing medications.”<sup>83</sup> Last, but not least, was the development of a health training institution in Malamulo. A school of nursing including midwifery and another for hospital technology (such as x-ray) were added, making Malamulo a renowned mission-training institute. Malamulo Mission Hospital graduated the initial African nurses in 1938—a first in the whole of the Southern African Division.<sup>84</sup>

The following discussion will focus on Adventist medical missions in South Africa, Lesotho, Namibia, and Swaziland, which now fall under the jurisdiction of the South African Union Conference of the Adventist Church.

## **Lesotho**

Adventist work in Lesotho was established at a village named Kolo in 1899 by J. M. Freeman, accompanied by the first Mosotho Adventist convert, David Kalaka.

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<sup>81</sup>Branson, *Missionary Adventures in Africa*, 49.

<sup>82</sup>*SDA Encyclopedia*, 1976 ed., s.v. “Malamulo Hospital and Leprosarium.”

<sup>83</sup>Chapman, “Missionary Nursing in South Africa.”

<sup>84</sup>Lois Burnett, “Report of Visit: Nokhuphila Mission Hospital—Western Native Township, Johannesburg, Transvaal, South Africa, 1952,” 2, Andrews University, Berrien Springs, MI.

However, medical work began with the Kolo Mission Dispensary in 1948, which later became the well-known Maluti (High Mountain) Mission Hospital (1951).<sup>85</sup> One of the major contributions of the Maluti Mission Hospital was the opening of a school of nursing in 1958,<sup>86</sup> offering training for African nurses for the first time in the country.

A second pioneering work of interest in Lesotho was the Emmanuel Mission, which was established in 1910 where later a dispensary was also added. Adjacent to the Emmanuel Mission, the Emmanuel Children's Home for babies born to leper parents was established.<sup>87</sup>

## **Namibia**

After William H. Anderson's pioneering work in Namibia in 1922, Ovid O. Bredenkamp was sent to establish the work in that country in 1923.<sup>88</sup> Until then, the territory did not have any Adventist medical work of significance. Therefore, there were no dispensaries, clinics, or hospitals. Despite early attempts to establish Adventist medical missionary work, the first Adventist medical clinic came only about a century later, opening on September 10, 2009, in Windhoek.<sup>89</sup> No Adventist hospital had been established by then.

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<sup>85</sup>Paul Bringle, "The Opening of Maluti Mission Hospital," *South African Union Lantern*, 1951, 1-2.

<sup>86</sup>Chapman, *Mission of Love: A Century of Seventh-day Adventist Nursing*, 275.

<sup>87</sup>*SDA Encyclopedia*, 1976 ed., s.v. "Emmanuel Children's Home."

<sup>88</sup>Priscilla E. Willmore, "Wedding," *African Division Outlook*, April 1, 1923, 8.

<sup>89</sup>Richard Nchabi Kamwi, "The Opening of the First Seventh-day Adventist Clinic," [http://www.healthnet.org.na/minister/speeches/SDA\\_Clinic\\_Officially\\_opening\\_Sept\\_09\[1\].pdf](http://www.healthnet.org.na/minister/speeches/SDA_Clinic_Officially_opening_Sept_09[1].pdf) (accessed March 14, 2010).

## Swaziland

Adventist missions in Swaziland resulted from the efforts of two pioneers who worked relentlessly in their service to the Swazi people. Queen Regent Gwamile refused J. C. Rogers entry; however, Joseph Hlubi (a Swazi national) succeeded in establishing the Adventist faith in the Mahamba area<sup>90</sup> where he founded an elementary school.<sup>91</sup> Swaziland had no significant medical mission work despite its geographical proximity to South Africa—the “mother” of all Adventist missions in southern Africa.

## South Africa

Though Adventist medical missions in South Africa began on a promising note with sanitariums, the northern frontiers fared much better, with a host of hospitals, dispensaries, and clinics, including training schools. Adventist medical missions that focused on native health care came decades later in South Africa.

The first Adventist hospital specifically set up for Africans was opened in 1936 in the southwestern township of Johannesburg—Nokuphila Hospital.<sup>92</sup> However, the hospital was short-lived as it had to be closed in 1959 because “the native town [was] included in the city planning as one of those housing areas which [were] condemned and moved to another location of the city.”<sup>93</sup>

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<sup>90</sup>Swaziland Conference, “Conference: Its [Adventist] Beginnings,” <http://swazilandconference.org.sz/beginnings.htm> (accessed March 13, 2010).

<sup>91</sup>Priscilla E. Willmore, “Zulu Mission Field Notes,” *The African Division Outlook*, July 1, 1922, 4.

<sup>92</sup>Burnett, “Report of Visit: Nokhuphila Mission Hospital—Western Native Township, Johannesburg, Transvaal, South Africa.”

<sup>93</sup>Ibid.

Two years after its opening, the hospital began a school of nursing program that trained both African and European nurses. Apart from Nokuphila Hospital, there were other medical mission activities run at a lower scale [dispensaries] by nurse missionary-wives. “The missionary nurse wives who provided medical care in the absence of doctors at mission stations were established north of the Cape Province.”<sup>94</sup> This would be the pattern of the development of dispensaries not only in South Africa, but also in other parts of southern African countries, including Botswana.

### **Adventist Medical Mission in Botswana**

#### **Challenges to Pioneer Adventist Mission**

Botswana was first entered by earlier pioneer missionaries of the LMS, with Robert Moffat visiting the Bangwaketse of Chief Makaba at Kgakgwe, near Kanye on August 1, 1824,<sup>95</sup> while Dr. David Livingstone visited and resided with the Bakwena of Chief Sechele at Kolobeng village from 1847-1852.<sup>96</sup> “It was at Kanye, [that] Robert Moffat stood on the hillside and ‘saw the smoke of a thousand villages.’”<sup>97</sup>

Another influential major tribe had also been entered by the LMS by Moffat and Livingstone—the Bamangwato of Chief Sekgoma of Shoshong in central Bechuanaland.

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<sup>94</sup>Chapman, *Mission of Love: A Century of Seventh-day Adventist Nursing*, 277.

<sup>95</sup>John Phillip, *Researches in South Africa: Illustrating the Civil, Moral, and Religious Condition of the Native Tribes*, vol. 2 (New York: Negroes Universities Press, 1969), 148.

<sup>96</sup>Janet Wagner Parsons, *The Livingstones at Kolobeng 1847-1852* (Gaborone, Botswana: Pula Press and Botswana Society: 1997), 34, 134.

<sup>97</sup>Patricia Rabe, “The Lure of Service in Bechuanaland,” *Australian Record and Adventist World Survey*, January 29, 1962, 1.

But, some German missionaries had also served among the Bamangwato tribe.<sup>98</sup>

However, it was during the reign of Chief Sekgoma's heir—Khama the Great—that LMS Christianity was not only fully accepted but also vigorously defended as the nation-state's faith.<sup>99</sup> William H. Anderson—pioneer-designate in Bechuanaland—had been warned that the king had signed an agreement with the LMS that no other mission society would be allowed into the country.<sup>100</sup> But Anderson had an alternative plan for reaching king Khama's land, if not Bechuanaland. He targeted the Tswana diaspora who worked in the South African mines and White settler farms. It was his hope to send these with the gospel to witness among their own peoples upon returning home.<sup>101</sup>

Based in Mafeking across the border in South Africa, Anderson providentially used another conduit to reach the forbidden land—a local native newspaper. Two native Adventist converts who purchased the newspaper that previously “printed quite a tirade against the work of the Seventh-day Adventists, . . . requested Elder Anderson to furnish them at least two columns of matter on present truth for each issue.”<sup>102</sup> Anderson explained that the paper was written in Setswana; he was allowed a “hundred copies each week for free distribution, and also four hundred more for the actual cost of the paper on

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<sup>98</sup>Robert Moffat, *Rivers of Water in a Dry Place or from Africanner's Kraal to Khama's City* (London: The Religious Tract Society: n.d.), 195.

<sup>99</sup>du Plessis, *A History of Christian Missions in South Africa*, 277-279.

<sup>100</sup>Virgil Robinson, *Desert Track and Jungle Trail: The Story of W. H. Anderson, Missionary to Africa* (Mountain View, CA: Pacific Press, 1968), 86.

<sup>101</sup>*Ibid.*, 87-88.

<sup>102</sup>William H. Branson, “The Work in Africa,” *The Adventist Review and Sabbath Herald*, August 4, 1921, 14.

which they are printed.”<sup>103</sup> The paper found circulation in the Bechuanaland Protectorate.

The presence of the LMS in Bechuanaland was significant because it had implications not only for Adventist missions in the territory, but also for other Christian missions. First, the chiefs had complete control of their own affairs because of the colonial administration’s ‘indirect rule policy.’ Thus permission had to be sought from the chief for any new Christian missionary work. Second, the LMS had exclusive rights, having entered into agreements with the chiefs in the country not to allow other mission societies. As a result “most of the Christians in Bechuanaland were adherents of the London Missionary Society, which was the only generally accepted religious society in the country.”<sup>104</sup> Hence, Adventist mission in the Bechuanaland Protectorate was barred for a protracted time.

The political setting also had its own ramifications for the start of an Adventist Mission in Bechuanaland. The colonial government was British, and so was the LMS. With those two entities collaborating with each another, the Adventist mission was understood by the British administrators to be an American interest.

When Adventists were finally allowed to enter in 1921, the LMS insisted that the new missionary society offer only medical services, with no preaching; the Adventists only managed to stand their ground when they threatened to leave the area.<sup>105</sup>

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<sup>103</sup>William H. Anderson, “A Providential Opening,” *Australasian Record*, October 3, 1921, 2.

<sup>104</sup>*SDA Encyclopedia*, 1976 ed., s.v. “Kanye Hospital.”

<sup>105</sup>Selelo-Khupe, *An Uneasy Walk to Quality: The Evolution of Black Nursing Education in the Republic of Botswana, 1922-1980*, 18.



The LMS protest was expected because the prevailing polity was that whichever mission society established first in a territory, it had exclusive rights to it. Thus, in places where the LMS arrived late, they also struggled to have access.

Some communities refused LMS missionaries because other societies had got there first: for example, Dutch Reformed missionaries from the Transvaal among the Kgatla Tswana in 1860 around Mochudi in Botswana, and Anglican missionaries principally among the Hurutshe in the Tati District. . . . The Roman Catholics, until well into the twentieth century, had no permission at all to carry on mission work in Tswana country.<sup>106</sup>

It would seem that access to a Tswana territory was on a first-come, first-serve basis, provided the community was impressed to accept the approaching missionaries. Coming in late, Adventist missionaries did not have easy access. Anderson approached other mission societies that had been established in Bechuanaland, but to no avail.<sup>107</sup>

In addition to the mission society-tribal agreements, the Adventist Mission had another challenge in establishing work in the territory—nominal Christianity. Since they were not the first to proclaim the gospel to the Tswana, Adventists found that the communities had long been exposed to Christianity through the agency of the LMS and others.

The zeal to listen to the gospel and commitment to it had waned; nominal Christianity abounded.<sup>108</sup> This, together with the African traditional religion biases against Christianity made Christian work extremely difficult. In 1937, Doctor Donald H.

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<sup>106</sup>Rodger B. Beck, “Monarchs and Missionaries among Tswana and Sotho,” in *Christianity in South Africa: A Political, Social, and Cultural History*, ed. Richard Elphick and Rodney Davenport (Berkeley, CA: University of California Press, 1997), 116.

<sup>107</sup>Branson, *Missionary Adventures in Africa*, 121.

<sup>108</sup>Paul Bringle, “In Old Bechuanaland, South Africa,” *The Advent Review and Sabbath Herald*, August 31, 1950, 15.

Abbott, who was in charge of the Kanye Medical Mission, could still lament about the Tswana being “nominal Christians for many years,” and that it was “difficult to touch their hearts with the gospel.”<sup>109</sup>

In spite of the several challenges missions faced at the beginning of the work in the Bechuanaland Protectorate, Adventist pioneers applied successful strategies.

### Kanye Adventist Medical Mission Hospital

Delegates attending the Eighth Biennial Session of the South African Union Conference in 1919 were informed that the native mission work would soon be extended to the Bechuanaland Protectorate. “W. H. Anderson with other help from America is contemplating opening work in Bechuanaland.”<sup>110</sup> Thus the Bechuanaland Mission Field was established with Anderson at the helm as its Superintendent based at Mafeking.<sup>111</sup>

Anderson perceived the difficult task that lay ahead, partly blaming procrastination in starting the work there. He lamented that for more than a quarter of a century, the Bechuanaland Protectorate had been by-passed as Adventist missionaries transited en route to Rhodesia (Zimbabwe) and beyond, despite the General Conference Committee Council’s voting for the work to start in Bechuanaland as far back as 1917.<sup>112</sup>

According to Anderson, the door opened for Adventist Mission in Bechuanaland

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<sup>109</sup>Donald H. Abbott, “Kanye Medical Mission,” *The Medical Evangelist: Devoted to Health Reform and Medical Missionary Work* 23 40 (1937): 2.

<sup>110</sup>Bringle, “In Old Bechuanaland, South Africa,” 15.

<sup>111</sup>Anderson, “A Providential Opening,” 2.

<sup>112</sup>William H. Anderson, “Bechuanaland Mission Field,” *The Adventist Review and the Sabbath Herald*, June 16, 1921, 21.

when he urged Dr. A. H. Kretchmar to sign a government document that he would not practice his religion publicly.<sup>113</sup> The door was open, but only partially. However, Anderson's wife, Mary, who had some limited home nursing care that she applied to care for the tribal peoples with good results in drawing them to the gospel, observed, "The medical work is the same the world over—an entering wedge for the gospel."<sup>114</sup>

But precisely what prompted and inspired the Andersons to focus on medical work as a precursor to evangelistic work? First, it likely was their inherent belief in the Adventist Church's view of medical work as the "right arm of the gospel."<sup>115</sup> Second, the Andersons' small-scale medical mission experiment inspired them. They set up evangelistic and medical work for people from the Bechuanaland Protectorate as they crossed the border to Mafeking for trade.

Soon their medical services impressed the people and also caught the attention of "the government doctor who was in charge of health services for the community and the regent then in control of the government."<sup>116</sup> As the people spoke highly of the Andersons upon their return to their homeland, the way for future Adventist medical work was slowly being worked out.

When Dr. A. H. Kretchmar began work at Kanye village and set up a small dispensary, the benefits of medical missionary work were instantly seen.

Dr. Kretchmar . . . has demonstrated that this line of work is a wonderful entering wedge when it is conducted along right lines, and we hope soon to see the work done

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<sup>113</sup>Branson, *Missionary Adventures in Africa*, 121.

<sup>114</sup>White, *Medical Ministry: A Treatise on Medical Missionary Work in the Gospel*, 54.

<sup>115</sup>*Ibid.*, 312.

<sup>116</sup>Bringle, "In Old Bechuanaland, South Africa," 15.

at Kanye duplicated in many places. The doctor reports that the little hospital is full most of the time, and that it is daily growing in favor with the people. Its influence is being felt for hundreds of miles around, and doors are being open to the Truth that was tightly closed until the medical missionary entered.<sup>117</sup>

Doctor Kretchmar's work was not only critical to Adventist Mission to Bechuanaland, but its success became the determining factor in the deployment of medical missionary doctors to other places in the African Division. Dr. Kretchmar appealed for more medical missionaries to come to serve in the region.<sup>118</sup>

As Dr. Kretchmar's medical work grew, the villagers increasingly became friendly to the Adventist Mission. With discerning wisdom Anderson, who superintended the Bechuanaland Mission Field, wisely kept evangelism on hold in order for the medical mission to establish contacts and create a welcoming presence for the gospel.<sup>119</sup> Anderson soon reported that the Queen of the 15,000-strong village of Kanye and her royal household had embraced the Adventist faith, keeping the Sabbath; he had the confidence to organize what could become the biggest church in southern Africa.<sup>120</sup>

Thus Anderson's evangelistic work was opened for him because Dr. Kretchmar's "ability to relieve suffering humanity proved the truth of the statement in the Spirit of prophecy that 'the most hard-hearted and apparently sin-encased souls may be approached in this way.' . . . Within weeks he had added the gospel ministry to his

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<sup>117</sup>William H. Branson, "Extracts of Report of the Work in Africa: Presented by Elder W. H. Branson at the General Conference Session," *The African Division Outlook*, June 1, 1926, 3.

<sup>118</sup>Authur Herman Kretchmar, "From Africa," *The Medical Evangelist: Devoted to The Promulgation of Health Reform Principles* 11 9 (1924): 1.

<sup>119</sup>William H. Anderson, "Encouraging Words from Africa," *The Medical Evangelist: Devoted to the Promulgation of Health Reform Principles* 10 49 (1924): 10.

<sup>120</sup>L. A. Hansen, "A Remarkable Development," *The Advent Review and Sabbath Herald*, June 28, 1923, 10.

armamentarium.”<sup>121</sup> Anderson conducted his first evangelistic series in Kanye, and even though 99 percent of the villagers were out in the farms, “the church has been crowded every night for several weeks. After only three weeks from the opening of the meetings, [Anderson] spoke on Sabbath morning to over fifty adults who had taken their stand for the Sabbath.”<sup>122</sup>

It is evident that the main Adventist Mission strategy for Bechuanaland was through medical work. Part of that approach was to also draw patients, not only from within the village and its immediate neighborhood, but also from distant lands. The next section discusses this type of mission—centripetal mission.<sup>123</sup>

People from different places heard how Kanye Medical Mission was restoring patients to physical health. They heard of the kindness of the doctor and staff who cared for all regardless of their status, race, or condition. This was at a time when the treatment of Africans was unequal to that of Europeans. For example, the small colonial government health posts in Gaborone, Francistown, and Motloutse were strictly for government employees and European settlers. When the colonial government medical department was formed in 1902, it was to the exclusion of the Africans.<sup>124</sup>

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<sup>121</sup>A. N. Donaldson, “Medical Missionary Work,” *The Medical Evangelist: Devoted to Health Reform and Medical Missionary Work* 21 20 (1934): 1.

<sup>122</sup>T. M. French, “Opening Providences in Bechuanaland,” *The Advent Review and Sabbath Herald*, October 11, 1923, 15.

<sup>123</sup>In centripetal mission, the people are drawn toward a center to receive the Word of God. For example, in the Old Testament, nations came toward Israel. See David J. Bosch, “Witness to the World,” in *Perspectives on the World Christian Movement: A Reader*, ed. Ralph D. Winter and Steven C. Hawthorne (Pasadena, CA: William Carey Library, 1981), 60.

<sup>124</sup>Selelo-Khupe, *An Uneasy Walk to Quality: The Evolution of Black Nursing Education in the Republic of Botswana, 1922-1980*, 11-17.

Just as in the Old Testament times when sojourners who came to Jerusalem heard of the Great Yahweh and left the city blessed and passed on the message to their folks at their places of origin, patients from distant places came to Kanye for medical help and passed on their experience and the gospel message to their kin upon returning to their homes. Those who heard the news visited the hospital for medical attention. There are illustrious stories from as far as Southern Rhodesia (Zimbabwe) where a patient praised the work at Kanye and recommended it highly.<sup>125</sup> Locally, there were stories about visiting patients from Serowe—the capital village of king Khama—who went back baptized and shared the gospel message and began secret Adventist churches.<sup>126</sup>

This experience repeated itself with people from other villages. The Africans who visited Doctor Kretchmar's little hospital in Kanye began spreading the Adventist message when they returned home. There was yet another (Zulu) patient from De Aar, South Africa, who had travelled over 600 miles to Kanye. When asked what made him traverse the land, "he said he had heard it said in his community that the Seventh-day Adventists had a doctor in Bechuanaland who was kind to the people."<sup>127</sup>

Remarkably, there were those who braved the Kalahari Desert to go to Kanye in response to the 'good news' they had heard. According William H. Branson,

Three men walked 300 miles through the desert. They had heard out there (I do not know how) that a new religion was being taught down where the Doctor was, and wanted to know about it. They felt so impressed that they walked those 300 miles

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<sup>125</sup>Isaac Xhiba, "The One Who Returned: Medical Department," *The African Division Outlook*, October 15, 1927, 2.

<sup>126</sup>William H. Branson, "The Work at Kanye," *The African Division Outlook*, November 15, 1925, 15.

<sup>127</sup>William H. Branson, "The Right Arm Ministry in Mission Work," *The Advent Review and Sabbath Herald*, September 20, 1928, 8.

across the desert sands to come and ask the Doctor to teach them about this new religion. They studied there and learned the truth, took a New Testament, and then went back home out into the middle of that desert to teach the message to their people out there.<sup>128</sup>

These illustrious examples show how centripetal mission worked to the service of peoples near and far and in places within and without the borders of Bechuanaland. As soon as evangelistic work started in Kanye, Doctor Kretchmar also began to visit areas outside the village, thus beginning centrifugal mission.

Mission outposts were part of the strategy to reach out to the villages with the Adventist message. By the 1950s, “the three outlying churches were . . . Manyana, Moshupa, and Taung.”<sup>129</sup> These were among the first mission outposts to be established.

When the Adventist missionaries at the Kanye Medical Mission became inundated with calls for the new message from different villages, they decided it was time to begin visiting those areas. Several times, such trips included the doctor. The record of Doctor Kretchmar’s experience of his visit to one of the nearby villages reveals the following.

Two weeks ago we visited the stads [courtyards] of Mashupa [*sic*] and Manyana. The people swamped us with medical work. The chief at Manyana gave Brother Walker [Bechuanaland Mission Field superintendent] a very cordial invitation to come there and hold meetings. Brother Walker asked him where he could hold the meetings and the chief said in the church. It was a Lutheran church, I believe.<sup>130</sup>

Here can be seen the striking blending of medical and gospel work. Doctor

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<sup>128</sup>William H. Branson, “The Work of Doctor Kretchmar: From Talk by Elder W. H. Branson,” *The Medical Evangelist: Devoted to Health Reform and Medical Missionary Work* 11 24 (1924): 2.

<sup>129</sup>Rodney H. Finney, *Judy Goes to Africa* (Nashville, TN: Southern Publishing Association, 1952), 124.

<sup>130</sup>Branson, “The Work at Kanye,” 15-16.

Kretchmar's medical work attended to the physical needs of the people, while Pastor Walker's evangelistic meetings took care of the people's spiritual needs. At first the people had prejudice against the doctor and his religion. Soon they realized they needed the doctor's medicine. The message of the gospel was eventually embraced. This was the true face of medical evangelism at work—the key strategy of Advent Mission in the Bechuanaland Protectorate.

Manyana was just one of the many successful mission outposts where “the doctor [went] out with Brother Walker and they [went] into villages and opened a clinic for a day or two.”<sup>131</sup> This would be followed by the organization of a company of believers in the village visited, and soon the company would be organized into a church.<sup>132</sup>

Often the doctor would combine the work of evangelism and health—this fulfilled the function of a medical-evangelist. In a related occasion, Doctor M. W. Fowler practiced what he called “Mobile Health Evangelism.”<sup>133</sup> This entailed mounting a sound projector on the back of an open truck and casting the image on a large screen, with the health-evangelist carrying out “some medical educational work among the natives.”<sup>134</sup> Thus, the listeners were made to understand the relationship between godliness and cleanliness.

In addition to mission outposts, dispensary outposts were established in both near

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<sup>131</sup>William H. Branson, “A Medical Station in Every Field,” *The Medical Evangelist: Devoted to Health Reform and Medical Missionary Work* 13 28 (1927): 24.

<sup>132</sup>O. R. Staines, “Bechuanaland Mission,” *The Medical Evangelist: Devoted to Health Reform and Medical Missionary Work* 13 44 (1927): 2.

<sup>133</sup>M. W. Fowler, “Health Evangelism: Mobile Health Evangelism,” *The Ministry: For World Evangelism*, April 1953, 24.

<sup>134</sup>*Ibid.*



and distant places. Places in the vicinity included the famous Moshupa village, which was twenty miles from Kanye.

About twenty miles from Kanye is another large native town of about 8,000 people. The doctor [Kretchmar] is going over there today to ask the chief to allow us to start work among his people. The doctor has been their physician for the last nine months, and now is sure he can be their spiritual adviser as well. He will do all he can to swing open the door there for this message.<sup>135</sup>

The doctor had been patient and eventually was given permission to set up a medical dispensary. Later in 1964, Kanye Hospital nurse Dawn Benham observed, “At Mashupa [*sic*] we have a very nice dispensary run by one of our trained nurses. One of our doctors calls at this place every Monday, as it is quite a large village.”<sup>136</sup> To date, Moshupa dispensary is the only operating Adventist clinic in rural Botswana.<sup>137</sup>

After the Moshupa dispensary, the next focus lay on the Kalahari Desert—a vast array of dry sandy grassland that covers over 60 percent of the country.

As early as 1926, a trader from the desert had visited our Kanye mission hospital, and had manifested interest in our work, and begged for a worker to accompany him back to his desert home to teach the native people living there. No one was able to go [for lack of personnel], but literature was supplied for distribution among the native chiefs and headmen of his district.<sup>138</sup>

Such calls from those deep in the desert, together with the long treks made by patients traversing several hundred miles of desert country to Kanye for medical attention, prompted the Kanye medical mission team to consider visiting the arid land.

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<sup>135</sup>Branson, *Missionary Adventures in Africa*, 125.

<sup>136</sup>Dawn Benham, “From Far Horizons: Kanye Mission Hospital,” *Australasian Record and Advent World Survey*, January 20, 1964, 6.

<sup>137</sup>*SDA Encyclopedia*, 1976 ed., s.v. “Kanye Hospital.”

<sup>138</sup>William H. Branson, “The Kalahari Desert Entered: Zambezi Union Mission,” *The African Division Outlook*, June 1, 1927, 3-4.

However, because of the distances involved, the difficult-to-traverse sandy terrain, and lack of personnel, the team decided to send “Itumelin [*sic*], the native evangelist.”<sup>139</sup>

Kanye hospital had broken down prejudice as far away as the Kalahari Desert, allowing native evangelists like Itumeleng to serve those areas without hindrance. A major outstation was set up in the desert village of Lehututu by a team of missionaries sponsored by the Zambezi Union Mission.<sup>140</sup> The visitors were well received by the chiefs and left with an urgent sense of a need to have a dispensary outpost in that area.

Subsequent work by a native evangelist and medical visits by the doctor resulted in this good report of 1928: “A company of [San or Basarwa] on the edge of the Kalahari Desert has accepted our message, and two of their number, a man and his wife are at the Solusi school, preparing for mission work among their people.”<sup>141</sup>

It was important that the San go to school so that they could serve their people in their own language, especially since that San language is one of the most difficult to learn.<sup>142</sup> The San “‘clacks’ his [or her] words out in one of the most difficult languages known to mankind.”<sup>143</sup> Thus sending this couple to Solusi was a good strategy for service in the Kalahari Desert.

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<sup>139</sup>Ibid.

<sup>140</sup>Ibid., 8.

<sup>141</sup>M. B. Van Kirk, “Some Reasons for the Need of a Large Midsummer Offering July 21,” *Southwestern Union Record*, July 10, 1928, 1.

<sup>142</sup>Dawn Benham, “Missionary from Bechuanaland,” *Australasian Record and Advent World Survey*, June 6, 1966, 9.

<sup>143</sup>L. C. Naden, “World Newsogrammes: Kanye, Bechuanaland, South Africa,” *Australasian Record and Advent World Survey*, May 11, 1959, 8.

Kalahari Desert doctor visits were popularized and systematized by yet another Canadian medical missionary evangelist, Doctor Jack Hay, based at the Kanye Medical Mission in the early 1950s.<sup>144</sup> By then the mode of transport had improved from ox carts to trucks. This was a typical visit experience:

The needs of the desert dwellers, who live without help and die without God, urged this missionary doctor to establish a chain of clinics to care for them. . . . [There were] little reception rooms, established at strategic points. . . . There are those who need surgery. They must go back with us on the truck, and then return with the doctor in two months' time. With stethoscope and Bible, with medicine and the message of God, the doctor and his African helpers come out six times a year from the mission hospital. They come because God gave them the vision of a need in the desert where are found some of the world's most primitive, most needy people.<sup>145</sup>

Dr. Jack Hay used Tshane as the main dispensary where “a dispenser [was] permanently stationed.”<sup>146</sup> However, there were stopovers at Kokong, Lehututu, and Hukuntsi—all villages in the heart of the desert.<sup>147</sup> Medical trips continued to the desert so that by 1964, “the hospital staff go on clinic trips away from the institution, mainly into the Kalahari Desert. One of the doctors accompanied by three or four nurses and other helpers, makes this trip every three months.”<sup>148</sup> The number of nurses accompanying the doctor is proof enough that the work in the desert was growing, thus demanded more professional personnel per trip.

In spite of the difficulties involved in the tedious trips into the Kalahari, medical

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<sup>144</sup>Karl Seligmann, interview by author, Gaborone, Botswana, June 20, 2009.

<sup>145</sup>W. L. Emmerson, “Around the World with World-Wide Advent Missions: Helping the Needy and Afflicted in Jungle Hospital and Desert Dispensary,” *The Bible and Our Time*, May 12, 1960, 10.

<sup>146</sup>Cripps Jean Donaldson, *The Arrow by Day* (Washington, DC: Review and Herald, 1965), 87.

<sup>147</sup>Seligmann, interview by author, June 20, 2009.

<sup>148</sup>Benham, “From Far Horizons: Kanye Mission Hospital,” 6.

work grew. In 1963 Dr. Carl J. Birkenstock (medical director of Kanye Hospital) assured all of the continued mobile medical work in the Kalahari Desert that yielded converts and helped the sick; new work had also started south of Kanye with clinical trips to attend to the ailing.<sup>149</sup>

However, as the work in the desert grew, it became evident that the doctor was spending a significant number of days away, at the expense of the patients at the mission hospital in Kanye. To resolve this challenge, a second doctor was called in. But the ultimate solution came—unthinkable during the days of Dr. Kretchmar—in the form of a flying mission to the desert. “A Cessna 185 . . . serves medical clinics in the Kalihari [*sic*] Desert, reducing the doctor’s absence from the Kanye Hospital from three months each year by truck, to several days by air.”<sup>150</sup>

In 1975, the Health Director of the then Trans-Africa Division noted, “Kanye Hospital, with Karl Seligman as medical director, provides not only excellent care at the hospital but also a far-ranging mobile clinic service for isolated villages in the Kalihari [*sic*] Desert. These, generally served by the plane donated by the Quiet Hour, are occasionally served by truck.”<sup>151</sup> However, Seligman points out that the flying mission soon ceased due to maintenance and operating costs.<sup>152</sup>

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<sup>149</sup>T. R. Flaiz, “News of Note: Medical Work on the Kalahari Desert,” *The Review and Herald*, July 4, 1963, 32.

<sup>150</sup>C. W. Griffith, “The King’s Business Requires Haste: Trans-Africa,” *The Atlantic Union Gleaner*, April 11, 1972, 4. The Cessna 185 “Skywagon” was dedicated to service on December 12, 1971. See Dunbar W. Smith, “Dedication of the Kanye Hospital Plane,” *Trans-Africa Division Outlook*, February 15, 1972, 2.

<sup>151</sup>Dunbar W. Smith, “Newsfront: Kanye Hospital Sponsors Kalahari Safari,” *The Review and Sabbath Herald*, October 30, 1975, 18.

<sup>152</sup>Seligmann, interview by author, June 20, 2009.

## Kanye School of Nursing

The missionary health professionals began to systematize their training program so that they could produce professional Batswana workers instead of unqualified staff who, though a great source of help, always needed direct and constant supervision. Plans for training locals began in two professional disciplines: missionary evangelism/pastoral care, and nursing. Those who were to be trained as pastor-evangelists were sent to the old Solusi Mission Training School, making true the words, “Thus Solusi will become the Southern Division’s African college for the training of future African leaders.”<sup>153</sup>

As for nursing, there was an obvious critical need at the hospital. As early as 1927, the Zambezi Union Committee “voted, that we look with favor on the plan of establishing a native nurses’ training school at the Kanye medical mission . . . that consideration be given to the course of study to be outlined, and that we endeavor to start the class January 1, 1928.”<sup>154</sup>

It was “Baine and Dr. Kretchmar who opened the school of nursing at Kanye [which began training] the three first candidates [who] all belonged to the royal class of Bamangwaketse.”<sup>155</sup> While the students had classes, most of their time was spent in the hospital wards as apprentice nurses. However, it was only in 1948 that the school of nursing at Kanye was officially opened.<sup>156</sup> It had accepted its first female formal student

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<sup>153</sup>Ralph S. Watts, “The Southern African Division,” *The Advent Review and Sabbath Herald*, June 6, 1954, 276.

<sup>154</sup>Horton J. Davies, “Actions Passed by Zambesi Union Conference,” *The African Division Outlook*, August 1, 1927, 8.

<sup>155</sup>Selelo-Khupe, *An Uneasy Walk to Quality: The Evolution of Black Nursing Education in the Republic of Botswana, 1922-1980*, 30.

<sup>156</sup>Vera Bergmann, telephone interview by author, January 18, 2009.

nurses in 1946 into its four-year training course.<sup>157</sup> No doubt this was a milestone.

An important missionary aspect in the existence of the school of nursing is that the Kanye Medical Mission had added a much valuable corps of local medical evangelists who helped in the spread of the gospel.

Natives and Europeans alike have learned to respect and love these native nurses for what they are doing. They are active in the church work and in the Sabbath schools and in the Missionary Volunteer work. They go out conducting branch Sabbath School; they conduct study groups with the natives in the village. . . . How thankful we are that we have a living church with a living message. . . . There is so much to be done for these people, and we feel that the nurses who are training in this field will do much to help spread this message.<sup>158</sup>

Clearly, this also enabled the doctor visits to more distant places like the Kalahari, knowing there was a better complement of nurses taking care of the patients back at the Kanye Hospital.

While the Kanye Hospital started work in the surrounding villages and in the distant Kalahari, there were still a lot of unmet medical needs in the rest of the country. However, an opportunity for further Adventist medical mission arose that led to the establishment of a second mission hospital at Maun, in the far northwest marshlands of Ngamiland.

#### Maun Adventist Medical Mission

The Maun Adventist Medical Mission was located in the Batawana reserve, a place endemic with diseases such as sleeping sickness and malaria. The presence of Europeans working for the government made it possible for the Batawana to be afforded

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<sup>157</sup>Myrtle Sather, "An Evening with the Southern African Division: A Nurse Tells Her Story," *The Advent Review and Sabbath Herald*, June 17, 1954, 315-316.

<sup>158</sup>Ibid.

some medical service. However, the need for a hospital was pressing.

According to the Principal Medical Officer in Mafeking, a hospital at Maun would be of great help to Europeans in the region including those in Ghanzi [a town 300 miles south-west]. In September 1932, two young Europeans died at Maun, one a teacher, and the other was said to be one of the most promising officials of the administration. In addition, other deaths which the Administration felt “might have been prevented” were on record.<sup>159</sup>

It is interesting that the initiative to establish a new hospital in this area did not come from the Adventist Church; instead, the colonial government on November 30, 1933, approached the Adventist Church and made a request for them to establish Christian medical service.<sup>160</sup> The request was attractive as the government promised some grants-in-aid. Although the government considered other mission societies such as the Roman Catholic and the LMS, the Adventists were perceived to offer better affordability and experience.<sup>161</sup>

Before the hospital was built, an agreement was signed between the Government and the Seventh-day Adventist Mission in Ngamiland. Some of the key conditions of the agreement were that the (1) government would provide a subsidy for both erecting the hospital and the operating expenses; (2) the mission would provide in the first year of operation, a doctor and nurse, and a second physician in subsequent years, and (3) the mission would conduct medical extension work—both legal and public health—on behalf

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<sup>159</sup>Fako, “Historical Processes and African Health Systems: The Case of Botswana 1800-1966,” 308.

<sup>160</sup>“Hospital: Maun--Question of Establishment of by Seventh Day Adventist Mission and Agreement with S. D. A. Mission,” 1934, MS S354/7, Fol. 6595/4, Botswana National Archives, Gaborone, Botswana.

<sup>161</sup>“London Missionary Society Observations on Proposals for Erection of Hospitals in Maun and Rakops,” 1934, MS S354/7, Fol. 6595/6, Botswana National Archives, Gaborone, Botswana. In a letter to the Botswana colonial authorities, the LMS sets out their reasons why they should be considered insteads.

of the government in the distant districts of Ghanzi and Chobe.<sup>162</sup> The failure by the mission hospital to provide the second doctor within the scheduled time would later rile the government, leading in part, to its unceremonious takeover.

When the hospital officially opened in Maun on February 15, 1937, it had twenty beds for Africans and four beds for Europeans.<sup>163</sup> However, the mission hospital did not reach its full potential as did its sister hospital in Kanye. There were a number of factors that robbed the Maun Medical Mission Hospital of its potential to grow and impact Ngamiland, leading to its takeover by the government. Apart from the fact that the government was already aggravated by the mission hospital's failure to add a second doctor due to issues of availability and expenses, the LMS queried the existence of the Adventist institution in 'their' territory and accordingly influenced the government to restrict the Adventists in non-medical mission activities.<sup>164</sup>

Despite the mission's efforts, relations with government grew worse. [The] government began to complain about the charges at Maun Hospital, and by 1944, a committee of government representatives began to think about placing a government medical officer in Ngamiland and even to take over the hospital at Maun. [The] government complained that the mission had been admitted to Ngamiland purely for medical and not for evangelistic work. . . . Thus, by October 1945, the government took over the American-based Seventh Day Adventist Mission Hospital at Maun.<sup>165</sup>

Thus came to an end a mission that might have accomplished much had it not been stopped prematurely. The Maun hospital was the last medical mission hospital to be

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<sup>162</sup>Ibid.

<sup>163</sup>Selelo-Khupe, *An Uneasy Walk to Quality: The Evolution of Black Nursing Education in the Republic of Botswana, 1922-1980*, 26.

<sup>164</sup>Ibid.

<sup>165</sup>Fako, "Historical Processes and African Health Systems: The Case of Botswana 1800-1966," 314.



built by the Adventists in the country; however, Kanye Medical Mission Hospital initiated the establishment of a health clinic in Gaborone, the capital city of Botswana in 1974. The clinic became known as Botswana Adventist Medical Services (BAMS).

### Botswana Adventist Medical Services

The Botswana Adventist Medical Services in Gaborone was the brainchild of Dr. Karl Seligmann who from the 1950s had long served as a missionary doctor at the Kanye Medical Mission Hospital. The doctor saw potential in medical mission work in this urban area. Besides, “in the 1970s there was a big interest in the part of government to expand [medical services] further.”<sup>166</sup> The initial location for this health clinic was planned for Lobatse, a town southeast of Kanye but south of Gaborone. According to Dr. Karl Seligmann, “it became apparent that the plot was very small and the competition with other private clinics was high.”<sup>167</sup> Thus, the Lobatse project was abandoned for the new location in Gaborone where BAMS is currently situated.

An important aspect of BAMS which distinguishes it from both the Moshupa SDA Health Clinic and the Kanye Medical Mission Hospital is that it has operated—save for initial grants during set-up—on a self-sustaining basis. BAMS’ success could be attributed to several factors that include:

1. Its location in an urban area where more clients have regular salaries and therefore can afford to enroll in various medical aid schemes compared to those in rural settings.

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<sup>166</sup>Seligmann, interview by author, June 29, 2009.

<sup>167</sup>Ibid.

2. Its institutional size was consciously kept to a minimum, thus ensuring that the number of medical and support staff did not impinge adversely on the income generated.

3. Its resolve to maintain and follow Adventist Christian principles that guide institutional procedures. This was largely possible because about 80 percent of the staff was Adventist, making sure prayer, Christian ethics, conduct, and deportment enhanced the credibility of the institution, and thus drawing in more new patients.

4. Its staff assumed a true missionary sacrificial role, enduring many years of understaffing and forfeiting housing allowances until the situation improved.

5. Its practice as a wholly private institution. This means that BAMS was able to charge their patients medical fees for service. This is in stark contrast to the main mission hospitals which, together with other Christian medical missions (such as the Deborah Retief and Bamalete Lutheran hospitals), had contractual agreements with the government of Botswana to charge capped minimal fees in exchange for state grants and subsidies.

Yet in spite of its size, BAMS has made some incredible contributions to the church community in particular and society as a whole. Seligmann reveals that the institution (1) contributed significantly toward education, for example by sending some young people for medical-related professional training, (2) served indigents free of charge, and (3) led many to have an encounter with the gospel through the clinic's work, with some making decisions for baptism.<sup>168</sup>

Thus, the BAMS health clinic may be considered as a possible model for further

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<sup>168</sup>Ibid.

Adventist-led medical services throughout the country because of its noted successes.

### **Missiological Implications**

Medical missions in southern Africa began with an array of challenges, which included politics and slavery, an acute lack of medical personnel, an underdeveloped philosophy of medical mission, and a negative attitude to traditional medicine. Several denominations and mission societies established medical missions—with almost all of them beginning their work in South Africa—but subsequently extending their work to the rest of southern Africa. The missionaries were not only able to see conversions of Africans to Christianity, but were also able to heal and alleviate suffering due to the diseases that were so prevalent at the time.

Adventist medical mission work also began in South Africa, first among resident Europeans, but later, Africans. Significant medical mission work among Africans was established in Botswana, Lesotho, Malawi, Swaziland, Zambia, and Zimbabwe, and belatedly, in Namibia.

Adventist medical mission in Botswana, which is the main focus of this research, began in Kanye in 1921. It took a lot of patience, prayer, and ingenuity to start the mission work in the country given the resistance that the host Batswana put up for any missionaries other than those of the already established mission societies. However, it became apparent that without the beachhead established by medical missionaries, the mission work in Botswana could have taken much longer to establish.

After the Kanye Adventist Medical Mission Hospital was founded, the missionaries further established (1) the Moshupa Dispensary, (2) the Kalahari Desert Dispensaries, (3) the Kanye School of Nursing, (4) the Maun Medical Mission Hospital

and, much later, (4) the Botswana Adventist Medical Services. The persistent challenge to Adventist medical mission work proved to be finances.

There are missiological lessons that can be drawn from chapter 4. The early missionary pioneers knew their call to duty was to spread the Word of God and provide medical care for all the people. However, because of the kinds of government systems that prevailed—for example, the apartheid and discriminatory systems of South Africa and Rhodesia, respectively—Europeans were given first preference in all aspects of life.

It is of missiological significance that some missionaries took the bold step to speak with a prophetic voice on behalf of the mistreated masses. The Moravian Society missionaries confronted the colonial government of South Africa about racism against the Hotentots. The LMS (discussed in an earlier chapter) helped the Tswana of Bechuanaland procure protection from land-grabbing neighboring White settlers. In the same vein, the Adventist medical mission in Botswana offered inclusive medical services for both Europeans and Africans.

Some African tribes refused to allow Christian missions that sought permission to establish some work in their territories. Sometimes this was at the instigation of other mission societies that feared competition. It is important then for Christian missions to dialogue with one another and have workable terms of reference—for the sake of the work of the kingdom of Christ.

However, a great missiological event in the Christian missions of southern Africa was the use of medical missions to break down the barriers of prejudice against Christianity. What needs to be made clear is that a medical mission is not supposed to be used as bait to lure people into Christianity. To the contrary, medical mission should be

seen as part of gospel work whose aim is to restore humanity to *shalom*. Hence Adventists consider medical mission the ‘right arm of the gospel’.

Christian mission hospitals have been established in southern Africa, but several of them had to close for one major reason—finances. Many governments offered fiscal support to these hospitals, but eventually they were taken over as it happened with the Maun Adventist Medical Mission hospital. There is no doubt that medical missions are still needed throughout Africa. But limited budgets continue to hamper this work. Perhaps cues need to be taken from the illustrious performances by the Botswana Adventist Medical Services. A medical mission model patterned after this clinic is a subject for future research, which may also consider the sharing of resources within sister institutions.

When all medical mission hospital staff are dedicated and committed to serve, they will work with compassion, love, and mercy; they will pray for their patients, make visitations to their homes, and bring a special appeal to the clients. Medical mission hospitals have lost some of this kind of service, relegating the spiritual work to the chaplain. This mind-set needs to be challenged and changed if the reason for the existence of medical missions is to be justified.

Chapter 5 will discuss present medical or healing models in Botswana, including traditional African medicine, Christian Spiritual healing, government or scientific medicine, and institutional approaches. Chapter 5 is of missiological significance because lessons can be drawn (from this milieu of healing paradigms) that will help chart holistic approaches toward medical mission in Botswana and beyond. Botswana are known for their medical pluralism, making selective use of all the models in order to

optimize their chances of maintaining health. This in itself may indicate that few, if any, of the existing models offer services that fully meet the needs of the African people.

## CHAPTER 5

### PRESENT MEDICAL MODELS IN BOTSWANA

Chapter 5 is of missiological importance because lessons can be drawn from the milieu of medical models discussed that will help chart the way forward for a holistic approach toward medical mission in Botswana and beyond. This chapter considers the present medical healing models in Botswana. In the country, “the health system consists of public, private for-profit, private non-profit and traditional medicine practice. The public sector dominates the health system, operating 98% of the health facilities.”<sup>1</sup>

“Medical anthropologists would describe contemporary Botswana as having a pluralistic health-care system, in which several quite varying styles of health care co-exist.”<sup>2</sup> In this case, the clients are said to be practicing pluralistic medicine where “several alternatives for health-care are available to the residents of Botswana, chiefly the official clinics and hospitals which operate under government or medical mission auspices; the faith healers of the Zionist or other recently emerged spiritualist churches; and the traditional healers.”<sup>3</sup> What are the underlying sociological, cultural, and religious

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<sup>1</sup>World Health Organization, “Botswana: The Health System,” [http://www.who.int/profiles\\_information/index.php/Botswana:The\\_Health\\_System](http://www.who.int/profiles_information/index.php/Botswana:The_Health_System) (accessed December 11, 2013).

<sup>2</sup>David I. Ben-Tovim, *Development Psychiatry: Mental Health and Primary Health Care in Botswana* (London: Tavistock Publications, 1987), 52.

<sup>3</sup>Priscilla R. Ulin, “The Traditional Healer of Botswana in a Changing Society,” in *African Therapeutic Systems*, ed. Z. A. Ademuwagun et al. (Waltham, MA: Crossroads Press, 1979), 243.

reasons for medical pluralism? This question is fundamental to chapter 5.

First, this chapter considers two major types of indigenous African medical models: (1) the traditional healing model, which applies natural plant medicine and/or ancestor-direction to healing and (2) a spiritual or faith healing model, which uses Christian prayer, water-based concoctions, and/or ancestor-consultation.

Second, the chapter discusses the secular or scientific government of Botswana model. Finally, this chapter explores the only two extant institutional medical mission models, which apply the scientific model along with Christian principles. These are the Bamalete Lutheran and Kanye Seventh-day Adventist hospitals.

## **Indigenous African Model**

### **Traditional Healing**

Traditional healer services refer to the application of knowledge, skills, and practices based on the experiences indigenous to different cultures. These services are directed towards the maintenance of health, as well as the prevention, diagnosis, and improvement of physical and mental illness. . . . In contrast, allopathic service providers are those trained in western medicine.<sup>4</sup>

The contribution of traditional healing in the sub-Saharan region is phenomenal. “Over 80% of Black patients visit the traditional healer before going to the doctor and the hospital.”<sup>5</sup> Thus, “for many people in these countries particularly those living in rural

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<sup>4</sup>World Bank Group, “Traditional Health Services,” <http://go.worldbank.org/433PVWTQL0> (accessed November 13, 2011).

<sup>5</sup>M. V. Gumede, *Traditional Healers: A Medical Doctor's Perspective* (Braamfontein, South Africa: Skotaville Publishers, 1990), iii. This is consistent with the World Health Organization. Ussy M. J. Kasilo, Jean-Marie Trapside, and Chris Ngenda Mwikisa, “An Overview of the Traditional Medicine Situation in the African Region,” *The African Health Monitor* no. 14 (2010), <http://ahm.afro.who.int/special-issue14/ahm-special-issue-14.pdf> (accessed November 6, 2011).



areas, this is the only accessible and affordable health-care.”<sup>6</sup> This is especially true for Botswana, where 3.4 physicians serve every 10,000 individuals in the population (2012).<sup>7</sup>

Even so, the vast majority of these Western-trained doctors practice in urban areas, making accessibility to a physician for the three-quarters of the population in the rural areas difficult.<sup>8</sup> This imbalance is offset by the services of traditional healers who play a vital role in the maintenance of their rural communities’ health. In 2012, “75 per cent of traditional healers were village-based,”<sup>9</sup> providing a healing service that Western doctors would have given.

Traditional healing in Botswana is under the direction of traditional doctors, an entity known as *Dingaka tsa Setso* or *Dingaka tsa Setswana*.<sup>10</sup> “There is a general recognition of the importance of traditional medicine within the health delivery system of Botswana. Those who wish to practice are required to register with the Botswana Dingaka Association and their practice is regulated.”<sup>11</sup> In the late 1970s the number of

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<sup>6</sup>Luis Gomes Sambo, “The Decade of African Traditional Medicine: Progress So Far,” *The African Health Monitor* no. 14 (2010), <http://ahm.afro.who.int/special-issue14/ahm-special-issue-14.pdf> (accessed November 6, 2011).

<sup>7</sup>World Health Organization, “Health Workforce, Infrastructure and Essential Medicines,” [http://www.who.int/gho/publications/world\\_health\\_statistics/EN\\_WHS2012\\_Full.pdf](http://www.who.int/gho/publications/world_health_statistics/EN_WHS2012_Full.pdf) (accessed December 12, 2013).

<sup>8</sup>Duncan P. Mann, Earl McFarland, and Monica Tselayakgosi, “Health Care in Botswana: The Government’s Role in Primary Health Care and Nursing Education,” in *The Evaluation of Public Expenditure in Africa*, ed. Henry J. Bruton and Catharine B. Hill, EDI Learning Resources Services (Washington, DC: World Bank, 1996), 61.

<sup>9</sup>Barbara N. Ngwenya et al., “A Globalized Context of Traditional Healing Practices in Botswana,” *International Journal of Food, Nutrition and Public Health* 5, no. 4 (2012), <http://www.worldsustainable.org> (accessed December 12, 2013).

<sup>10</sup>These are Tswana cultural or traditional healers whom the colonists and missionaries formerly called witchdoctors.

<sup>11</sup>Botswana Embassy, “Beliefs, Values and Practices,” <http://www.botswanaembassy.or.jp/culture/index3.html> (accessed June 3, 2011).

traditional healers in the country was estimated at 2,000, including faith healers;<sup>12</sup> but three decades later the WHO reports that “there are about 3100 traditional health practitioners in Botswana, approximately 95% of whom reside in rural areas.”<sup>13</sup> This shows that the demand for traditional healers is still strong.

### **Selection and Qualification of a Traditional Healer**

By Western standards, there is no academic training for the traditional healer. However, a new apprentice must learn through observation and on-the-job training. A traditional healer may inherit his or her career. In most cases traditional healing knowledge is passed from father to son. Training may take up to seven years.<sup>14</sup> The apprentice may serve under different traditional practitioners to whom he or she is expected to pay a fee of one or more cattle.<sup>15</sup>

Some traditional healers entered the healing practice through a ‘call’ from their ancestors, usually impressing the nominee through visions or dreams. However, if the person is reluctant, the ancestors or spirits unleash some misfortune upon the ‘rebel’ in various forms, including serious illness. Upon recovery, there is no choice but to pick up

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<sup>12</sup>M. H. Mills, “Infrastructure and Health: Some Pro's and Con's,” in *Proceedings of the Seminar on Health/Illness and the Socio-Cultural Background Held at the National Museum, Gaborone 24-26 April, 1979*, ed. Thabo T. Fako (Gaborone, Botswana: National Institute of of Development and Cultural Research Documentation Unit, Universtiy of Botswana, 1980), 8.

<sup>13</sup>World Health Organization, “Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide Review,” <http://apps.who.int/medicinedocs/en/d/Jh2943e/4.3.html#Jh2943e.4.3> (accessed December 13, 2013).

<sup>14</sup>S. A. Symon, “Notes on the Preparation and Uses of African Medicines in the Makoya District, Northern Rhodesia,” in *Rhodes-Livingstone Communication*, The Ann Kercher Memorial Collection on Africa (Lusaka, Zambia: The Rhodes-Livingstone Institute, 1959), 22.

<sup>15</sup>Isaac Schapera, *A Handbook of Tswana Law and Custom: Compiled for the Bechuanaland Protectorate Administration*, ed. International African Institute, Classics in African Anthropology (Gaborone, Botswana: The Botswana Society, 1994), 255.

the tools of the trade and follow the ancestral instructions. “Despite being raised Catholic, [Sudzani] Podiephatshwa was pre-ordained by her ancestors to become a traditional healer. She resisted the signs at first and paid dearly with her health that was only restore [sic] after she submitted to her calling.”<sup>16</sup>

### **Duties and Specialties of a Traditional Healer**

According to Frants Staugård, “the traditional healer in the Tswana village . . . is not only a medicineman. He is also a religious consultant, a legal and political advisor, a police detective, a marriage counselor and a social worker.”<sup>17</sup> This signifies the holistic nature of traditional healing services, for they touch almost every aspect of communal traditional life.

Inasmuch as there are several specialists in biomedicine, “the group of *Dingaka* [Tswana traditional doctors] comprises of many types of Tswana healers, such as diviners, suckers, [and] herbalists.”<sup>18</sup> These traditional healers in Botswana are grouped into two major classifications, the *dingaka tsa dinaka*, or divine-healers, and *dingaka tse dichochwa*, or herbalists.<sup>19</sup> F. M. Mulaudzi further adds traditional surgeons and birth

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<sup>16</sup>Otshidile Onkabetse and Kibo Ngowi, “Icons of Botswana,” *Mmegi Online*, <http://www.mmegi.bw/index.php?sid=6&aid=1421&dir=2011/November/Wednesday16> (accessed November 16, 2011).

<sup>17</sup>Frants Staugård, *Traditional Medicine in Botswana: Traditional Healers* (Gaborone, Botswana: Ipelegeng Publishers, 1985), 12.

<sup>18</sup>Ibid., 13. See also Adam K. Arap Chepkwony, “African Traditional Medicine: Healing and Spirituality,” in *Science, Religion, and Society: An Encyclopedia of History, Culture, and Controversy*, ed. Arri Eisen and Gary Laderman (Armonk, NY: M.E. Sharpe, 2007), 642.

<sup>19</sup>Ulin, “The Traditional Healer of Botswana in a Changing Society,” 243.

attendants to the list of African traditional healers.<sup>20</sup> Thus specialist traditional healers undertake such work as “divination, medical treatment, and the ‘doctoring’ of people and homesteads as a protection against sorcery (*boloi*), and of fields, cattle, and women for fertility.”<sup>21</sup>

The clientele of the traditional doctor has two major expectations. The doctor must not only heal a perceived ailment, but also must provide protection from harm coming in any form, including sorcery. Since it is a huge task to meet these expectations, it would be imprudent to expect a single doctor to accomplish this. Hence, the traditional healing system has evolved and come up with different areas of specialization, just like the biomedical sphere.<sup>22</sup>

It is important to note that traditional medicine and healing are anchored in African Traditional Religion (ATR). Therefore, “a proper understanding of the traditional healing practices of any culture requires a knowledge of the prevailing religion and cosmology.”<sup>23</sup> The most famous of the specialist traditional doctors were the diviners (*sangoma*) who

practiced divination through *ditaola* (special bones from hoofs of animals). By

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<sup>20</sup>F. M. Mulaudzi, “Traditional Health Practice,” in *Integrative Healthcare: A Guide to Meet the Needs of Africa*, ed. N. C. van Wyk (Cape Town, South Africa: Juta, 2009), 38.

<sup>21</sup>Adelle van Schalkwyk, “The Indigenous Law of Contract with Particular Reference to the Swazi in the Kingdom of Swaziland” (Doctor of Law dissertation, University of South Africa, 2006), 22.

<sup>22</sup>Gordon L. Chavunduka identifies eight main categories of traditional healers. He points out that within each category there are specialists in areas that include divine healing, women’s illnesses, children’s diseases, mental disorders, and so on. See Gordon L. Chavunduka, “ZINATHA: The Organization of Traditional Medicine in Zimbabwe,” in *The Professionalization of African Medicine*, ed. Murray Last and Gordon L. Chavunduka (Manchester, U. K.: Manchester University Press, 1986), 32-34.

<sup>23</sup>Una Maclean, “The WHO Programme for the Integration of Traditional Medicine,” in *African Medicine in the Modern World*, ed. Una Maclean and Christopher Fyfe, Center of African Studies (Edinburgh: Center of African Studies, University of Edinburgh, 1987), 9.

reading the positions in which the different bones fell, they could establish the source of the disease, death, or misfortune as well as identify the victim's *moloji* (that is, sorcerer). They had also the ability to cause harm to the responsible *moloji*.<sup>24</sup>

A diviner works within the precincts of ATR as a priest-doctor; he or she receives spiritual guidance from ancestors in diagnosis, prognosis, treatment, and ultimate healing. However, the main function of the diviners originally was diagnosis. “The diviners . . . are consulted to find out why what has happened—why the cows are barren, why the fields are not producing plenty of crops, why the young bride . . . is not having a baby after two years of married life, why the baby is ill . . . why the cow died—in fact why anything has gone wrong?”<sup>25</sup> Causative attributions are a key part in traditional healing.

The next critical healer specialist in the Tswana traditional health-care system is the *ngaka e tshotshwa*, or simply the herbalist. This doctor specializes in phytotherapy—herbal medicine that makes extensive use of plant roots, stems, and leaves. While the diviner may function as a herbalist, the *ngaka e tshotshwa* does not ordinarily function as a diviner, that is, the herbalists may not necessarily get revelations or guidance from the ancestors (though sometimes they do) to execute their expected duties.<sup>26</sup> Usually, the herbalists use their training, experience, and inherited knowledge to diagnose and treat their patients. However, there is a strong collaboration between the diviner and the herbalist.

Una Maclean finds futility in the “debate about whether traditional healing is a

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<sup>24</sup>Selelo-Khupe, *An Uneasy Walk to Quality: The Evolution of Black Nursing Education in the Republic of Botswana, 1922-1980*, 2.

<sup>25</sup>Gumede, *Traditional Healers: A Medical Doctor's Perspective*, 69.

<sup>26</sup>Iyona Selala, interview by author, Gaborone, Botswana, June 10, 2009.

purely spiritual matter or, alternately, has simply to do with herbs. Careful study of most societies . . . reveals an enormous range of practitioners and practices, from the purely pragmatic to what could, loosely, be termed psychotherapy.”<sup>27</sup>

### ***Materia Medica and Healing Practices***

*Materia medica* and pharmacognosy<sup>28</sup>

Traditional healers use various materials and substances in their practice, even though the majority of medicine men and women treat their patients with herbal formulations. Historically,

the herbs were generally derived from roots, barks, leaves, and fruits. They also used bones, excreta, oils, skins, fur, feathers, fishes, other animal products, and other ingredients suitable for yielding medicinal extracts. These substances were usually processed into powders, liquids, or oils. Herbs were generally used to treat common ailments such as stomach upsets, malaria, migraines, asthma, arthritis, wounds, and skin ulcers. The bone specialists, apart from using herbal jellies, adjusted sprained and fractured bones [with] dexterity comparable to any surgical operation today.<sup>29</sup>

Maclean argues that “the enduring value of African medicine lies not in its materials but in the methods and concepts which underlie them.”<sup>30</sup> The view is that

Africans make a distinction between what appears and what is inherent in an object or being. What is inherent—the invisible power, the active principle, the source of

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<sup>27</sup>Maclean, “The WHO Programme for the Integration of Traditional Medicine,” 10.

<sup>28</sup>Pharmacognosy “literally means studying medications of natural resources that has been a part of medical arts and sciences since mankind first began to treat illnesses . . . [such as] plant, animal, mineral, and other natural medications.” Mahnaz Kazemi et al., “Clinical Pharmacognosy—A New Interesting Era of Pharmacy in the Third Millennium,” *DARU Journal of Pharmaceutical Sciences* 20, no. 1-5 (2012): 1, <http://www.darujps.com/content/20/1/18> (accessed December 15, 2013).

<sup>29</sup>Chepkwony, “African Traditional Medicine: Healing and Spirituality,” 643.

<sup>30</sup>Una Maclean, *Magical Medicine: A Nigerian Case Study* (London: Penguin Press, 1967), 5.

energy—is the intrinsic element. Healing and even remission from sin may depend on this vital center, as all symbols used in this connection should contain some of this vital energy.<sup>31</sup>

This helps to explain that in addition to plant-based medicine, Africans use non-plant medicine believing that their Creator God has endowed certain substances in nature such as hills, rivers, and pebbles with supernatural healing power.

In a survey interview of traditional doctors and their patients conducted in the 1950s in the Kawamba and Makonya districts of Northern Rhodesia (Zambia), researchers were able to detail “the medicines, their preparation, their doses, and the fees charged, for other maladies-diseases of the ear, nose and throat, of the intestines, venereal diseases and miscellaneous others.”<sup>32</sup>

Researchers found some degree of success in the preparations of medicine and treatment. However, they made some disturbing observations: (1) medicine was prepared without due consideration to governance of chemical toxicity or alkalinity, (2) infections or virulent organisms were included in the concoctions, (3) lack of hygiene (use of saliva on an eye patient), and (4) lack of precise measurements for dosage.<sup>33</sup> Despite these negative aspects, scientific research has successfully isolated active ingredients in several medicinal plants used by Africans to prepare pharmaceutical drugs.<sup>34</sup>

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<sup>31</sup>Gerhardus C. Oosthuizen, *Afro-Christian Religions* (Leiden, The Netherlands: E. J. Brill, 1979), 10.

<sup>32</sup>R. J. Apthorpe, “Introduction,” in *Rhodes-Livingstone Communication*, The Ann Kercher Memorial Collection on Africa (Lusaka, Zambia: Rhodes-Livingstone Institute, 1959), i.

<sup>33</sup>C. M. Phillips, “Blindness Survey in Chief Mununga's Area, Kawamba District, Northern Rhodesia,” in *Rhodes-Livingstone Communication* (Lusaka, Zambia: Rhodes-Livingstone Institute, 1959), 10, 11.

<sup>34</sup>Elujoba et al., “Traditional Medicine Development for Medical and Dental Primary Health Care Delivery System in Africa,” 46.

## Healing practices

Many Africans believe that illness or disease may come through natural causes, the wrath of God or the ancestors (because of some ritual that was omitted or done at the wrong time), or bewitchment.<sup>35</sup> Hence they will seek the presence and assistance of a healer who will help appease their ancestors and provide protection for his or her clients from damaging charms and poisons.

Basically, the herbalist would attend to physiological sickness while the diviner would treat ritual and mystic illness.

Diagnosis . . . typically proceeds from a multiple-causation model of illness and health. . . . It usually includes . . . several procedures: 1) observation of the patient's attitudes, movements, and close relations; 2) divination and possession, which may lead beyond diagnosis to prognosis and prescribed therapy; 3) case history, which may be intensive and include the patient's extended family and social milieu; 4) clinical examination, including palpation physical inspection; and 5) biological diagnosis, through examination of blood, urine, stools, and discharges.<sup>36</sup>

A traditional doctor's first diagnostic step is to determine whether the disease is "European" or "Tswana" (African). If African, then causal attributions need to be ascertained by the traditional doctor.

In certain areas traditional healers have a better impact . . . particularly because the Western care completely forgets about the culture of the . . . people. When they cure and look after you . . . they don't stop to think about the sort of things you believe in and your expectations as a black person. . . . In diseases what you believe has much more influence over the healing of your body. . . . [Traditional healers] move from the cultural aspect and the person can understand them better. We need to establish

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<sup>35</sup>Charles M. Good, "A Comparison of Rural and Urban Ethnomedicine among the Kamba of Kenya," in *Traditional Health Care Delivery in Contemporary Africa*, ed. Priscilla R. Ulin and Marshall H. Segall, Foreign and Comparative Studies Program/African Series (Syracuse, NY: Maxwell School of Citizenship and Public Affairs, Syracuse University, 1980), 17.

<sup>36</sup>Ibid.



where the traditional healer would understand when to refer a person to the western doctor and when the western doctor will know when to refer [to the African healer].<sup>37</sup>

Tswana diseases have three basic categories, and central to their diagnosis is the metaphysical question of ultimate causality.

1. A patient may suffer from *meila*, which are a result of breakdown in traditional morality such as the transgression of taboos associated with childbirth and sexual relations.

2. A patient may suffer from *boloi* or witchcraft from a spell cast by an enemy who had consulted a witchdoctor to do so, causing lightning to strike, crops to wither, or cattle to die. Diseases attributed to *boloi* can be *sejeso*, which is an internal growth, which develops from the presence of a foreign substance like a bone, hair, or piece of wood, or flesh that has been introduced through food poisoning or some other means by an enemy.

3. A patient may suffer from *badimo* (ancestral spirits), which cause a plethora of emotional symptoms such as disturbed sleep, restlessness, and floating anxiety. In this case, the displeased ancestors need to be pacified as part of treatment.<sup>38</sup>

To the question “How do you know what kind of medicines to give in the treatment of sick people?” a diviner responded that it was “through dreams that he learns of the sick who are on their way to see him and know which medicines are appropriate.”<sup>39</sup> But the diviner is not restricted to dreams; he or she can use *bola* (bones),

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<sup>37</sup>Serara Selelo Mogwe, interview by author, Gaborone, Botswana, July 20, 2009.

<sup>38</sup>Ulin, “The Traditional Healer of Botswana in a Changing Society,” 244-245.

<sup>39</sup>Michael C. Kirwen, *The Missionary and the Diviner: Contending Theologies of Christian and African Religions* (Maryknoll, NY: Orbis Books, 1987), 84.

which he or she throws on the ground.<sup>40</sup> The diviner then interprets and explains the meaning of the spread of the bones on the ground.

There are various methods of treatment applied by traditional doctors.

Treatment through inhalation is used in some illnesses. . . . A blanket is placed over the head of the patient and he is told to inhale the steam of the boiling mixture. Asthma is generally treated in this way. . . . Other common methods of treatment include sucking where foreign bodies are believed to be in the patient's body. The healer sucks with his mouth and spits out any such foreign bodies. The cupping horn . . . is also used frequently in illnesses such as a severe headache. . . . The healer first makes an incision on the patient's skin, and then applies the wide end of the cupping horn to the incision. He then sucks through the narrow end of the horn.<sup>41</sup>

One can deduce that some of these treatment and healing methods can be dangerously risky both to healer and patient, especially in light of the prevalence of HIV/AIDS and other diseases. No doubt something needs to be done to educate the traditional practitioners.

The difference in diagnosis between the traditional and allopathic systems is that the former has no capacity to carry out any laboratory tests; hence the practitioner depends on visual signs and revelations whereas the latter has the benefit of the science of pathogeny. However, the scientific laboratory is compensated by divination in the traditional healing system. As much as the laboratory could be more precise, the healer is content with the traditional system of diagnosis.

The *badimo* [ancestral spirits] . . . make visits to the dreams of their healer-descendants to guide interpretation of the bones or to indicate the location of a particular medicinal plant, but they are not characteristically regarded to be the

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<sup>40</sup>In both cases, the diviner healer depends on the input of ancestral spirits for diagnosis, treatment, and healing. See Edward C. Green and Lydia Makhubu, *Traditional Healers in Swaziland: Toward Improved Cooperation between the Traditional and Modern Health Sectors* (New York: International Human Assistance Programs 1983), 7.

<sup>41</sup>Gordon L. Chavunduka, *Traditional Healers and the Shona Patient*, vol. 3 (Gwelo, Zimbabwe: Mambo Press, 1978), 26.

ultimate source of traditional medical knowledge. Traditional wisdom is said to reside in the divining bones themselves, immutable and ordained by God at the creation of man.<sup>42</sup>

While African medicine is based on examining the causes of an illness, the diagnosis is not complete until the therapist or diviner has given its interpretation.<sup>43</sup> Who has caused the illness, and why? What measures need to be taken to remedy the situation and to prevent future recurrence (that is, to give protection to the victim)?

There are six categories of therapies identified by traditional healers: (1) magico-religious, (2) herbal, (3) magico-herbal, (4) massage/traditional surgery, (5) midwifery services, and (6) generalist therapy.<sup>44</sup> Midwifery needs special attention, as it comprises a vital part of community health services.

For example, in 2008, in Botswana 1.5 percent of births happened outside of health-care facilities, compared to 31.5 percent in Zimbabwe and 56.6 percent in Zambia.<sup>45</sup> Midwifery services are those “rendered by local midwives at client’s home in prenatal, natal and postnatal cases.”<sup>46</sup> Further, traditional midwives in Botswana—as in other African countries—make use of medicinal plants in pregnancy and childbirth.<sup>47</sup> In

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<sup>42</sup>Ulin, “The Traditional Healer of Botswana in a Changing Society,” 244.

<sup>43</sup>Bernard Hours, “African Medicine as an Alibi and as a Reality,” in *African Medicine in the Modern World*, ed. Una Maclean and Christopher Fyfe (Edinburgh: Center of African Studies, University of Edinburgh, 1987), 47.

<sup>44</sup>For definitions of these terms see K. P. Shukla, *Traditional Healers in Community Health* (Varansi, India: Gomati Krishna Publications, 1980), 79.

<sup>45</sup>World Health Organization, “Proportion of Births Attended by a Skilled Health Worker 2008 Updates,” [http://www.who.int/reproductivehealth/publications/maternal\\_perinatal\\_health/2008\\_skilled\\_attendant.pdf](http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/2008_skilled_attendant.pdf) (accessed February 25, 2014).

<sup>46</sup>Shukla, *Traditional Healers in Community Health*, 80.

<sup>47</sup>Sandra Anderson and Frants Staugård, *Traditional Medicine in Botswana* (Gaborone, Botswana: Ipelegeng Publishers, 1986), 12.

cases of difficult birth or similar complications, women herbalists with midwifery specialization were often called to assist the traditional birth attendant. Thus the woman herbalist would dispense protective treatment (that is, from bad luck and evil) to the mother and the baby.<sup>48</sup>

### **Patient Visitation and Fees**

In the Setswana language there is an adage that says “*molwetse o lata ngaka*” meaning, “it is always the patient who visits the traditional doctor.” As such the healer will expect visitations from patients, some of them from distant or even cross-border areas. In essence the traditional healer sees outpatients, admitting none. However, only in exceptional cases does the doctor visit the patient and only when the patient is seriously ill.

Traditional healers always practice in their homestead. The healer constructs a separate hut in the far corner of the backyard.<sup>49</sup> In it the diviner carries out consultation, divination, diagnosis, and treatment. Usually when the consultation is in progress, the doctor allows the patient’s family or relatives to be there so they can support the patient and be able to later help the patient follow treatment instructions.

One of the major differences between the traditional doctor and the Western-trained one is that with the former, client consultation is communal because the whole family or clan is perceived to be affected—actually they say to the doctor, “*Re a lwala,*”

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<sup>48</sup>Selelo-Khupe, *An Uneasy Walk to Quality: The Evolution of Black Nursing Education in the Republic of Botswana, 1922-1980*, 3-4.

<sup>49</sup>Most traditional doctors who were interviewed by the researcher had their ‘consulting’ room tucked in the far backyard, perhaps to ensure utmost privacy to the patient and his or her accompanying family members from the prying eyes of the public.

“We are sick,” even though only one of them has taken ill. In the Western tradition, the patient is seen privately on an individual basis so as to protect his or her rights to confidentiality. But Africans believe it is an advantage to involve the presence of their next of kin because of the added sympathy and care for the sick person.

The charging and payment of fees by traditional healers in the past was not only affordable, but also done after the patient was healed or felt better; however, current traditional healers charge consultation and treatment fees that must be paid before the patient leaves.<sup>50</sup>

By paying a cow to the healer, the family was not only ensured of a permanent family practitioner, but also of health insurance for a considerable period until both agreed it was time to pay another cow or renew this traditional form of health insurance. This has changed with modernization, making the regulation of fees not only difficult, but also unpredictable.

Diviner-healers are expected to charge higher fees for two major reasons. First, they “are not only experts in herbalism, but also practice bone divination as a means of diagnosing. . . . Becoming a diviner-healer is considered a more complicated process, requiring several years’ apprenticeship.”<sup>51</sup> Second, it is perceived that interacting with the spirits or ancestors may at times be a risky undertaking for the traditional diviner, particularly the *sangoma*.

In addition to traditional healers, patients will also visit Christian spiritual healers.

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<sup>50</sup>Green and Makhubu, *Traditional Healers in Swaziland: Toward Improved Cooperation between the Traditional and Modern Health Sectors*, 13-14.

<sup>51</sup>Ulin, “The Traditional Healer of Botswana in a Changing Society,” 244.

## Christian Spiritual Healing

African Independent Churches (AICs) as Christian spiritual healing (a.k.a. Faith healing) institutions play a significant socio-cultural role in the African communities' ritual and healing processes. "These churches have identified and attend to the greatest spiritual and physical needs of their people and explain many of the practices and doctrines of the Church in Tswana cultural terms that are easily understood and most appreciated by Batswana."<sup>52</sup>

Spiritual healing and faith healing are synonymous in that both refer to some form of healing attributed to a supernatural power.<sup>53</sup> Faith healing is central to Christian Spiritual healing churches. "The element of faith healing includes divination, [*sic*] administration of Tswana traditional medicine is a center of attraction . . . where Jesus is preached explicitly as the Great Physician who allows and effects healing not by faith alone but also through the use of traditional medicine."<sup>54</sup> For Christian spiritual healers, the Holy Spirit is seen as giving revelatory diagnostic and healing powers.

### **Qualifications and Duties of the Spiritual Healer**

A Christian spiritual healer must have a certain calling, training, or succession in order to perform his or her duties efficiently and professionally. However, there is more importance attached to the call-to-healing by God than to training since the apprentice

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<sup>52</sup>James N. Amanze, *African Christianity in Botswana: The Case of African Independent Churches* (Gweru, Zimbabwe: Mambo Press, 1998), xiii.

<sup>53</sup>*Ibid.*, 88. The terms spiritual and faith healing are used interchangeably in this paper.

<sup>54</sup>UN Economic and Social Council, "Commission on Population and Development."

begins his or her healing duties with immediate effect.<sup>55</sup> The most important aspect of the healer is the prophetic-healing gift because “the role of the prophet is widely associated with healing throughout Southern Africa.”<sup>56</sup>

Prophecies are usually closely bound up with pastoral work. Hence the *Shona* word *kuporofita*, to prophecy, means in the first place to reveal God’s will for a ‘patient’ (as regards getting a job, marital problems, . . . diagnosis of an illness, sorcery, etc.), and only very rarely a prediction of the remote future. As a means of exposing destructive powers and expelling them the prophetic task represents a powerful *control* in the Spirit-type churches. As exercised by authentic and adult prophets, this form of ministry helps greatly to alleviate individual stress and promote harmony in congregational life.<sup>57</sup>

Not unlike the traditional healer, the prophet-healer is the spiritual guardian of the community in which she lives. Thus, the prophet is instrumental in the protection and healing of the people physically, spiritually, and socially. Recognizing that the source of the revelations could either be the Holy Spirit or the devil, the spiritual healer must be capable of discerning the spirits, thus enabling the healer to know what to accept or reject.

The prophet . . . concentrates on [the] healing ministry. This is a result of the mission Churches having more or less discarded healing within the Church by pushing it into the cold atmosphere of western oriented, individualistic hospitalization. In Africa healing always had a religious connotation, in spite of being associated with magic. In the African Independent Churches the prophet is now the analyzer, the seer, the

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<sup>55</sup>Amanze, *African Christianity in Botswana: The Case of African Independent Churches*, 88. See also Oliver H. Osborne et al., “Final Report: Continuities between the Practices of Traditional and Scientific Botswana Health Care Practitioners,” (Washington, DC: African-American Scholars Council, 1977), [http://pdf.usaid.gov/pdf\\_docs/PNAAF590.pdf](http://pdf.usaid.gov/pdf_docs/PNAAF590.pdf) (accessed June 5, 2011).

<sup>56</sup>Gerhardus C. Oosthuizen, *The Healer-Prophet in Afro-Christian Churches* (Leiden, The Netherlands: E. J. Brill, 1992), 2.

<sup>57</sup>Marthinus L. Daneel, *Quest for Belonging: Introduction to a Study of African Independent Churches*, Mambo Occasional Papers—Missio—Pastoral Series No. 17 (Harare, Zimbabwe: Mambo Press, 1987), 148.

diagnostician, the visionary. [Thus,] the prophet is a reformer who needs a religious disposition that takes note of contemporary human needs.<sup>58</sup>

Hence the prophetic gift has, of necessity, diagnostic functions in the physical, psychological, and spiritual healing of patients and the community at large—especially the church members who follow the prophet.

A. S. van Niekerk argues that Christian spiritual healers offer what neither Western-trained doctors nor missionary clergy are able to, that is, treating misfortune, providing protection against witchcraft and evil spirits, and restoring disturbed traditional harmonious relationships.<sup>59</sup> These are the key healing functions of Christian spiritual healers. Faith healers should be counted among the variety of practitioners as they, to some extent, inherited the psychotherapeutic functions of traditional priests and healers.<sup>60</sup> However, faith healers have unique diagnostic and treatment procedures and some healing *materia*, which they apply to heal their clients.

### ***Diagelo*, Diagnosis, and Treatment**

*Diagelo*:<sup>61</sup> Institutionalized places of healing

It is believed that faith brings patients to faith healers. “Psychological,

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<sup>58</sup>Gerhardus C. Oosthuizen, “Diviner-Prophet Parallels in the African Independent and Traditional Churches and Traditional Religion,” in *Empirical Studies of African Independent/Indigenous Churches*, ed. G. C. Oosthuizen and Irving Hexham (Lewiston, NY: Edwin Mellen Press, 1992), 163. The question of fake, quack, or false healer prophets is paramount, but is not discussed in depth in this paper.

<sup>59</sup>A. S. van Niekerk, “African Independent Churches and Daily Life,” in *Empirical Studies of African Independent/Indigenous Churches*, ed. G. C. Oosthuizen and Irving Hexham (Lewiston, NY: Edwin Mellen Press, 1992), 267.

<sup>60</sup>Maclean, “The WHO Programme for the Integration of Traditional Medicine,” 10.

<sup>61</sup>Amanze states that “prophets are required to be present at ‘*diagelo*’ (a special place in the church where praying for the sick takes place) to pray for the sick daily.” Amanze, *African Christianity in Botswana: The Case of African Independent Churches*, 151.



sociological, and parapsychological research shows that faith can be protective against illness, productive of well-being and health, and potentially effective in healing at a distance.”<sup>62</sup> Faith healers always have a church to lead and guide, and provide their followers with the full range of faith-healing services.

In Botswana, faith healers are known as *badiri-ba-diagelo*<sup>63</sup> (practitioners of the treatment centers), *baporofiti* (prophets), or *basebeletsi* (those who serve).

Characteristically, their obligations are first to their church members, and then to any client from the community. Depending on how successful the faith healer is, patients may come from far away places, including from across the border.

Unlike Western medicine where hospitals are institutions of healing, faith healers usually use their church or the churchyard as a place where consultancy, diagnosis, and treatment take place. In effect, the church is a hospital to the community who are seeking not only spiritual healing and nourishment, but also physical, social, and psychological healing. Only in special occasions do healings take place at the patient’s home, especially if ritual exercises need to be carried out.

While generally churches are the sites for consultation, diagnosis, treatment, and healing, some prophet-healers have set up hospital-like facilities known also as *diagelo* or *metlaagana*<sup>64</sup>—where for a fee, patients visit the healer and are offered accommodation

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<sup>62</sup>Lisa J. Schwebel, “Interdisciplinary Approaches to Faith,” *Science, Religion, and Society: An Encyclopedia of History, Culture, and Controversy* (Armonk, NY: M. E. Sharpe, 2007).

<sup>63</sup>Morena J. Rankopo, “The Influence of Traditional Health Practices as Human Development: Implications for Human Service Delivery,” in *Indigenous Knowledge and Its Uses in Southern Africa*, ed. Hams Norman, Ina Snyman, and Morris Cohen (Pretoria, South Africa: Human Sciences Research Council 1996), 13.

<sup>64</sup>*Ibid.*, 18.

for the days of their visit. These treatment centers, designed more like the monastic lauverate types described in chapter 3, are comprised of several simple huts, a common pit-latrine, a place of worship, the faith-healer's house, and a small room for consultancy which also hosts medical *materia*.<sup>65</sup>

The several huts serve as wards. One of the interviewees, Kalafo Kalafi, attests, "In 2004 I had 18 patients sleeping in my [treatment] center. As you can see my buildings, those patients with the same diseases share the same room. I built different buildings so that they [patients] don't end up infecting each other."<sup>66</sup>

### Diagnosis

More than 300 prophets and prophetesses in Botswana's African Independent Churches have been identified,<sup>67</sup> making their role in religious, social, and health matters important to both their church members and non-church clients. "Prophecy is a dominant phenomenon in the life and work of African Independent Churches in Botswana and the success of their ministry is said to be based on their prophetic nature. . . . Practically every African Independent Church has a prophet operating alone or a group of prophets operating as a team."<sup>68</sup> A prophet must determine the cause of disease in the patient,

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<sup>65</sup>While in Botswana for interviews, I observed that the prophet-healers' treatment centers had huts that were lined up one after another, but with a worship house central to them.

<sup>66</sup>Kalafo Kalafi, interview by author, Moshupa, Botswana, June 7, 2009.

<sup>67</sup>James N. Amanze, *Botswana Handbook of Churches: A Handbook of Churches, Ecumenical Organizations, Theological Institutions and Other World Religions in Botswana* (Gaborone, Botswana: Pula Press, 2001), 1-308.

<sup>68</sup>Amanze, *African Christianity in Botswana: The Case of African Independent Churches*, 149.

cognizant of the fact that it is not only bodily ailments that are of concern, but other possibilities such as acts of witchcraft, curses, and the effects of evil spirits.<sup>69</sup>

There are two key diagnostic methods used by the prophet healer. One way to determine the cause for disease is through prophetic revelation. The source of the revelation for the prophet is not the ancestors as in the traditional diviner healer's case, but it is claimed to be the Holy Spirit.<sup>70</sup> However there seems to be a vague distinction between the source of revelation for the traditional diviner and that of the prophet healer. This is because some AICs in Botswana "pray to God through [ancestors] for good health, food, shelter, bearing of children and acquisition of other material," thus "quite often no distinction is made between the Holy Spirit and the ancestral spirits."<sup>71</sup> So prophet healers may use the Holy Spirit and/or ancestral spirits for diagnostic purposes.

The other diagnostic mechanism is what may be called "extrasensory perception-mirrored pain," that is, the faith healer feels the pain of the patient in the exact spot where it hurts.<sup>72</sup>

### *Materia medica* and healing practices

The title "Spiritual Healing Churches" given to Botswana's AICs adequately describes what these churches are best known to perform—healing.

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<sup>69</sup>Rankopo, "The Influence of Traditional Health Practices as Human Development: Implications for Human Service Delivery," 17.

<sup>70</sup>Bengt Sundkler, *Bantu Prophets in Africa* (London: Oxford University, 1961), 115.

<sup>71</sup>Amanze, *African Christianity in Botswana: The Case of African Independent Churches*, 165.

<sup>72</sup>Kalafi, interview by author, June 7, 2009.

Spiritual healing genres include (1) the Bible, prayer, and the laying of hands, (2) baptism, (3) the administration of blessed or holy water, (4) exorcism, (5) animal sacrifices, (6) steaming, (7) traditional herbal medicine, (8) massage using dedicated Vaseline (petroleum jelly), and (9) the wearing of wool strings around the neck, waist, arms, and legs.<sup>73</sup> All these have different applications meant to bring healing and protection (from misfortune and/or evil) to the clients, but only the fundamental ones will be discussed.

The prophet healers use the Bible extensively, which is read and consulted through prayer for guidance in healing the sick. “The Bible tells me. I inquired through prayer if the Bible would allow me to help the illness of the patient through prayer.”<sup>74</sup> If permitted, the prophet then has confidence that the patient will be healed. The healer then begins the healing process through prayer and the laying on of hands.

Connected to matters of Christian religion and faith is healing through baptism and blessed water. Water, whether used in baptism, ritual baths, or as *sewacho*, is quintessential to the religious practice of healing as “it is seen to represent cleansing and purification from evil, sin, sickness and ritual pollution.”<sup>75</sup>

Because of the power of water, baptism is used not only for initiating new

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<sup>73</sup>Amanze, *African Christianity in Botswana: The Case of African Independent Churches*, 174-184.

<sup>74</sup>Lefoko Leaalafa, interview by author, Moshupa, Botswana, June 7, 2009.

<sup>75</sup>James Kiernan, “Saltwater and Ashes: Instruments of Curing among Some Zulu Zionists,” *Journal of Religion in Africa* 9 no. 1 (1978): 30. Lagerwerf describes *sewacho* as “white ashes of the *motswere* (a tree) and ashes of cow-dung” which are added together with salt to water. See Allan H. Anderson, “The Lkganyanes and Prophecy in the Zion Chrisitan Church,” *Journal of Religion in Africa* 29 no. 3 (1999): 298. However, not all spiritual churches make use of *sewacho*, preferring to simply pray over pure water. Lagerwerf, *They Pray for You . . . Independent Churches and Women in Botswana*, 72.

members, but also for exorcism.<sup>76</sup> Baptism is also for “protection, helping and well being, e.g., the restoring of relationships”; particularly, “subsequent immersions are meant for purification, protection against bad luck or for help in case of problems.”<sup>77</sup>

According to the AIC credence, sometimes a patient may be ill because of demon and/or unhappy ancestral spirit possession. In this case prayer is needed in order to exorcise the offending spirit. However, it is believed that an object exuding evil power may have been planted surreptitiously either in the patient’s body, yard, house, or inside a pillow in the bedroom.<sup>78</sup> Such an object must be found, exposed, and destroyed or

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<sup>76</sup>Frederick Klaitis, *Death in a Church of Life: Moral Passion During Botswana's Time of AIDS* (Berkeley, CA: University of California Press, 2010), 143.

<sup>77</sup>Lagerwerf, *They Pray for You . . . ' Independent Churches and Women in Botswana*, 64-65.

<sup>78</sup> Richard Werbner, “Holy Hustlers, Schism, and Prophecy: Apostolic Reformation in Botswana,” in *The Anthropology of Christianity*, ed. Joel Robbins (Berkeley, CA: University of California Press, 2011), 142-161. Case example: “Residents of Kopong . . . [in Botswana], were shocked last week when a casket-like box was removed from the ceiling of Maoto Kgowe's house. A terrified-looking Kgowe revealed that prophets from . . . Rama Church told him that he was being bewitched and he [*sic*] went to pray for him whereupon they walked to his home only to unearth evil looking objects. ‘First they prayed for me. I spewed out a rock-size hairy thing. At home, they told me there is a ‘coffin’ on the ceiling of my house. Indeed, we found it, stashed inside the ceiling. It was the size of a face-brick. It was wrapped up with a red cloth and inside were hairy objects and small bottles with medicine,’ he said. He also revealed that at the gate, the prophets dug out a rope made out of green and yellow wool, two bottles of medicine in his . . . house. Kgowe . . . revealed that he was shocked when . . . the prophets took out two bottles of medicine from his toolbox. ‘I was surprised because I use the tool box on a daily basis and I have never seen the bottles,’ he said. The 59-year-old Kgowe . . . had problems in the past two years. His cars gave him a problem and many times they nearly killed him in very unusual accidents. Once . . . [the] brakes suddenly failed when he tried to stop the car to avoid hitting a donkey and all of a sudden ‘a wheel jack flew out from under my car seat and flew past my face, missing my neck by an inch only to knock out the door,’ he said. His livestock is dwindling. His goats go missing. Others just die without cause. This . . . explains why the evil-looking paraphernalia was found at his home. . . . ‘I had nightmares almost every day. In the dreams, I saw faces of three people who are closely related to me. My relatives. When the praying session was conducted I contacted one of them to come and witness with the crowd what would be unearthed, but he did not turn up. Since that time they have never appeared here, not even in my dreams. These prophets have helped me quite a lot,’ he said. Prophet Kopano Ditshupo of Rama Church said that they met Kgowe through his daughter who had come for services at their church in Kopong. Through her, he said, that they realized that her father is undergoing serious trouble and that his life was under threat from wizards bent on squeezing out his material possessions until they even killed him. ‘This ‘coffin’ was created in such a way that he would lose all his property and at the end his life ebb away slowly until he dies completely. When we met him, he was having a breathing problem but now after we removed those things and prayed for him, he has no health problems,’ he said.” Ephraim Keoreng, “The Witches Have Me,” *The Monitor*, June 29, 2009.

rendered powerless. This also constitutes exorcism.

Prophets journey as seers . . . from diagnosis to exorcism. Prophets share . . . a common heritage of the occult hunt. A patient's own home is the main end of the trail. In the yard, by the four corners where traditional witchfinders [*sic*] place their potions of substances to protect the bounded home space against occult attack, prophets replace that untrustworthy treatment with faithful holy water, the substance of Jesus's dew.<sup>79</sup>

This might explain why the traditional diviner and the prophet healer tend to be at cross-purposes with each other—a factor which will be considered later in the discussion of integrating the variant medical models.

The prophets also use sacrifice in order to bring healing to the sick. “Apostolic churches in Botswana are differentiated by their practice of sacrifice as a burnt offering to God, as an offering also to the ancestors, who receive blood or the smell in accord with the traditional practice.”<sup>80</sup> These churches believe that the ancestors receive the offering and ultimately pass them on to God.

The prophets do not hesitate to use traditional herbs to heal their sick. However, some of the spiritual healing churches reject traditional healing methods that involve ancestors.<sup>81</sup> One prophet attests to different means she uses to bring healing to a patient—all at the promptings of the Holy Spirit. She is inspired to dig up some roots to help the patient who will then get healed and they do get

healed. . . . When I pray I have visions that show me what I need to heal the patient. Sometimes I am told to go and get some water and pray for it and then give it to the

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<sup>79</sup>Werbner, “Holy Hustlers, Schism, and Prophecy: Apostolic Reformation in Botswana,” 35.

<sup>80</sup>Ibid. See also Amanze, *African Christianity in Botswana: The Case of African Independent Churches*, 190-191.

<sup>81</sup>Oosthuizen, *Afro-Christian Religions*, 9.

patient to drink. Other times I am told to go to the chemist [pharmacist] to look for certain things and then make the patient drink it.<sup>82</sup>

The AICs believe plant medicine is a gift from God that must be used to fully heal their sick. However, unlike the herbalist doctor who by his professional standards needs to know the plants to be used for medicine, the prophet only has to rely on revelation from the Holy Spirit and/or ancestral spirits.

### **Patient Visitation and Fees**

While any client needing healing is welcome to visit the prophet healer at his church or *diagelo*, the AICs have an obligation first to their church members. Usually the members do not expect to be charged any fees, but are expected to pay a meager monthly amount as a voluntarily act “demonstrating” love.<sup>83</sup> This becomes a huge recruitment incentive because many non-church members are tempted to join these churches so as to benefit from the free health services.<sup>84</sup> No wonder AICs are growing much faster than mainstream churches, which also lose a lot of their members to the former.

The downside of the prophet as healer practice is that at times they deny their members access to other alternative healing systems.

The belief in the healing power of Christ in the church is so strong in some African Independent Churches that they do not allow their members to seek healing outside the church. Churches . . . do not allow their members to consult doctors in modern hospitals and diviners and medicine men on the understanding that this form of

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<sup>82</sup>Kalafi, interview by author, June 7, 2009.

<sup>83</sup>Klaits, *Death in a Church of Life: Moral Passion During Botswana's Time of AIDS*, 161.

<sup>84</sup>Osborne et al., “Final Report: Continuities between the Practices of Traditional and Scientific Botswana Health Care Practitioners,” 34.

healing negates the healing power of God which can be achieved through faith alone.<sup>85</sup>

As a result, the prophet healers do not receive as much recognition from Western hospitals as the traditional healers. Besides, the religious element in their practice makes it impossible to investigate their diagnosis and treatment scientifically. However, other healing systems can draw lessons from AIC medical and healing practices such as the use of natural herbs for healing and exorcism to free clients from spiritual bondage.

Having considered traditional and faith healing systems, the next section discusses the state or government (scientific) model. “Government is the main provider of health services and facilities, although missionaries, mines, and private commercial health institutions also provide services.”<sup>86</sup>

### **Government (Scientific) Model**

#### Public Health as Social Welfare

Administratively, the country operates a six-tiered health-care delivery system comprised of primary, district and referral hospitals, clinics, health posts, and mobile stops.<sup>87</sup> The Botswana government is responsible for funding public health, providing health-care, infrastructure, and health sector human resources. This applies to all public hospitals, clinics, and health posts that are owned and funded by the government. This health-care system closely follows the Beveridge model.

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<sup>85</sup>Amanze, *African Christianity in Botswana: The Case of African Independent Churches*, 176.

<sup>86</sup>Emmanuel Olufemi Owolabi, “Botswana,” in *Global Perspective in Workplace Health Promotion*, ed. Wolf Kirsten and Robert C. Karch (Sudbury, MA: Jones & Bartlett Learning, 2012), 38.

<sup>87</sup>Abdullah R. Bamidele, Muhammad E. Hoque, and Henry van der Heever, “Patient Satisfaction with the Quality of Care in a Primary Health Care Setting in Botswana,” *South African Family Practice* 53, no. 2 (2011), <http://www.safpj.co.za/index.php/safpj/article/view/1633/2269>.



Health-care is provided and financed by the government, through tax payments. There are no medical bills; rather, medical treatment is a public service. . . . These systems tend to have low costs per capita, because the government, as the sole player, controls what doctors can do.<sup>88</sup>

In a cautious refinement of the Beveridge model, patients in Botswana are expected to pay only an initial paltry token fee of US \$0.35 per doctor-visit, regardless of the complexity of the ailment, diagnosis, treatment, surgery, confinement, and medication.<sup>89</sup> The Botswana government health model ensures that everybody has access to minimum health-care, especially the very poor.

The government also offers substantial subventions to the two Christian mission hospitals in Kanye and Ramotswa. “At the moment [2009] we fully sponsor all the mission hospitals, so at least we give them 90% of their annual budget from government coffers.”<sup>90</sup> In addition, complicated cases for which neither expertise nor medical technology exists in the country are referred to South Africa at government expense.

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<sup>88</sup>T. R. Reid, *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health* (New York: Penguin Books, 2010), 18-19.

<sup>89</sup>The decision to make the medical fees almost free to Botswana was “both for equity reasons and to induce rural people to use traditional medicine less and modern medicine more.” Mills, “Infrastructure and Health: Some Pro's and Con's,” 7. The small fee is also meant to instill a sense of responsibility to the nation; however, the very poor are never turned away for lack of money. Lately (2011), “health-care services are virtually free at the public facilities, requiring only a nominal charge of 5 Botswana pula (US\$0.70 at the exchange rate of 1 US\$ = 7.2 pula). It is worth noting that the maternal child health-care and family planning services are exempted from the nominal fee.” Bamidele et al., “Patient Satisfaction with the Quality of Care in a Primary Health Care Setting in Botswana.”

<sup>90</sup>Kolataamo C. S. Malefho, interview by author, Gaborone, Botswana, June 20, 2009. This effectively limits the Christian medical missions from operating as private hospitals charging full fees.

Unquestionably, this government health model is meant to safeguard the key determinants of health—equity and sustainability.

### Primary Health Care

The Botswana government, through the Ministry of Health (MOH) and the Ministry of Local Government, Lands, and Housing (MLGLH), is “at pains to stress that individuals and communities must themselves have the prime responsibility for their own health.”<sup>91</sup> The government health-care model is based on Primary Health-care (PHC), which is the hub of the national health system in Botswana.<sup>92</sup>

The concept of PHC applied is an adoption from the Alma-Ata declaration of September 1978, held under the auspices of the World Health Organization (WHO) and United Nations Children’s Fund (UNICEF).<sup>93</sup> PHC was defined as “essential health-care made universally accessible to individuals and families in the community by means

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<sup>91</sup>Mann et al., “Health Care in Botswana: The Government's Role in Primary Health Care and Nursing Education,” 68. “Health services are under management of both the Ministry of Health (MOH) which oversees all hospitals (referral, districts and primary) and the Ministry of Local Government, which is in charge of clinics, health posts and mobile stops.” Botswana Central Statistics Office, “Stats Brief: Access to Health Services in Botswana,” [http://www.cso.gov.bw/templates/cso/file/File/access\\_healthservices2007.pdf](http://www.cso.gov.bw/templates/cso/file/File/access_healthservices2007.pdf) (accessed January 26, 2012).

<sup>92</sup>Initially, “health-care services in Botswana were hospital-based until 1973. Since 1973, the Government of Botswana accepted Primary Health-care as the most appropriate strategy for the attainment of Health for All.” See United Nations Children's Fund, “Multiple Indicator Cluster Surveys (Mics2)-- Botswana,” [http://www.childinfo.org/mics2\\_botswana.html](http://www.childinfo.org/mics2_botswana.html) (accessed January 30, 2013). The MOH states, “Health System Health-care in Botswana is delivered through a decentralized model with primary health-care being the pillar of the delivery system. Botswana has an extensive network of health facilities in the 27 health districts. In addition to an extensive network of [271] clinics, 338 health posts and 844 mobile stops[,] Primary Health-care services in Botswana are integrated within overall hospital services, being provided in the outpatient sections of all levels of hospitals. It is through these structures that a complement of preventive, promotive and rehabilitative health services as well as treatment and care of common problems are provided.” Botswana Ministry of Health, “Overview,” <http://www.gov.bw/en/Ministries--Authorities/Ministries/MinistryofHealth-MOH/About-MOH/About-MOH/> (accessed January 25, 2012).

<sup>93</sup>World Health Organization, “Declaration of Alma-Ata: International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978,” [http://www.who.int/publications/almaata\\_declaration\\_en.pdf](http://www.who.int/publications/almaata_declaration_en.pdf) (accessed June 12, 2011).

acceptable to them through their full participation, and at a cost that the community and country can afford.”<sup>94</sup> This health model

[so] relied on the foundation that most community health problems can be resolved by . . . health-care . . . made affordable, accessible and acceptable to the community. It included the best public health strategy that is prevention and the highest ethical principle of public health that is equity.<sup>95</sup>

In pursuit of PHC, Botswana has different levels of health-care meant to provide individuals, families, communities, and the society access to affordable health facilities. “The country has an extensive network of health facilities comprising hospitals, clinics, health posts, (local, village-based health centers), mobile health stops, all spread around 24 health districts.”<sup>96</sup>

The remotest health institutions apart from traditional healers are the Health Posts in the far hinterland. In places where a population of between 500-1,000 live within a radius of 15 km, Health Clinics exist or are considered. The next level of health-care are the Health Centers, which in essence serve as miniature hospitals. The District and Regional Hospitals come next, the main referral hospital being Princess Marina Hospital in Gaborone, [to which the Nyagabgwe Referral Hospital in Francistown, has been added since].<sup>97</sup>

PHC in the country has been designed in such a way that all people do have access to health-care, though some would have to travel quite a distance to get better care. However, the primary hospital sends patients to the district and/or the referral

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<sup>94</sup>World Health Organization and United Nations Children's Fund, “Declaration of Alma-Ata,” in *International Conference on Primary Care* (Alma-Ata, Kazakhstan, USSR: World Health Organization: 1978).

<sup>95</sup>R. Karkee, “Revitalizing Primary Health Care,” *Kathmandu University Medical Journal* 6 23 (2008): 297.

<sup>96</sup>Mann et al., “Health Care in Botswana: The Government's Role in Primary Health Care and Nursing Education,” 61.

<sup>97</sup>K. K. Prah, “Stratification in Health: Class Perspective of Health in Botswana,” in *Proceedings of the Seminar on Health/Illness and the Socio-Cultural Background Held at the National Museum, Gaborone, 24-26 April, 1979*, ed. Thabo T. Fako (Gaborone, Botswana: National Institute of Development and Cultural Research Documentation Unit, University of Botswana, 1989), 20.

hospitals depending on the complexity of the patients' conditions.

### **Mobile Stops and Health Posts**

The health post is the most fundamental unit of health-care in Botswana. It usually targets the rural and remote areas of the country. This facility is

staffed by a Family Welfare Educator (FWE). Any rural village which has a population of 500–1000 people should have a health post and FWEs. The Ministry of Health firmly believes that all individuals themselves have a major responsibility for their own health, but it is the job of the FWE to be a health motivator and educator in family and community health, and also to be the community's first point of contact and referral to higher level health personnel.<sup>98</sup>

The FWE therefore is instrumental in disseminating information on preventive health-care. This health provider plays an important role as a health community worker. She often expects regular visitations from her nurse supervisor who comes to check on the community's health needs and attend the more complicated health cases.

Nurses make further visits through health mobile stops<sup>99</sup> to other smaller areas such as cattle posts and farms. Mobile stops ensure the most remote citizens have access to health even if the service is minimal. "Mobile stops increased from 740 in 1998 to 860

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<sup>98</sup> Owolabi, "Botswana," 28. "Health posts have fixed facilities, usually limited to three rooms and outdoor plumbing facilities. Staffed by one nurse and a family welfare educator . . . , health posts deliver a broader range of services, including expanded maternal and child health, school and environmental health, and first aid. Health posts receive periodic visits from supervising clinics. Health education, case finding, and follow-up are important functions of the health post, particularly in communities without a resident clinic. The family welfare educator plays a key role in this regard." Scott Stewart, "Botswana," in *World Health Systems: Challenges and Perspectives*, ed. Bruce J. Fried and Laura M. Gaydos (Chicago, IL: Health Administrative Press and Association of University Programs in Health Administration Press, 2002), 399.

<sup>99</sup>The concept of health mobile stops dates back to 1973/74 when the government of Botswana noted that in "1973/74 [it] spent about £7.50 per capita on health-care for people living less than 5 miles from a hospital [typically urban areas], while for the 40% of the population living more than 25 miles from a hospital and 10 miles from a clinic [most rural areas], the government spent only £0.90 per capita. In an attempt to redress the present imbalance in the allocation of health service resources, the Botswana government has been considering the expansion of mobile health services." Godfrey Walker, "Primary Health Care in Botswana: A Study in Cost-Effectiveness," *Proceedings of the Royal Society of Medicine*

in 2006. However, the number of mobile stops sometimes fluctuates. This might be due to the fact that a visit to the areas out of reach by [a] mobile clinic depends on the availability of staff and transport at the clinic in that catchments area.”<sup>100</sup> Rudimentary service at the health mobile stops may include “the routine monitoring of child and prenatal health, the diagnosis of common illnesses, and health education. New enrollees and complex cases are referred to health posts or clinics for consultation.”<sup>101</sup>

The position of the nurse in Botswana is critical. She not only manages her clinic, she supervises health posts and mobile stops. In addition, she diagnoses common illness, prescribes medicine for treatment, and makes the important decision whether to refer a patient to a hospital or not. For example, “in several African settings, such as Botswana and Lesotho, nurses are performing expanded roles in ART [Antiretroviral Therapy] service delivery, including drug prescription and management.”<sup>102</sup>

After the health post, the clinic is the next higher health institution in the Botswana health-care system.

## **Clinics**

Clinics and health posts complement each other as they provide basic health services and information on ante- and post-natal care, nutrition, tuberculosis, venereal

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69, (1976), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1864748/pdf/procrsmed00023-0082.pdf> (accessed January 25, 2012). To save cost, land mobile services were preferred over air. See *ibid*.

<sup>100</sup>Botswana Central Statistics Office, “Health,” [http://www.cso.gov.bw/index.php?option=com\\_search&q=health](http://www.cso.gov.bw/index.php?option=com_search&q=health) (accessed January 25, 2012).

<sup>101</sup>Stewart, “Botswana,” 399.

<sup>102</sup>Sophie Beauvais, “Guidance for Nurse Prescription and Management of Antiretroviral Therapy,” Family Health International, <http://www.ghdonline.org/adherence/discussion/guidance-for-nurse-prescription-and-management-o-2/> (accessed December 20, 2008).

disease, etc., to the communities. In contrast to the health posts,

the nurses at the clinics cover a wider range of educative health subjects, collect statistics, carry out immunizations, and have up to ten beds of curative and maternity care. . . . The criteria for the establishment of clinics in the rural areas is that there should be a population of between 4,000 and 8,000 people within a radius of 30 km, while in the larger villages and towns a clinic would serve a rather greater population because of the nearness of other higher level facilities.<sup>103</sup>

As frontline institutions, the clinics need special attention, especially the training of personnel so that they have the technical skills and are also culturally relevant to the community. Clinics are essential to the life and welfare of the community patients because they are the ones that make referral to the hospitals in cases of complex medical situations.

### **Hospitals: Primary, District, and Referral**

“Botswana has consistently improved its health service infrastructure and facilities. The health infrastructure network comprises 31 hospitals, 243 clinics, and 340 health centers.”<sup>104</sup> Primary hospitals (which receive referrals from clinics, health posts,

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<sup>103</sup>Mills, “Infrastructure and Health: Some Pro's and Con's,” 9. Clinics “have several rooms, a covered waiting area, and at least one vehicle used for patient transportation, the operation of mobile stops, and visits and other facilities. Clinics may be staffed by several nurses but rarely have a physician, except for maternity clinics in larger urban areas. Clinics provide all of the primary care services available at their subsidiary facilities, and they augment with clinical and laboratory support. As such, clinics have a much greater role in providing curative care. Delivery services also are provided at maternity clinics.” Stewart, “Botswana,” 399-400.

<sup>104</sup>Africa Economic Outlook, “Botswana,” [http://www.africaneconomicoutlook.org/fileadmin/uploads/aeo/Country\\_Notes/2011/Full/Botswana.pdf](http://www.africaneconomicoutlook.org/fileadmin/uploads/aeo/Country_Notes/2011/Full/Botswana.pdf) (accessed January 30, 2012).

and mobile stops) “have 20-70 beds for general, maternity, and tuberculosis care; they offer more complete laboratory services and outpatient services than clinics do [as] they include x-ray and surgery facilities.”<sup>105</sup>

Primary hospitals make their referrals to district hospitals, which in turn send their critical patients to referral hospitals. Referral hospitals send life-threatening cases to neighboring South Africa, which has excellent facilities, but is costly to the Botswana government.<sup>106</sup> District hospitals, in contrast, are placed in major villages and towns.

With 71-250 beds, district hospitals offer special services for complex cases and a broader range of surgical and rehabilitative care. They refer clients to . . . national referral hospitals . . . as . . . they offer an extended range of specialty care in addition to the full range of care found at other points in the system. When needs are so specialized that national referral hospitals cannot meet them, referrals may be made to facilities in South Africa or, occasional[ly] to . . . private hospital[s] in Gaborone.<sup>107</sup>

While these facilities offer general medical treatment, there is one unique area of health that needs mention—mental health—because of its complexity and need for specialized training. This is also an area which traditional doctors claim to treat successfully. The shortage of mental treatment centers in the country is often relieved by the practice of these doctors. However, “care of the mentally ill in Botswana is provided at different levels of sophistication. There is a single [referral] mental hospital in the country. Attached to the district hospitals are psychiatric outpatient clinics run by

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<sup>105</sup> Stewart, “Botswana,” 400. Primary hospitals are “staffed by doctors, pharmacy technicians, laboratory technicians, radiographers and nurses.” Nel Druce et al., “Impact of Public-Private Partnerships Addressing Access to Pharmaceuticals in Low and Middle Income Countries: Botswana,” Initiative on Public-Private Partnerships for Health, <http://www.hlsp.org/LinkClick.aspx?fileticket=Yo9Vc5E-NwY%3D&tabid=1814&mid=3517> (accessed January 29, 2012).

<sup>106</sup> Mike Olivier, “Botswana Paying South Africa Company over P2.4 Million a Year for Referrals,” *GABZ FM News* (2011), <http://gabzfmnews.wordpress.com/2011/03/14/botswana-paying-sa-company-over-p2-million-a0year-for-patient-referrals/> (accessed February 2, 2012).

<sup>107</sup> Stewart, “Botswana,” 399.

psychiatric nurses and a psychiatrist who visits them on [a] monthly basis.”<sup>108</sup>

Though doctors do make some visits to the clinics, hospitals are their purview. The human resource needs for doctors in Botswana cannot be overemphasized. In a study of the “effectiveness of non medical prescription in primary care in relation to safety and appropriateness of prescribing by nurses and other professionals allied to medicine . . . [researchers found that] some prescribing of antibiotics by those nurses may have been inappropriate and not evidence-based.”<sup>109</sup>

This challenge may be resolved in two ways. The first is to train more doctors so that the doctor density per population is enough to relieve the nurses of the task of diagnosing patients and prescribing medications. The second, due to expenses involved in recruiting and training doctors, the MOH could consider giving a special cadre of nurses some specialized training in certain areas of bio health prescription.<sup>110</sup>

In general, the “scarcity of trained health workers is recognized as the main constraint on improving equity and levels of health-care in Botswana. Skills scarcity persists in a number of crucial areas especially at [the] primary health-care level.”<sup>111</sup> As

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<sup>108</sup>E. S. Seloilwe and G. Thupayagale-Tshweneagae, “Community Mental Health Care in Botswana: Approaches and Opportunities,” *International Nursing Review* 54 2 (2007): 173.

<sup>109</sup>Sadiq Bhanbhro et al., “Assessing the Contribution of Prescribing in Primary Care by Nurses and Professionals Allied to Medicine: A Systematic Review of Literature,” *BMC Health Services Research* 11 Suppl. 1 (2011): 330. Further, “a mixed methods survey of adherence to treatment guidelines in primary health-care facilities in Botswana found that antibiotics were prescribed in 27% of all 2994 consultations. The study reported that full adherence to prescribing guidelines (defined as complete adherence to national recommended treatment guidelines) occurred in 44% of prescriptions, acceptable compliance in 20%, acceptable but with one or more useless although not dangerous drugs in 33% and insufficient or dangerous treatment in 3% of the consultations.” Ibid.

<sup>110</sup>A considerable number of nurses are doing the prescriptions anyway, not only in hospitals but also most certainly in clinics as well, which outnumber the hospitals.

<sup>111</sup>Druce et al., “Impact of Public-Private Partnerships Addressing Access to Pharmaceuticals in Low and Middle Income Countries: Botswana.”



part of its grand plan for health cadre training, the government has embarked on a program that addresses the health needs of the country.

### **Training and Human Resources**

The training of health personnel has always been a perennial challenge to the country's health sector. "One of the biggest challenges for provision of high quality accessible and equitable health-care in Botswana is a shortage of trained health professionals of all types. There are for instance only 4 doctors, 26 nurses and 2 pharmacists for every ten thousand people."<sup>112</sup> Nevertheless,

training capacity exists domestically for registered nurses, midwives, nurse practitioners, anesthetic nurses, pharmacy technicians, x-ray assistants, and dental therapists. As of 1996, all other categories of service provider were required to train outside the country. To meet shortages the MOH and the MLGLH regularly recruit from other countries in Africa and further abroad.<sup>113</sup>

Whereas the key personnel in health posts are FWEs, their counterparts in clinics are nurses. In essence, both form the backbone of the modern health system in Botswana, as they are the initial contact with the community.<sup>114</sup> This is important for a country that has been hard hit by the HIV/AIDS pandemic.

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<sup>112</sup>Human Resources for Primary Health Care in Africa, "School of Medicine, University of Botswana, Botswana," <http://www.huraprim.ugent.be/drupal/> (accessed February 22, 2012).

<sup>113</sup> Stewart, "Botswana," 397. The MOH reveals that "basic programs offered are all at higher diploma level and they are; general nursing, medical laboratory technology, pharmacy technology, dental therapy, health education, environmental health, [while] post basic programs are all advanced diplomas; midwifery, family nurse practice, nurse anesthesia, community health nursing, ophthalmic nursing and psychiatric mental health nursing." Botswana Ministry of Health, "Health Training Institution Program Information," <http://www.moh.gov.bw/> (accessed January 30, 2012).

<sup>114</sup>Stewart emphasizes the key role played by nurses: "Given the shortage of physicians, nurses are the backbone of Botswana's health-care system. Accordingly, they command considerable influence with regard to healthcare policy and planning. Nurse-matrons often supervise district health teams, and those with graduate training in public health have risen to head full ministerial departments." Stewart, "Botswana," 400.

According to World Health Organization (2002) nurses and midwives are the backbone of health-care in systems in most countries around the world. Indeed in Africa, the attainment of the Health for All goal is to a large extent dependent on nurses. Therefore, they are ideally positioned to assume a leadership role in providing evidence for interventions that can facilitate meeting national goals.<sup>115</sup>

As a result, the Botswana government has taken seriously the training of this section of the health human resource so as to improve community health and quality of life. It has done this through the establishment of Health Training Institutions (HTIs), augmented by those that were established by Christian medical institutions at Kanye and Ramotswa.

Health Training Institutions (HTIs) were established in the early 1970s to prepare nurses to meet the health needs for the country. It started with the institution in Gaborone (Capital City) with four satellite campuses in Francistown, Lobatse, Molepolole and Serowe. Over the years, the number of institutions has grown to eight (8) with additional ones in Mochudi, Ramotswa and Kanye. Of the eight institutions, two (2) are mission owned but all funded by government through Ministry of Health. Other six (6) are government owned. . . . All the eight . . . are affiliated to the University of Botswana (UB).<sup>116</sup>

Nurses working in hospitals need to attain at least a Bachelor's degree in order to improve their efficiency. According to one research finding, "results show that some hospitals with a larger proportion of nurses who have a bachelor's degree had better

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<sup>115</sup>Sheila Shaibu, "Evidence-Based Nursing Practice in Botswana: Issues, Challenges, and Globalization," *Primary Health Care Research and Development* 7 (2006): 309, <http://ubrisa.ub.bw/bitstream/handle/10311/509/Evidence%20based%20nursing.pdf?sequence=1> (accessed January 30, 2012).

<sup>116</sup> Botswana Ministry of Health, "Health Training Institution Program Information." On September 18, 2009, the Minister of Health, Lesego Motsumi, officiating at the graduation ceremony of the joint health trainee graduands declared, "From a total of 681 graduates; 357 were general nurses; 202 midwives; 19 community health nurses; 19 medical laboratory technicians; 16 environmental health officers; 15 pharmacy technicians; 12 family nurse practitioners; 12 ophthalmic nurses; 12 health education officers; 8 community health nurses and another 8 dental therapy technicians." Botswana Ministry of Health, "The 13th Affiliated Health Training Institutions Joint Graduation," <http://www.moh.gov.bw/> (accessed January 30, 2012). Again the number of nurses, midwives, and community health workers speaks volumes to their centrality in the public health-care system.

quality and safer care, as well as higher patient satisfaction.”<sup>117</sup>

However, one of the challenges faced by the public health sector is the spate of resignations especially by nurses and health instructors. “A study on why nurses migrate has revealed that the intent to find greener pastures abroad among nurses in Botswana is still rife.”<sup>118</sup> This exacerbates the nursing shortage situation in the country.

The nursing shortage is felt particularly sharply in Botswana. In the United States there are between 10 and 13 nurses per 1,000 people. The ratio of nurses in Botswana is about 3.8/1,000 whereas globally, the ratio varies between [less than] 1 to [greater than] 15/1,000. . . . Nurses are performing roles and activities that, in the U.S., would be considered beyond our practice. The high prevalence of HIV/AIDS has affected nursing more than any other profession. Retaining nurses . . . has become an even bigger challenge due to all these issues: compromised working conditions, high workloads, and the expanded scope of practice. Nurses are leaving the profession or emigrating.<sup>119</sup>

Certainly, medical doctors are a critical part of the health-care system in Botswana. An important milestone for Botswana was the establishment of a medical school at the University of Botswana that was scheduled for 2009.<sup>120</sup> It was anticipated that the new school would bring long-term solutions to the high attrition and turnover rates among local doctors.

The brain-drain is also evident: “Between 1990 and 2010 some 800 doctors sent

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<sup>117</sup>Petra Kendall-Raynor, “Linking between Staffing Levels and Outcomes Cannot Be Ignored,” *Nursing Standard* 25, no. 39 (2011): 12, <http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=61875067&site=ehost-live> (accessed November, 2012).

<sup>118</sup>Chandapiwa Baputaki, “Nurses Migrate for Greener Pastures,” *The Monitor*, June 29, 2009, 3.

<sup>119</sup>Debra Rose Wilson, “The ‘Botswana I Am Proud to Be a Nurse’ Campaign,” *Tennessee Nurse* 73 4 (2010): 8.

<sup>120</sup>Dana Benson, “White Coat Ceremony Another Step in Development of New Medical School in Africa,” Baylor College of Medicine, <http://www.bcm.edu/news/item.cfm?newsID=1526> (accessed January 31, 2012).

abroad graduated, but only 120 Batswana doctors work in the country.”<sup>121</sup> Fortunately, “the SoM [School of Medicine] has qualified capacity to run medical education in Botswana and it is cheaper to train students in this country; further, most doctors sent to train outside do not return to serve their country.”<sup>122</sup>

### **Public Health Care, Faith, and Healing**

This section discusses the philosophy and practice of healing vis-à-vis faith, in the secular (scientific) setting of the public health sector in Botswana.

There is no doubt that scientific medicine is evidence-based, tested and tried, and has proven in most cases to be effective in treating (especially infectious) diseases in the broad spectrum of health issues. However, regular medicine is not always successful in its attempt to treat problems such as allergies; mental illness; cancer; acute infections associated with viruses; metabolic, nutritional, chronic degenerative, and auto-immune diseases; and psychosomatic diseases.<sup>123</sup> A consequence of this is that alternative therapies such as traditional and faith healing get constructively engaged by patients.

Turning to alternative medicine is further exacerbated by the fact that

regular doctors tend to pay attention only to physical bodies, ignoring the mental and spiritual aspects of humans that are always involved in health and illness. (Indeed, this is the chief theoretical defect of the system.) Further, allopathic medicine as an organized enterprise is not only close minded toward alternative practices but has

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<sup>121</sup>Dikatso Selomogwe, “UB School of Medicine Not Accredited,” *The Botswana Gazette* February 1 (2012), <http://www.gazettebw.com> (accessed December 13, 2013).

<sup>122</sup>Ibid.

<sup>123</sup> Andrew Weil, *Health and Healing: The Philosophy of Integrative Medicine* (Boston, MA: Houghton Mifflin, 2004), 83.

waged constant and often unfair wars against other therapeutic systems, regarding as competition rather than intellectual challenges.<sup>124</sup>

Public health-care facilities function as non-religious institutions. This helps to ensure that no religion is imposed on anyone, and that none should be prejudiced on this account.<sup>125</sup> However, individuals or religious groups wishing to visit patients and offer prayers are allowed. Of all spiritual activities, prayer is the most common in the public health sector. Typically, “the clinic [or health post or hospital] starts with a morning prayer and health talk organized by the staff for all patients in the clinic. The patients then disperse, moving on to the appropriate unit for their appointments.”<sup>126</sup>

### **Institutional Medical Missionary Models**

The Bamalete Lutheran Hospital (BLH) in Ramotswa and Kanye Seventh-day Adventist Hospital (KSDAH)<sup>127</sup> are the only major Christian medical mission institutions left in Botswana. Both are district hospitals. These mission institutions have very well-developed schools of nursing. They share several other common features, as well as some differences.

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<sup>124</sup>Ibid.

<sup>125</sup>For more detail on religious freedom in Botswana, see Fidelis Nkomazana, “The Botswana Religious Landscape,” in *The Faith Sector and HIV/AIDS in Botswana: Responses and Challenges* (Newcastle upon Tyne: Cambridge Scholars, 2011), 2-4.

<sup>126</sup>World Health Organization, “From Access to Adherence: The Challenges of Antiretroviral Treatment--Studies from Botswana, Tanzania and Uganda,” <http://apps.who.int/medicinedocs/en/d/Js13400e/8.6.4.html#Js13400e.8.6.4> (accessed January 31, 2012).

<sup>127</sup>I served at KSDAH as hospital chaplain from 1996–1998, and a member of the Hospital Board, including the years 2000-2005, when I was a local Conference administrator. During my chaplaincy at KSDAH, I made mutual exchange visits to BLH with that institution’s chaplain.

### **Government Memoranda of Agreement**

Public health-care in Botswana had largely been the burden of Christian medical missions even a decade into the country's independence. Therefore, a transient discussion of the performance of the health sector in Botswana prior to the signing of the memoranda of agreements between the government and the mission hospitals might prove useful in putting the prevailing status into perspective.

At this time the main health-care financiers were the government, Christian missions, and local communities. Across the country, church organizations and communities established mission hospitals, clinics, and health posts. Poverty-stricken communities—especially following a devastating drought between 1964 and 1966—contributed labor and management services to health facilities, while mission agencies raised funds for construction, drug procurement, and salaries of health personnel. The government focused its limited resources on upgrading the country's few hospitals and constructing some clinics in densely populated areas.<sup>128</sup>

Gradually, as the state's financial standing improved, the government made well-intentioned proposals to the careworn mission hospitals that culminated in the signing of memoranda of agreement.

However, the contract had its own ramifications. The mission hospital fees were immediately affected. Both Christian hospitals were obliged to follow the same nominal fee regimen used by government hospitals. Even though these mission hospitals would have preferred to charge higher medical fees to meet other costs, they were (and still are) incapacitated to do so. These agreements were necessitated by different needs faced by the three parties.

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<sup>128</sup>Patrick P. Molutsi, "District Control and Accountability in Botswana's Health Care System," in *Sustainable Health Care Financing in Southern Africa: A Paper from an EDI Health Policy Seminar Held in Johannesburg, South Africa*, Learning Resources Series (Washington, DC: The World Bank, 1998), 84.

The hospitals' main challenge has always been lack of human and financial resources to independently operate and develop their entities.<sup>129</sup> On the other hand, the government (1) did not initially have the resources to build duplicate hospitals in the same locations,<sup>130</sup> let alone in other needy places such as rural areas and (2) had to ensure the rural poor had equal access to public health as in any other parts of the country.<sup>131</sup> The government struck a deal with mission hospitals in which the government was expected to provide the finances to absorb the running costs, including the wages and salaries of the workforce of the mission hospitals. In turn, the medical missions would continue to provide public health service in a way that was accessible to all.

Though government financing came with great relief to the mission hospitals, there were unintended consequences, including (1) the possibility of compromised Christian principles, (2) restricted infrastructural development, and (3) an uncertain future.

Compromised Christian principles refer to those values that the medical missions esteemed, but could no longer follow as when they were the sole players in running the hospitals.<sup>132</sup> Gradually, these institutions came to realize that the privilege they had in

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<sup>129</sup>Serame Seretse Sibiyi, interview by author, Gaborone, Botswana, July 6, 2009. Sibiyi further explained that the Kanye College of Nursing benefited when government made funds available, some of which were later prudently used for improving the institution's facilities.

<sup>130</sup>“Government took a deliberate decision that they would not establish hospitals where they were already existing medical hospitals under missionaries and . . . instead of putting up structures and duplicating the work they would rather give some subventions to these missionary hospitals and so government developed a memorandum of understanding between government of Botswana and the missionaries and ensured that . . . both parties were able to reach their goals without compromising the goals of the other.” Patson Mazonde, interview by author, Gaborone, Botswana, June 20, 2009.

<sup>131</sup>Molutsi, “District Control and Accountability in Botswana's Health Care System,” 83.

<sup>132</sup>“The problem is that . . . there are issues and ethics where the church may take a certain position but government would expect that that service must be honored. For example, we do not as a church

procuring (suitable) Christian employees who were committed to upholding Christian values was also curbed. “Since independence, it has been more difficult for mission hospitals to provide doctors who are also missionaries, and many mission hospitals are now staff[ed] at least partially by secular medical personnel. As a result, prayer is now increasingly separate from medical care at these institutions.”<sup>133</sup>

Infrastructural development of the BLH and KSDAH was also stymied, especially for KSDAH. This is because though the government did not restrict the mission hospitals from extending their hospitals, by default it did since there was no provision for capital expenses.<sup>134</sup> As the populations of the communities grew, it became evident that the hospitals were increasingly having limited capacity to handle the challenge, for there were no adequate finances for infrastructural expansion.

In 2008 Southern District Council Chairman Kentse Rammedi told state President Festus Mogae that “the Seventh Day Adventist Church hospital in Kanye was overwhelmed by the number of patients, hence the need for a bigger hospital.” The president’s response was, “As it is I know that your hospital needs to be renovated and

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believe that termination of pregnancy is the right thing except under strict medical conditions, but you know there is law right now that allows for a termination of pregnancy and then the law says this should be done in a hospital where there are doctors and therefore we would be expected to do that. . . . But . . . the relationship between the church and the government has been a cordial one. . . . All these things should not overshadow the good relationship . . . [over] all these years.” Mazonde, interview by author, July 20, 2009.

<sup>133</sup>Julie Livingston, *Debility and the Moral Imagination in Botswana* (Bloomington, IN: Indiana University Press, 2005), 282. When the government began paying full wages and salaries, it required those on its payroll to accept transfers to any part of the country. This eventually brought in hospital workers who were not even Christians and so were not obliged to uphold the Christian values. Nevertheless, the government allowed these Christian hospitals to retain their administrators.

<sup>134</sup>The government expected BLH and KSDAH to do their part in extending the hospital as needed. Adrian C. Mpofu explains that “the appropriations that they [mission hospitals] get from government are not even meant for [the] upkeep [maintenance] of these hospitals.” Adrian C. Mpofu, interview by author, Gaborone, Botswana, June 22, 2009.



extended but frankly speaking I do not think you need a district hospital now.”<sup>135</sup> He, however, did not rule out the possibility of the government building a second and even more complex hospital in the future.<sup>136</sup>

Faced with a threat to compromised Christian principles and stifled infrastructural development, the mission hospitals were seemingly left in limbo. A continual lack of infrastructure development could eventually solicit a government takeover, thus bringing an end to a century-old ministry. This reality of uncertain future is uppermost in the minds of the hospital administrators. But such woes befalling the mission hospitals may not all be blamed upon the government, which continuously gives assurances it will not unilaterally take over the mission hospitals.

Adrian Mpofu explains that “the introduction of these [unfavorable] policies [that set new standards] and the downfall of the support of overseas [mission] institutions have contributed to the non-smooth running of [mission] hospitals.”<sup>137</sup> The mission agencies were also failing to raise enough funds for development and operations.

In spite of all the challenges brought about by the memoranda of agreements, there are several areas the government needs recognition for. First, the government’s intervention was timely in providing health financing that had threatened the very existence of the mission hospitals. Second, the government sent technical and expert

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<sup>135</sup>Chippa Legodimo, “Kanye Needs Hospital, Bangwaketse Tell Mogae,” *Mmegi*, February 26, 2009, 3.

<sup>136</sup>President Mogae further said, “But as for the hospital maybe it is a blessing in disguise that we are delaying the delivery of these projects because by the time we start them we would obviously come up with better infrastructure than the ones we have already built in other areas.” *Ibid.*

<sup>137</sup>Mpofu, interview by author, July 22, 2009. The mission agencies could no longer afford to run their hospitals as costs spiraled.

personnel to these hospitals especially in the areas of need such as doctors, nurses, pharmacists, etc. Thus, in-service and specialist training expenses were covered by the state. This ensured continuity and certainty in providing health-care to the communities.

Third, “administration [of the mission hospitals] remained in the hands of the church missionaries,”<sup>138</sup> a positive assurance from the government that it recognized the mission hospitals’ ideals and principles. Fourth, the mission hospitals were allowed to run a small private wing where they could charge higher fees to those clients who preferred that service.<sup>139</sup> Though limited, the mission hospitals could take advantage of that opportunity to serve those who would otherwise go to the towns and cities for the same service; they could also raise some funds toward operational costs of the hospital.

Besides, the two mission hospitals have continued to operate under the auspices of their respective Christian ethos, albeit in the broader sense. Both BLH and KSDAH have a chaplaincy department. However, BLH has associate chaplains who help in the spiritual sphere; KSDAH works with a single chaplain who covers the whole hospital.

### **Faith-based Healing**

BLH and KSDAH remain committed to the Christian service they offer with all hospital staff being self-motivated to treat their patients with love, compassion, and care, while at the same time pointing them to God’s healing power. “Although it is true that the mission work at Ramotswa [BLH] had started with its biblical foundation, that is, the preaching of the Gospel and the building of the Church, the historical developments of

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<sup>138</sup>Sibiya, interview by author, July 6, 2009.

<sup>139</sup>Mazonde, interview by author, July 20, 2009.

the mission work there show a clear interest in diaconal work.”<sup>140</sup> ‘Diaconal work’ refers to rendering a service that addresses the total needs of humanity, including spirituality—not merely proselytizing.

Despite ELM's [Evangelical Lutheran Mission] focus on spiritual matters in its mission work, diaconal missionary outreach—education and medical work—has always been part of its endeavors to spread the Good News. From the early beginnings of its mission work, many missionaries and their wives were sent especially to rural areas in order to promote the Christian message not only by preaching the Word of God, but also by helping the sick. One could even go so far as to say that mission stations were often centers of general education and health-care—a kind of holistic ministry!<sup>141</sup>

KSDAH shares similar views and principles with their counterpart. The hospital’s motto, “but to minister,”<sup>142</sup> is derived from Matt 20:28, “Even as the Son of man came not to be ministered unto, *but to minister*, and to give his life a ransom for many.” This indicates the hospital’s desires to follow the footpath of its Master and Chief Physician who came not to be served, but to serve, save, and give life to many.

Allan R. Handysides, former Health Ministries Director at the Adventist World Church Headquarters in Washington, D.C., puts the Adventists’ biblical healing into perspective:

The mission statement of the gospel’s proclamation utilizes the three methodologies of preaching, teaching, and healing. These modalities, under the guidance of the Holy Spirit, have served the church well throughout the decades. In considering our Adventist global health ministry, it is important to recognize that service to others—caring for the welfare of the whole person—is as much the goal of the church as is

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<sup>140</sup> C. Steinert, “The Evangelical Lutheran Responds,” *Mmegi* December 2 (2009), <http://www.mmegi.bw/index.php?sid=2aid=2008dir=2011/March/Monday28&aid=150&dir=2009/December/Wednesday2> (accessed August, 2010).

<sup>141</sup> *Ibid.*

<sup>142</sup> The motto appears as part of the logo in the hospital’s letterhead, vehicle doors, and so on.

caring for [one's] own personal well-being. The beauty of its focus [is] upon Jesus, the author of all health.<sup>143</sup>

## Distinctions Between BLH and KSDAH

### **Types of Health Services**

There are notable differences between the BLH and KSDAH; this shows in the types of services that the two mission hospitals offer. While both hospitals had somewhat equal access to the government subventions, BLH seemed to have advanced itself in providing specialized services that were usually nonexistent in other general hospitals. Without such services, the government and other mission hospitals (including KSDAH) had to refer some of their patients to BLH.

“BLH functions as a district hospital for general medical patients, but also as a referral hospital. Specialist services in ear diseases, pediatrics, hydrocephalus and general surgery, orthopedics, obstetrics and gynecology are offered at the hospital.”<sup>144</sup> One of the most famous BLH departments is known as the ENT (Ear Nose and Throat).

The hospital also offers palliative care in the form of a hospice, a key feature that is missing at the KSDAH.

The hospice was founded in 1992, initially to provide day care for the elderly and chronically ill. It soon became used for HIV positive patients and soon cancer patients. The hospice operates a home-based care service, offering nursing and counseling to approximately 48 patients at a time. . . . Daily respite care is available

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<sup>143</sup>Allan R. Handysides, “Adventist Global Health Ministry: We Don't Call It ‘the Right Arm of Our Message’ for Nothing,” *Adventist Review*, June 25, 2009, 4.

<sup>144</sup>Edgar Tsimane, “Botswana: Hospital Celebrates 70 Years of Service,” *Mmegi*, September 13, 2004, 4.

when necessary. A day care center operates twice weekly where patients are fed; they can also partake in occupational pursuits such as beadwork and sewing.<sup>145</sup>

In addition, the Lutheran hospital helped establish the Botswana Society for the Deaf, becoming in 1979 the Ramotswa School for Deaf Education,<sup>146</sup> which later received government financial assistance.

The BLH anticipates continuing with many other projects to enhance and diversify its health services to the communities, in spite of the financial constraints it is facing. Speaking at the BLH fund-raising dinner for the planned Physical Therapy, then Vice President, Honorable Lt. General Mompoti Merafe, noted that “in recent years though, the Church and funding organizations in Germany have scaled down their operations in this country and let Government of Botswana take over [the financing]. However their contribution is still significant.”<sup>147</sup>

In contrast, KSDAH depends solely on the government for funding. The institution no longer receives appropriations from the Church’s headquarters in the United States, nor from its regional Division.

### **Development of Infrastructure**

The BLH has grown more rapidly than KSDAH. Mmitsi Mmitsi, speaking at the BLH seventieth anniversary, commended the hospital’s dedication for starting from

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<sup>145</sup>Lancaster University, “Botswana: Palliative Care Service Provision,” [http://www.lancaster.ac.uk/shm/research/ioelc/international/pdf/botswana\\_country\\_report.pdf](http://www.lancaster.ac.uk/shm/research/ioelc/international/pdf/botswana_country_report.pdf) (accessed February 26, 2012).

<sup>146</sup>Shirley Nkepe, “MOE [Ministry of Education] Asked to Build Senior School for Special Needs,” *Mmegi*, February 5, 2004, 4.

<sup>147</sup>Republic of Botswana, “Remarks by His Honour the Vice President, Lt. Gen. Mompoti S. Merafhe, MP at the Bamalete Lutheran Hospital Dinner Dance,” <http://prgobw.blogspot.com/2009/04/remarks-by-his-honour-vice-president-lt.html> (accessed December 13, 2013).

humble beginnings in 1934 to 2004, which saw the construction of a P2 million laundry facility and a P1 million nursing school administration block.<sup>148</sup>

There are several explanations for BLH's infrastructural success. First, apart from the regular government subventions, the hospital's policy has allowed it to apply for capital funds from the government in order to develop infrastructure. Second, the institution has skillfully solicited the help of Non-Governmental Organizations (NGOs) and even parastatal bodies.<sup>149</sup>

Third, BLH has an array of institutional 'friends' who have come to its rescue financially when called upon. "With the continuing support of the government, the Evangelical Lutheran Mission of Hermannsburg in Germany, assisted by the Lutheran Aid Organisation 'Bread for the World,' Stuttgart and Christoffel Blinden Mission Benshein, further extensions and renovations have led to the present day BLH."<sup>150</sup> The active support of the mission agency and its auxiliaries is particularly significant.

On the other hand, KSDAH's non-government fiscal support has been somewhat limited, fast diminishing from maximum to zero. William G. Johnsson poignantly observes, "Our hospitals and publishing houses, on the other hand, do not receive

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<sup>148</sup>Edgar Tsimane, "BLH Commemorates 70 Years of Existence." *Mmegi*, September 23, 2004.

<sup>149</sup>The Botswana Housing Corporation (BHC) completed several rural community projects in 2007 which included "Bamalete Lutheran Hospital . . . and Motswedi Rehabilitation Centre in Mochudi." Wanetsha Mosinyi, "BHC Hands over Day Care Center," *Mmegi*, September 13, 2007, 4; Steinert, "The Evangelical Lutheran Responds." Another example is establishment of the Ramotswa Infectious Diseases Care Clinic (IDCC) in 2007 at the BLH premises. "ACHAP (African Comprehensive HIV/AIDS Partnerships) in collaboration with the Bamalete Lutheran Hospital contributed to the construction of the clinic with ACHAP providing funding in the amount of P1 million of the estimated P3,4 million cost for the facility. This IDCC will provide services such as treatment, HIV testing, and consultation, in addition to storage and dispensary of ARV drugs." ACHAP, "Ramotswa IDCC Officially Opened," *African Comprehensive HIV/AIDS Partnerships*, October 2007, 3.

<sup>150</sup>Tsimane, "Botswana: Hospital Celebrates 70 Years of Service."

appropriations: they must sink or swim by their own efforts.”<sup>151</sup> This is consistent with the long-held policy of the mission’s policy of ‘church-state’ separation in almost all spheres, including finance.

The key to such a policy is to limit the bearing of ‘outside’ influence on the hospital, which might lead to a compromise of its operations and Christian ethos. This single factor may be the sole explanation as to why KSDAH is lagging behind its sister mission hospital (BLH) in the development and diversification of services.

Nevertheless, the KSDAH received a major boost in the 1980s when the Seventh-day Adventist World Services, Inc., won for it a grant from the United States International Cooperation Agency for International Development amounting to \$1,000,000.<sup>152</sup> The purpose for this grant was to “expand its primary health treatment and preventive care capability with the construction and equipping of a community health-care building and replacement construction of the School of Nursing.”<sup>153</sup> This construction marked a colossal change in the hospital’s landscape from the colonial buildings to the modern facility it holds today.

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<sup>151</sup>William G. Johnsson, “Four Big Questions,” *Adventist Review*, May 25, 2006, 11. Historically, the hospital had been relying much on appropriations from the General Conference of Seventh-day Adventists, headquartered in Silver Spring, Maryland, U.S.A., and through the regional divisions. However, as the World Church labored under the burden of financing such institutions as hospitals, it at the same time encouraged local churches and administrations to assume the responsibilities of helping these institutions to self-sufficiency. This was a great challenge especially in low-to-middle income countries, making government financial offers very attractive, though consequential.

<sup>152</sup>David A. Santos, *Grant by the United States of America to General Conference of Seventh-day Adventists Seventh-day Adventist World Service, Inc.* (Washington, DC: Agency for International Development, 1979).

<sup>153</sup>*Ibid.*

The next notable building project at KSDAH was the extension of the buildings at the Kanye College of Nursing. This state-of-the art infrastructure was built through savings from previous budgets for the school, which entirely came from the government.

### **Implications to Missions**

This chapter has discussed the three extant medical models in Botswana. The first is the indigenous African model in two forms: the traditional, practiced by traditional doctors, and Christian spiritual healing, practiced by prophets. The second is the government (scientific) model that is generally known as public health, and as practiced by Western-trained medical doctors. The last is the institutional medical missionary model—the Bamalete Lutheran Hospital (BLH) and the Kanye Seventh-day Adventist Hospital (KSDAH).

One of the major differences between the Christian spiritual medical model and the government scientific model is that the former attempts a more holistic approach to healing within the African context, whereas the latter relies much more on scientific evidence to the exclusion of religion and locally perceived psycho-social concerns that have a bearing on social, community health, and healing.

However, institutional medical missions also attempt to follow a holistic regime, even though they could learn a lot from the traditional and spiritual models in addressing local contextual issues as part of their daily activities. There is a dire need for medical missions to consider training its workers in socio-cultural aspects of the communities they serve so that they may be culturally knowledgeable and competent. There is a need for all three models to collaborate and develop—through dialogue—ways by which they can help each other with their diverse knowledge and skill resources. African healing



models far outpace the government and institutional models in terms of holistic approaches. Useful lessons can be drawn from these African models so that the psychosocial concerns of the Batswana can be addressed and reconstructed, but not necessarily in the way of the indigenous model.

Essentially, the government medical model is increasingly assuming prominence as the medical mission hospitals decrease in number and influence. The BLH has proven to be more dynamic in its approach to developing itself and diversifying its specialist services than has KSDAH, mainly due to the latter's stand on church-state separation.

The next chapter suggests an appropriate Adventist medical mission model for Botswana and southern Africa, considering the medical models already studied, the contemporary challenges of medical mission, and the contextual relevant biblical model of Adventist mission model is suggested.

## CHAPTER 6

### A SUGGESTED ADVENTIST MEDICAL MISSION MODEL, CONCLUSIONS, AND RECOMMENDATIONS

#### **Challenges to Adventist Medical Mission**

This research involved an in-depth missiological and historical-to-current study on the development of Adventist medical missions in southern Africa, with particular reference to Botswana. There are several challenges and lessons that can be learned from the study. The medical mission model that is proposed below is a response to some of the challenges that Adventist medical missions face.

First, Adventist medical mission encounters are complicated by the fact that African communities practice medical pluralism, seeking health care and healing from an assortment of medical service providers: Adventist medical missions, government public health care, African Traditional Medicine (ATM), and Christian Spiritual healing.

However, an immediate danger is when the patients receive and use medication from all three or four health-care systems without disclosing that fact to their practitioners. The complications can be far-reaching, considering that drugs might interact adversely. This indicates that there is minimum interaction, dialogue, or collaboration, if any, between the health service providers, to the detriment of the patients.

Furthermore, this suggests that—from the perspective of the traditionalist clients,

who are largely rural, illiterate, and poor—none of these parallel medical systems provide adequate services that wholly meet their needs. Thus, medical pluralism is a primary indicator that exposes a host of difficulties that not only patients face, but also medical service providers—though in differing ways.

Second, the Adventist medical mission faces a people with health disparity or inequality, because the rural poor (especially in other African countries) can neither afford the cost of travel to access distant modern health care nor the cost of treatment or medication once they get there. The situation leaves them with one option, which is to consult a traditional doctor or prophet.

Third, however, as this research has shown, there are several medical concerns associated with traditional health care. For complex diseases, undesired or dangerous outcomes are precipitated by higher probabilities of misdiagnosis, wrong treatment regimes, lack of standardized dosages and medication, etc.

Fourth, there are significant cases of malnutrition, infant mortality, and lack of hygiene that particularly affect the rural poor in many regions in southern Africa, if not the whole of Africa. In the case of Botswana, this is exacerbated by mostly parched land that experiences erratic rainfall, thus leading to crop failure and poor animal husbandry. Coupled with the fact that government and Christian medical mission treatment regimes are cure-oriented, with minimum preventive measures, public health is often compromised.

Fifth, the cultural life of Botswana has medical service ramifications. For example, it is a challenge to provide the nomadic San with long-term medical health care, as facilities such as clinics would be underutilized. The majority of Botswana also have

three homes: in the town, the village, and at their cattle posts or farms.

There are two problems that are encountered by both the government Ministry of Health (MOH) and Christian medical missions in serving nomads and people with multiple dwellings: (1) fiscal constraints in providing duplicate health facilities which are used seasonally, and (2), with the prevalence of HIV/AIDS, the increased chances of infection as persons (especially husbands and other men) commute between places.

Last but not least, Adventist medical services, not only in Botswana, but also in other regions of Africa, lack an adequate number of medical professionals such as nurses, doctors, specialists, and so on. In spite of budgetary constraints, such personnel are sourced usually from developed countries. The medical professionals upon arrival face a new culture to which they have little or no knowledge. Unless trained in cultural competency, the cultural baggage they bring with them makes it almost difficult for them to serve their host communities effectively because of cultural blindness.<sup>1</sup>

However, this is not a new problem, which needs to be addressed. This study has shown that, historically, because of feelings of religious or cultural superiority, mission churches have often lost their members to AICs. When medical staff exhibit such attitudes, medical pluralism is only strengthened. Local worshipers and patients will seek systems that adequately address their socio-cultural, emotional, and spiritual needs.

As a result, many local people continue to consult Western medicine for what they perceive to be “European” diseases, and ATM for “African” diseases. This in itself indicates that Africans do not experience a full complement of expected outcomes from

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<sup>1</sup>Maya Kalyanpur, “The Challenge of Cultural Blindness: Implications for Family-Focused Service Deliver,” *Journal of Child & Family Studies* 13 (1998): 317.

Western-oriented health-care providers, including Christian medical missions.

In the light of the challenges discussed above, and certainly there are others, perhaps the question is, How can Adventist medical missions help meet the needs of the communities in ways that address their concerns more holistically? The knowledge gained from this research concerning the historical and social background of Botswana, the Christian mission beginnings, cultural, economic, health-care settings, and the historical and biblical models of medical missions has helped in understanding the sensitivity needed to develop a contemporary medical mission model.

### **Appropriate Holistic Adventist Medical Mission Model**

This suggested model has three components. First, it argues that its foundation is the Scripture and that its position must be biblically derived as well as culturally relevant. Second, it offers a holistic, multistage process for whole-person treatment. Lastly, it suggests that interactive aspects of Adventist medical mission must be tailored to provide a comprehensive and holistic service to the community and society at large. Recognizing the medical pluralism that is practiced not only in Botswana, but also throughout the sub-Saharan African region, the model suggests the need for dialogue between the parallel medical systems—in the interest of the client.

In this model, Adventist medical mission should be seen as a vital, but not separated part of God's mission. This means that the Church, which has been given the overall mandate to execute God's mission, must work in tandem with medical mission in a fully coordinated way, just as it does with its other church entities such as education, publishing, ministry, and so on. The Adventist Church needs to be reminded that medical mission is indeed the "right arm of the gospel" and as such there is need for a higher level

of interaction between the two aspects of ministry in a more integrative way. If the Church fails to integrate its parts, it will fail to execute its mandate in mission.

#### Scripture: The Foundation of Christian Medical Mission

Adventist medical mission cannot exist in a vacuum. If it does, it will render a chaotic (dis)service or, at best, an equivalence of secular medical health care. What must inform Adventist medical service are the biblical principles to guide, and from which a sound theology of mission, including Christian medical mission, must be derived. This is important because medical mission is part of the *Missio Dei*—God’s mission. Thus Scripture remains the authority in theology and in the practice of missions.

It is not within the scope of this dissertation to present a theology of mission. But it is important that in doing so, the Church’s hermeneutical community must come up with a biblically shaped worldview whose contributors are not only theologians at the Adventist Church’s institutions of higher learning, but also missiologists, chaplains, medical practitioners, and pastors at the local level.<sup>2</sup>

Thus, a sound theology of mission together with a biblically shaped worldview will help in addressing African traditional worldview issues including power encounters, fear, need for protection, and the need to appease spirits. Such a theology would bring biblical, cultural, and historical aspects into a right and balanced perspective.

When Scripture has been considered and a biblically shaped worldview has been put in place, it will be clear, as has been shown in this dissertation, that God desires to

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<sup>2</sup>Hiebert argues that in a world of competing worldviews, we need a biblically shaped worldview because “if the worldviews are not also converted, in time they distort the explicit message of the gospel and turn Christianity into Christo-paganism. The behavior and beliefs are Christian, but the underlying

fully restore humanity to its original state. Therefore, the biblical diachronic concept of *shalom* calls for a holistic restoration and healing of God’s people that have been affected by sin relationally, physically, mentally, socially, spiritually, environmentally, and so on. Thus, the Church and its organs, including Adventist medical missions, should have a holistic view of humanity. See figure 2. A holistic approach to humanity aims at restoring individuals’ relationship with God, among themselves, and with their environment in order to have peace and tranquility.

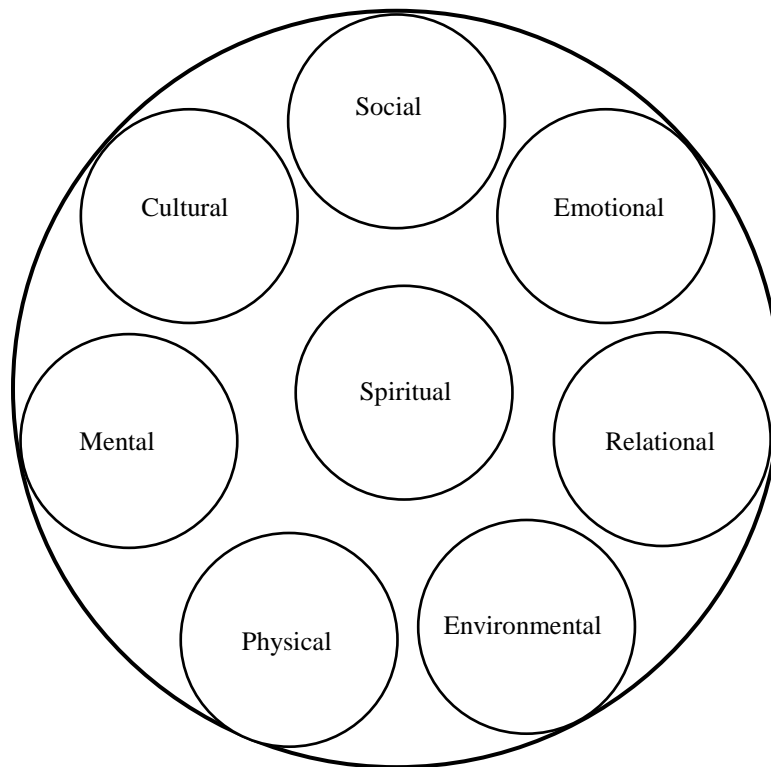


Figure 2. Whole-person needs.

A holistic approach to people effectively deals with the loopholes discussed in

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assumptions, categories, and logic are pagan.” Paul G. Hiebert, *Transforming Worldviews: An Anthropological Understanding of How People Change* (Grand Rapids, MI: Baker Academic, 2008), 267.

this dissertation concerning the “flaw of the excluded middle,” first by discarding Western worldview values and assumptions that dichotomize the body and the soul, and second by recognizing that a human being has more than physiological and mental challenges and needs.

#### Holistic Multistage Model for the Whole-Person Treatment

Once a biblical and theological foundation of mission that is culturally relevant to the local communities has been considered, Adventist medical mission will need to apply a more holistic approach. Figure 3 shows a recommended multistage model that stresses whole-person treatment. As shown in the flow of the diagram, the approach to a patient or client is informed by theological, biblical, and socio-cultural considerations.

First, the model stresses that each client is a human being who is made in the image of God and who needs restoration. The client needs to be treated with understanding, love, and compassion. Considering that illness is perceived as a social construct, the assumption is that the client or patient might be out of harmony with her “system.” In other words, she might be having at least one issue affecting her; it might even be a relative or a neighbor whom she is concerned about, but in the African tradition the person is still considered ill.

The client has come to the clinic or hospital because there is an imbalance in her *shalom*. In other words, her whole needs must be considered. Therefore, a whole-person assessment needs to be carried out. This helps to avoid simplistic diagnosis that is based on the physical symptoms, without looking deeper into the patient’s inner challenges.



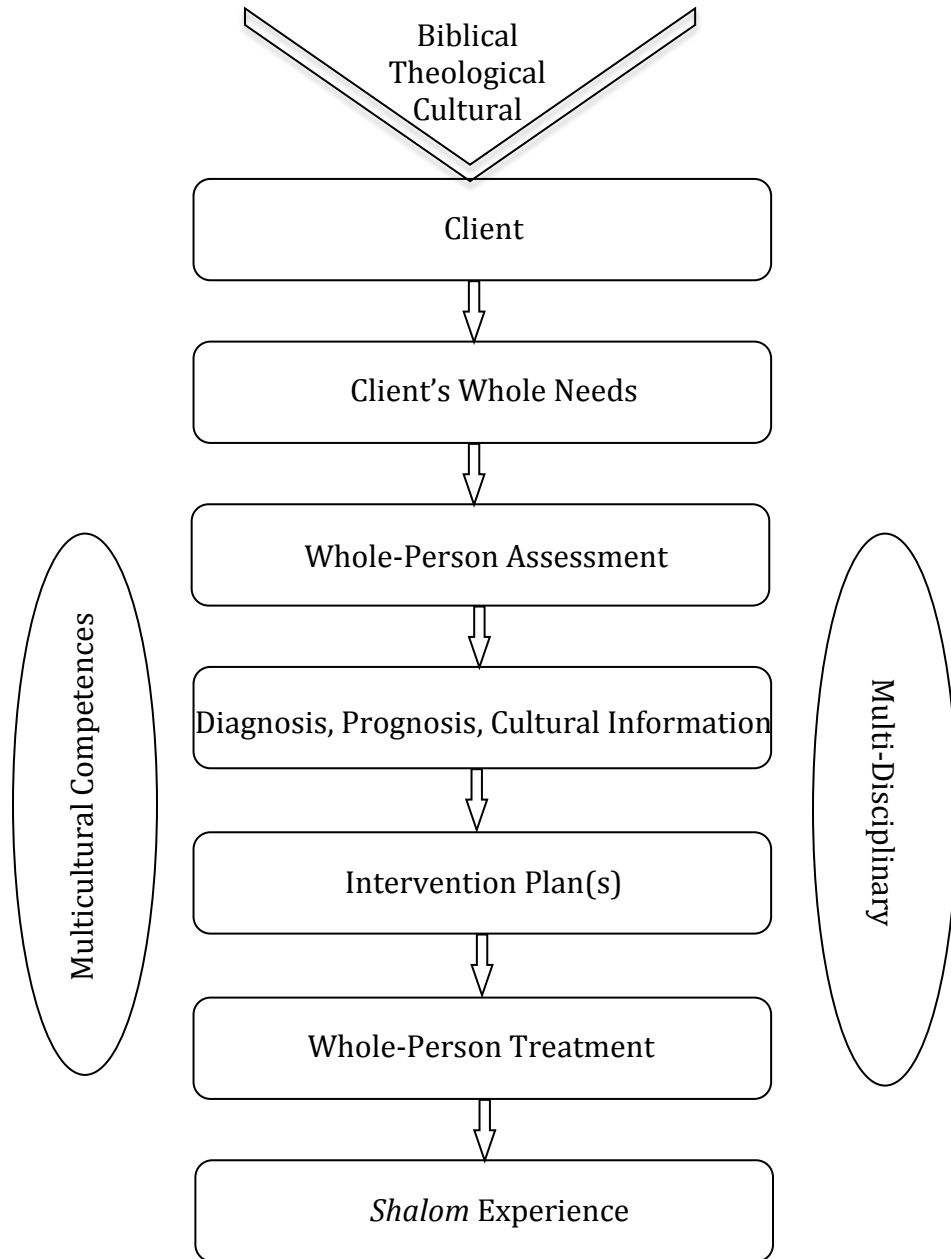


Figure 3. A holistic multistage model for whole-person treatment.  
 Source: Adapted from Center for Substance Abuse Treatment, *Screening and Assessing Adolescents for Substance Use Disorders*, vol. 31 (Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999), <http://www.ncbi.nlm.nih.gov/books/NBK64364/> (accessed February 8, 2014).

For example, the patient's presenting problem might be symptoms such as unrest, fatigue, and anxiety. While there could be several causes for this, if the assessment is not holistic, the practitioner may miss the fact that the patient believes the problem is caused by the harassment of evil spirits at night. Knowing that many Western-oriented doctors do not believe in evil spirits, she would never dare to disclose that information unless prodded.

Therapists and other practitioners will need multicultural competencies that will help them not only to discover this information, but also to acknowledge the presenting problem as real to the client that needs to be addressed.<sup>3</sup>

In a hospital setting, it is impossible to have a single person assigned to gather this collateral information. Thus, in multidisciplinary settings as in a hospital, practitioners need to be equipped with multicultural competencies.

This model allows for whole-person assessment that will lead to a more comprehensive diagnosis and prognosis that does not exclude the social, cultural, environmental, and other concerns of the patient. This step intentionally avoids the erroneous Western worldview assumptions that often dichotomize the body and the soul. When an intervention plan—how the treatment is going to be done—is made, the attending practitioner has the opportunity to either directly address the patient's presenting problem or do referrals. In the example given above of the patient harassed by

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<sup>3</sup>Olaotse Obed Gabasiane, "Cultural Humility: Reflexive Lessons for Cultural Competence in Mission," term paper, Berrien Springs, MI, February 8, 2014, 3-5. In this paper, I argue that all cross-cultural workers need training in cultural competence so that they can do their work with cultural humility, awareness, and tolerance.

spirits, the physician may consider referring her to the chaplaincy services for therapy.<sup>4</sup>

The model anticipates that there can be medical and non-medical referrals, depending on the presenting problem. For example, prayer needs to be offered before seeing the doctor; Adventists believe there are spiritual forces and thus intend to treat the whole person.

This approach to a client attempts to ensure whole person-treatment. There is a strong likelihood that when a client is convinced that her issues are addressed holistically, she will have a credible reason to come back to the same health-care provider either for follow-up or when faced with new problems. As discussed in this research, patients practice medical pluralism in seeking a more holistic treatment that addresses all their presenting problems. Therefore, the goal of this model is *shalom*.

### Interactive Aspects of Adventist Medical Mission

In order for Adventist medical mission to provide a comprehensive and holistic service to the community and society, this model suggests some proactive interactive aspects to help achieve its mission.

#### **Cross-cultural Training**

The aspect of cross-cultural training in various facets, levels, and settings is paramount. It is important to consider including cross-cultural training in the curricula of all disciplines be they medical, therapy, or other non-medical areas. In an increasingly

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<sup>4</sup>While serving as hospital chaplain at the Kanye Seventh-day Adventist Hospital, an Adventist physician referred an adolescent female who, together with her parents, had indicated she was being harassed by the evil spirits. After the therapy, which included prayer, the patient was healed and was able to go back to school full time. If the doctor had not had multicultural competencies, he would not have

diversifying world, clients and workers can be from different cultures. Therefore, there is a need for cross-cultural readiness, which means any Church mission worker must be prepared to work with those of a different culture or worldview.

For this model to hold, all workers in the Church and its departments such as health, education, social welfare, ministry, etc., need to be equipped with multicultural competences. This will ensure that at the point of contact with a client, any worker will be able to provide a service that at least recognizes the whole needs of the client. Such training must be ongoing in the form of seminars.

### **Spiritual Dimension**

On the spiritual front, it is also important to sensitize and train every worker to realize that each one of them is a living witness. In the hospital setting, many times witnessing is left in the hands of the chaplain. However, when every worker exhibits the qualities of love, compassion, and care, clients are drawn to the Christ who ministers to them through God's people and are likely to understand that the Church's mission is to restore humanity holistically.

Further, as a demonstration of their calling and in response to serving the Christ whom they profess, health workers will, among other things at appropriate times, conduct worship, personal prayers, home visitations, and prayers for the demon possessed. Although distinguishing between mental illness and demon possession is sometimes difficult, workers would have to be trained to differentiate between the two, so they can provide appropriate care. It is significant that every worker needs to know that there is

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acknowledged the patient's presenting problem as real, let alone referred her to the chaplain. However, the physician needs to use his or her training to distinguish between mental illness and spirit oppression.

mental illness that is not demon possession. This is a complex, but urgent subject needing further research.

This was the experience of the early Christian Church that led to the forming and thriving of the Christian medical mission. The result was that many people who had not known God before had the opportunity to experience and respond to the love of Christ. Thus Christian medical mission purports to bring holistic healing to people in all facets of their lives including the physical, spiritual, and so on.

### **Dialogue with Other Health-care Providers**

Another crucial interactive aspect of Adventist medical mission is dialogue with other health-care providers. What should draw together the various medical systems of African Traditional Medicine, African Spiritual Healing, Government Public Health Care, and even other Christian medical missions is, first and foremost, the patient. While there is cooperation, corroboration, and active interactions between the Christian medical missions and the Government Public Health Care, indigenous medical systems are often left out of the picture.

Unfortunately, zero dialogue between these entities will have unimaginable or indeterminate consequences for the client. In the absence of dialogue, the patient is at risk of multiple dosages, incongruent treatment regimens, toxicity, unnecessary expenses, and so on. Patient safety may be the factor that could move Adventist medical mission to dialogue with the indigenous medical systems.

Table 1 shows common ground in birth-attendants, herbs, and holistic approaches, etc. (see bold), for example, between African Traditional Medicine and Adventist medical mission could set dialogue in motion. Dialogue with herbalists may

Table 1. Models of healing: Ground for dialogue

Model Trait	AIC's Spiritual Healing	<b>African Traditional Healing</b>	<b>Christian (Adventist) Medical Healing</b>	Government Medical Healing
Healer training & qualification	Vision- directed, little internship	Ancestor- directed, lengthy internship	Western-oriented, lengthy internship	Western-oriented, lengthy internship
Religion involved	Yes	<b>Yes</b>	<b>Yes</b>	No
Healing approach	Holistic	<b>Holistic</b>	<b>(Ideally) holistic</b>	Psychosomatic focus
Diagnostic means & tools	Angels, Holy Spirit, prayer	Ancestors, <b>prayer,</b> bones	Scientific, <b>Prayer</b>	Scientific
Exorcism	Yes	<b>Yes</b>	<b>Yes</b>	No
Specialists in common	Birth attendant, Herbalist	<b>Birth attendant, Herbalist</b>	<b>Midwife, Pharmacist</b>	Midwife, Pharmacist
Perceived level of hygiene	Low	Low	High	High
<i>Materia medica</i> in common	Raw herbs	<b>Raw herbs</b>	<b>Pharmacologically approved &amp; treated herbs</b>	Pharmacologically approved & treated herbs
Level of understanding of African cosmology & psyche	High	High	Minimal	Minimal

result in some form of cooperation that will lead to research in plant medicines that are used traditionally, or turn them (herbalists) into simple health dispensary workers. The

same could be said about traditional midwives. Therefore, dialogue will open opportunities for Adventist medical missions to provide training to indigenous practitioners in areas of patient drug treatment safety, occupational hygiene, and the importance of timely referrals to avert complications.

Dialogue and cultural understanding can help Adventist medical missions appreciate the deeper insights of the holistic approach that is practiced by indigenous traditions. Adventists will need to avoid the big-brother approach where the dialogue is unidirectional and the indigenous party is viewed as the only one needing to learn. For dialogue to be meaningful, both parties need to demonstrate respect and some degree of tolerance for one another and a willingness to learn from each other.

### **Social Services**

With the view of providing holistic services to their communities and societies at large, this model expects Adventist medical missions together with the wider church to provide social services at the praxis level that range from education to advocacy. Again, greater cooperation and coordination levels are encouraged between the Church, Adventist medical missions, and other supporting entities of the Church.

In order to avoid sedentary lifestyles and other health impediments that will negatively impact the general public, Adventist medical missions should also consider a program of public health education in a variety of settings. Programs could include information on public health, nutrition, cooking lessons, as well as exercise. These and several other programs could form the basis of preventive medicine as an indicator of a conscientious move from curative medicine to more emphasis on prevention.

This task is more than the hospital can accomplish by itself. For example,

Adventist mission hospitals encounter a lot of cases of malnutrition, particularly among children from distant rural areas. The health institutions could link up with the Church and its social welfare organs such as Adventist Development and Relief Agency (ADRA) to assist with teaching better horticultural methods. The Church could work with its Adventist Community Services wing to help train rural folk on how to do better gardening.

In this model, Adventist medical missions will need to link up with other institutions such as schools, prisons, churches, *dikgotla* (village meetings summoned by the village chief), etc., to provide health awareness programs. During evangelistic series organized by Adventist medical missions or by the Church, health presentations should also be made. Temporary health stops could be set up to provide free and basic medical check-ups while referring serious cases to the hospitals.

HIV/AIDS is a serious threat to Botswana and the rest of sub-Saharan Africa. In this suggested model, Adventist medical mission will take a lead in furthering public awareness about the spread of the disease. Working together with the Church's Family Life departments, Adventist medical missions could show these departments how to fuse the message of HIV/AIDS prevention with their marital and pre-marital programs. As funds are available, the Church could pool resources and offer recreational centers where youth can learn how to keep safe from HIV/AIDS and substance abuse.

The issue of triple homes in Botswana is serious in that it has a potential to spread HIV/AIDS infections and is a factor that overstretches the finances of public health services. Adventist medical missions could arrange for mobile health clinics to disseminate public health awareness and provide basic services. While it could be



extremely difficult to provide health services to the nomadic San, Adventist medical missions, in addition to mobile clinics, could set up small health posts at some of the San settlements where the nomadic groups could return to in times of medical need.

Another social contribution of Adventist medical mission could be advocacy—not necessarily in the political sense, but in the way of speaking out against child (sexual) abuse, violence against women, and for the plight of those living in abject poverty. Hospitals do meet and treat cases resulting from these instances. It is important that social workers are engaged to address the situation and to advise legal action as necessary. Together with the Church, Adventist medical missions could open telephone services for victims of abuse and violence, especially children and women.

### **Implications of the Adventist Medical Mission Model**

The model suggested above is far from being perfect. However, it does help in sensitizing Adventist medical missions, the Church, as well as its other supporting organs to the fact that a single entity or individual cannot achieve the mission of God. God has mandated the Church to execute His mission. It is through the agency and concerted efforts of its various organs that the Church can accomplish this mission.

Therefore, the foundation of all mission must be grounded in the Scripture, which is authoritative and a guide. But the Church does not operate in a vacuum; it works within a culture that is already tainted by sin, but which still bears the footprints of God. However fallen this culture might be, Adventist medical mission must show cultural sensitivity. Thus, mission service needs to be holistic in its approach so that the people's needs are addressed comprehensively. This can be accomplished only when every worker demonstrates faith in God and plays an active role in His mission.

## Summary and Conclusion

This dissertation has investigated the history of and analyzed Adventist medical mission work in the Republic of Botswana for two main reasons. The first was to contribute in part to the body of knowledge on the history of Adventist medical mission in the country, while the second was to develop guidelines for future Adventist medical missions in Botswana and beyond. These guidelines were epitomized in a suggested alternative model for Adventist medical mission that emphasized biblical principles and cultural considerations.

Thus the research questions that directed this study were:

1. What is the history of Adventist medical mission in Botswana?
2. Why do parallel medical systems exist?
3. How can Adventist medical mission engage Indigenous Medicine?
4. What alternative model can the Adventist medical mission in Botswana use?

In order to gain a deeper understanding of Adventist medical mission work in Botswana, this dissertation first set out to reconnoiter the socio-historical context of Adventist medical missions in Botswana. To place this knowledge into a wider perspective, the study explored a historical overview of Christian medical mission in southern Africa in general, and then Adventist medical mission in particular.

The research also explored biblical and Christian medical paradigms from which possible theological and practical principles could be derived. Because Botswana and other Africans at large practice medical pluralism, the research analyzed the present medical models that are found in Botswana. This helped in part to answer the query, Why do Africans utilize Christian medicine, public health care (government), spiritual

healing, as well as African traditional medicine?

This qualitative research used a combination of two methods of data collection that included written and oral primary sources. The written sources were texts and documents, some of which were online or on-site archival material. On the other hand, the tape-recorded and later transcribed interviews were open-ended and semi-structured. Most of the interviews were in person, that is, conducted on a one-on-one basis, while a few were telephone interviews because of the geographical distances involved.

The research has brought about a number of research findings. The most obvious findings to emerge from this study is that Christian medical missions are struggling financially to maintain and develop their organizations, necessitating the government of the Republic of Botswana to provide fiscal assistance. This of course complicates the medical missions' situation, as their Christian ethos is likely to be compromised.

However, one of the more significant missiological findings to emerge from this study is that Botswana, and indeed Africans at large, have a deep understanding of what constitutes the well-being of a person. To them, any disturbance in the harmony of their life settings indicates some form of illness that needs to be addressed in its entirety. Africans will go to great lengths to seek help (including medical) to ensure restoration of any imbalance.

This seeking after holistic healing is at the core of medical pluralism. Although this finding builds on existing knowledge on this subject, what makes it even more significant is the challenge that Christian medical missions—especially Adventist medical missions—has in providing full address to this African phenomenon.

The second major finding is that without a biblical theology of mission that

addresses the African worldview, serving Africans will remain irrelevant to them, as it has been before. The Western worldview that dichotomizes the body and the soul continues to ignore some or all aspects of African Traditional Religion such as belief in ancestors, spirits, witchcraft, and misfortune that denies the people an appropriate and relevant mode of healing. If Adventist medical mission indiscreetly follows the Western worldview, then it is not reaching its mission goals for Africans.

This research has also revealed that there is no collaboration between Adventist medical mission and the indigenous medical systems—namely African traditional medicine and spiritual healing. Though the study shows that this is mainly because of major differences in the worldviews of these entities, this problem has existed for a long time in Africa. Thus, the challenge is for all these parallel systems to change the status quo, and for the sake of their clients, to find ways to dialogue with one another beginning with common ground.

Lessons could be learned from the Early Church that was able to use some of the secular medicine ideas without relinquishing their Christian ethos. In addition, the Early Church used herbs to heal their sick. The herbal knowledge that is locked in African medicine needs to be unveiled and considered for application, but that can happen only if there is meaningful dialogue between Adventist medical mission and indigenous medical systems. While there is no direct link to African traditional medicine, the writings of Ellen G. White emphasize the use of natural remedies, including herbal or plant medicine.

The results of this research support the idea that the approach to the condition of humanity must be holistic in nature. Human beings are affected by various aspects of life

that include the spiritual, physical, social, cultural, emotional, mental, environmental, and relational facets. Since God originally created people to enjoy total peace or *shalom*, His grand plan is to restore it. This is demonstrated by His Son Jesus Christ, whose mission on earth was to preach the gospel of the kingdom, teach, and heal all manner of disease (Matt 9:35). Jesus has since charged the Church and mandated it to continue this mission.

Thus, in order to carry out this mission, the Adventist Church needs to have a deeper understanding of the cultures it is working in. For example, this study has shown that the Church needs to deepen its perception of the African worldview. Once the Church senses that the Africans' worldview considers humanity holistically, Adventist medical mission will be shaped by ways that not only apply the concept of God's *shalom*, but also practically appeal to the person. A further implication of this research is that understanding the African worldview will help the Adventist medical mission to begin dialogue with indigenous healing systems.

The present study, however, makes two major noteworthy contributions to the current literature. First, this is an initial study of the history of Adventist medical mission in Botswana. Thus, this dissertation contributes to the existing knowledge of the Adventist Church and medical mission in the country by providing a body of work in a single volume. Previously, a loose tapestry of documents and texts scattered from various sources is what constituted the history of Adventist medical mission of Botswana.

Second, this research has developed and suggested an alternative Adventist medical mission model that is based on the concept of the biblical *shalom*. This model discards the Western worldview that includes the "flaw of the excluded middle." Rather,

it embraces a holistic view of the condition of humanity. This view immediately resonates with the African worldview—a good indication that Adventist medical mission will provide the necessary responses in serving Africans in a more holistic way.

### **Recommendations**

Based on this research, I make the following recommendations.

1. Adventist medical missions should pursue the prospect of developing several clinics using an adjusted model of the Botswana Adventist Medical Services (BAMS) in order to serve more communities and also to generate additional funding to support the Kanye Seventh-day Adventist Hospital (KSDAH).

2. The Adventist Church should consider cultural competency training for all Adventist Church workers. Present training curriculum should be modified to include courses on diversity and (African) culture. Doctors, nurses, pastors, and chaplains working in medical institutions especially need this type of training. If these workers are already practicing but came to the medical institutions without cultural diversity training, they should be required to attend seminars in order to equip them in this vital area.

3. Adventist medical missions must seek ways to enter into dialogue with indigenous healing systems to open avenues to collaborate and corroborate, at least in areas dealing with client treatment and information exchange.

4. KSDAH needs to consider working in collaboration with the Adventist medical system in Brazil or Loma Linda, California (USA), to test the potency, toxicity, and efficacy of indigenous plant medicine, which has been used by herbalists for ages. Involving Loma Linda would be appropriate, as the university medical system there has advanced medical research protocols that utilize cutting-edge laboratory technology.

5. Since medical pluralism in Botswana and beyond does carry some risk to the client, the parallel medical systems should jointly conduct research on the impact of multiple medications on clients. This is a good example of integrative processes that would involve all the various health-care providers and clients.

6. In addition, KSDAH should consider offering—as part of its exchange with indigenous systems—training to traditional practitioners in areas of hygiene and even germ theory. Training birth attendants would be a good place to start. Such an approach will appeal not only to the local communities, but also to the government Ministry of Health.

7. Under the auspices of the General Conference and the Southern Africa-Indian Ocean Division, a task force should be set up to develop a holistic biblical theology of Adventist medical mission in Africa. I recommend that the health ministry departments of the Church should work together with theological institutions, missiologists, chaplains, local pastors, medical practitioners, and the laity in order to develop a holistic theology of mission.

8. The KSDAH chaplain, with support from the Adventist Church and the Health Directors at the Division and Union, will need to develop training and motivational protocols for all medical workers. The aim would be to help workers participate with zeal and determination, serving with love, care, and compassion, and as life examples. It is then that all medical staff shall perceive that it is the responsibility of each one of them to provide the spiritual aspect of medical work within the broader spectrum of holistic service to the clients and the community. Further, there is a need to train the church community to minister to the spiritual aspects of sickness.

9. To an organization that is already struggling financially, I recommend that in order to increase the quality of chaplaincy services at KSDAH, the hospital should consider training volunteer or part-time chaplains. If possible, the engagement of retired pastors or their spouses would provide additional help in hospital chaplaincy because of their vocational and life experiences.

10. Full-time chaplains must be fully qualified—with at least Clinical Pastoral Education (CPE)—who have done qualifying courses that go beyond basic seminary education.



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