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Pastoral Caregivers in Botswana Government Hospitals: A Holistic Pastoral Theological Approach

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Abstract

This paper seeks to assess the contribution that local churches in Botswana make to health and wellbeing. It is part of an ongoing study on the impact of religious beliefs on health seeking and health provision behaviors in Botswana. The hypothesis of the study is that religion contributes immensely to better health and wellbeing. This paper seeks to contribute to the hypothesis by asking the question on what local churches in Botswana do in order to contribute to health and wellbeing. It argues that wholeness and health are some of the most important concerns of Batswana and the global community. Illness is complex in that it often defies remedy even when people seek remedy in hospitals. The study shows that biomedicine by itself has limited capacity in fulfilling the human quest for meaning. The paper argues that it is necessary to include pastoral care as a valuable and a necessary human resource and partnership for healthcare and development. Religion and spirituality have been suggested as vital in many people's quest for meaning. This study has employed a holistic pastoral theological methodology.

KEY WORDS: Pastoral Care, Health, Illness, Spirituality, Wholeness, An Integrated Theological Methodology

Introduction and Background

This article simply suggests that pastoral caregivers should work hand in hand with other health care practitioners in order to provide a significant holistic caregiving to health seekers. Since its inception, the Christian Church has always been engaged with matters of health in Botswana. From around 1847, the London Missionary Society (LMS) practiced medicine in their mission station at Kolobeng among the Bakwena of Sechele. We learn of David Livingstone being a medical missionary. It was through medicine that it was possible to introduce the gospel with more ease among the local tribes of the Batswana (Macaulay 1889:40). In one of the letters to his countrymen, 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 (Macaulay 1889:40).

The above extract shows that people were attracted to Livingstone because of medicine and his acts of compassion. Health and religion thus remain inseparable entities. The Livingstone medical mission model had more to offer in the context of Botswana as it reached out to the spiritual, social, physical (medical), and welfare needs of the people. The model aimed at addressing all dimensions of human existence hence holistic. It was also communal since he engaged local people in continuing propagating the Gospel during his absence. Engaging locals in God's mission shows that David Livingstone made cultural considerations. However, Mudimbe (1964) highlights that the formal education system that was introduced by missionaries was designed to alienate them from their cultures and people.

Notwithstanding, holistic, communal, contextual and intercultural pastoral theological approaches that are proposed in this article are therefore not new; they were used by David Livingstone during his missionary work among Batswana. History teaches that Western medicine in the form of hospitals, was introduced in Botswana around 1922 by Christian missionaries led by the Seventh-day Adventists (SDA) in Kanye (Molefe 1996). Around the same time, we hear of dispensaries in the Kalahari Desert where missionaries came in hundreds to hear the Word of God as Western medicine was used in their bodies. Five years later the Dutch Reformed Church (DRC) opened its medical mission hospital institution in Mochudi, while in 1934 a mission hospital was opened by the LMS in Molepolole. In 1933 the Lutherans and the Catholics began with clinics at Ramotswa and Kgale, respectively. The second hospital of the Adventist Church was opened in Maun in 1938 (Molefe 1996).

As years passed by, medical missions encountered challenges such as capital needs, plurality in the use of various medical systems available i.e. biomedicine, spiritual or faith healing and traditional healing (McGilvray 1981). The overwhelming prevalence of HIV and AIDS in Botswana drained the finances of the hospitals and human resources.

This study maintains that there is an interchange and exchange among African traditional healing, modern medicine, and Christian healing. The paper aims at helping parallel medical systems, especially the spiritual or faith healers and biomedical healers to work together for the health and wellbeing of the people. Missionaries such as David Livingstone used medical work in missions because they believed it to be complementary to the gospel message.

In African countries such as Botswana, faith healing and modern medicine have an old historical connection. As mentioned above, the church started building hospitals, clinics and health centres in order to provide healing to African people. Their concentration was not on spiritual needs only; it was also on physical needs. Their mission was holistic in approach.

The above background suggests that health and Christianity were initially inseparable entities. The approach that was used was holistic. Initially, healing was used to attract people to Christianity. Today, the Church neither does have the means nor the capacity to attend to health and wellbeing of the people holistically. Both Christian medical missions and the government provide primary Western health-care. The faith healing and modern medicine are entities working in parallels. The public sector dominates the health system,

operating 98% of the health facilities (WHO 2013). Bamalete Lutheran and Kanye Seventh-day Adventist hospitals respectively are medical mission hospitals that apply the scientific model along with Christian principles.

This article is focused on the official government hospitals or health care centres which exclusively use Western medicine. At these health facilities, medicine is used to address the physical impact of illness upon the sufferer while the Church addresses causes of suffering upon the sufferer through spiritual comfort. The connection between faith and health, and the multifaceted nature of illness i.e. spiritual, physical and social dimensions of health and healing make it inadequate to address healing from one perspective only. "The medical model which seeks to treat patients by focusing on medicine and surgery and gives less importance to belief and to faith in healing is no longer satisfactory" (WHO 1998). Therefore, for the medical model to be effective in treating certain diseases, it should integrate all dimensions of sickness, including the spiritual (Hill and Smith 2010). Religious and spiritual aspects should be integrated in healing because cultural values, norms, principles and beliefs which are often embedded in religion and spirituality influence people's perception of illness and their decisions for or against medical treatment.

Which diseases can only be healed through integration of modern medicine and faith healing? How do cultural values and beliefs influence people's perception of illness and how can the integration of faith healers and medical practitioners facilitate health and wellbeing of individuals? This paper answers these questions by presenting and discussing findings on the views of faith healers and medical practitioners in Botswana. Our discussion will start with the methodology, followed by the presentation and discussion of the findings and the conclusion.

Methodology

The data that is used in this paper is from a study that was conducted in 2018 and 2019. The study adopted a mixed methods approach. The quantitative data was collected through questionnaire while qualitative data was through interviews and focus group discussions. The first methodology for data collection that the research employed was literature review. The literature reviewed included studies in the field of Pastoral Care and its relationship, relevance and contribution to hospital care. Literature such as journals, books, conference proceedings and internet sources were utilized in order to have the grounds for the theoretical analysis and to connect the outcomes to broader discussions about the role and importance of the pastoral care in hospital care. It should also assist in showing the importance of integrative approach to health care and authentic pastoral care approach that can address the needs of people within hospitals in Botswana. The second method was conducting specific oral and written interviews with the medical health practitioners, traditional healers, faith healers, health seekers and policy makers. The third method of data collection was questionnaires with medical health practitioners, traditional healers, faith healers, and health seekers. Data was also collected through focus group discussions with health seekers and health providers. Data was collected from eighteen research sites across the country.

Holistic Pastoral Theological Methodology

Holistic care is understood to refer to caring for the whole person. This caring model should focus on the therapeutic interventions that are directed to meet the needs of the whole person. Pastoral Care must cover a person's whole being; holistic health care. It has been argued that any care delivery endeavor that does not attend to the needs of the whole person is inadequate. Peter Hampson (2010), for example, argues that a true and broader meaning of pastoral care is that which acknowledges the complexity of human beings and attends to human beings holistically. Therefore, pastoral caregivers are advised to make use of the holistic approach in order to address mind, body and soul. Existentialists appreciate that human beings have complex dimensions of existence which are physical, social, emotional/psychological, spiritual to name the least (Van Deurzen 2009). Within the Tswana worldview, ideal care incorporates physical, social, mental, and spiritual dimensions and emphasises that the care and wellbeing of the community and the individual are interdependent and equally important (Tshalana 1991). Msomi (2008) argues that pastoral care and counselling should take the cultural, social, religious and political factors seriously in the context of its operation.

In light of the issues raised above, the holistic pastoral theological approach embodies an intercultural perspective of Pastoral Care practice for the effective implementation of pastoral care in any context. This model takes seriously the message of Scripture, the person of the care seeker and the context in which the care seeker is embedded. Appropriate care responds in a balanced way to people's needs and expectations by improving the life situation of individuals, families and communities. This approach goes beyond mere preaching or prayer or administering sacraments; it takes on issues of advocacy, justice, development and empowerment as well as moral and bioethical issues. Pastoral Care should be concerned with the whole person (Rattray 2002). The pastoral needs are varied, depending on the coping resources available to a care seeker, which require pastoral assessment (Driscoll-Lamberg 2001).

Findings and Discussions

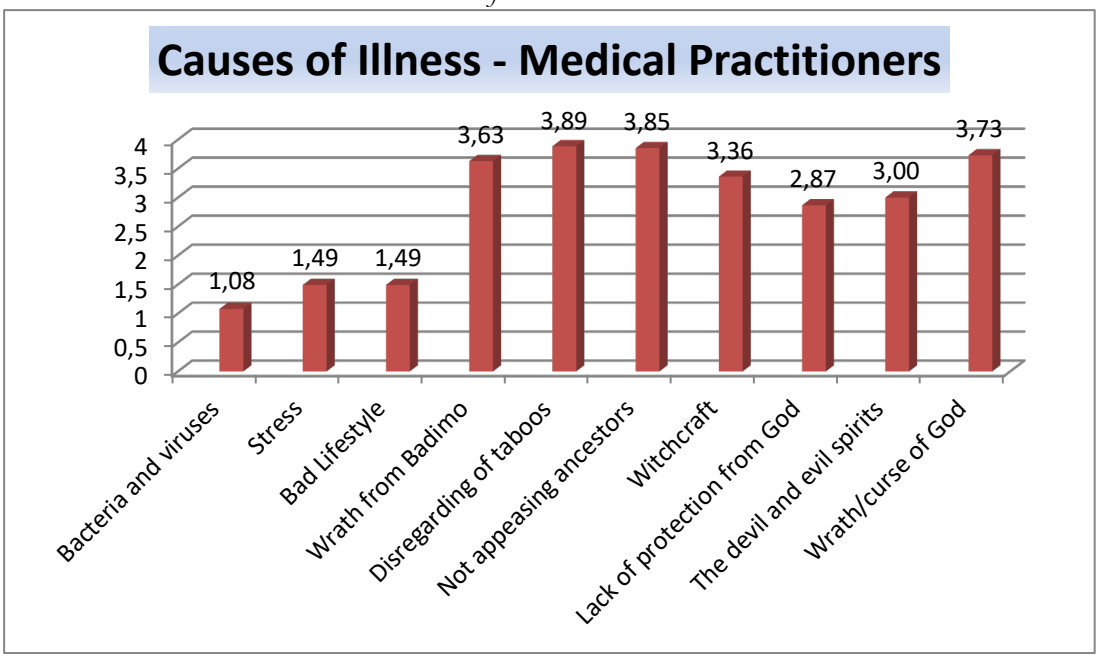
Both the quantitative and qualitative tools had questions to establish the faith healers' views on which illnesses and diseases can only be healed through integration of modern medicine and faith healing. The tools also assisted in establishing cultural values and beliefs that influence people's perception of illness and how the integration of faith healers and medical practitioners facilitate health and wellbeing of individuals. Researchers started preparing for data analysis in the first quarter of 2019 with statistical analysis through using SPSS. Statistical data was analyzed and presented in tables, pie charts and graphs. In the case of interview data, the interviews were transcribed and stored electronically and on paper. The researchers analyzed the data and identified themes that emerged from it. The next section deals with data analysis and discussions of themes that emerged from the data.

Views on Illnesses and Diseases that can only be Healed through Integration of Modern Medicine and Faith Healing

Causes of Illness – Medical practitioners

Data presented here was collected from medical practitioners. The table below summarizes medical practitioner's views on causes of illness:

Table 1: Causes of Illness- Medical Practitioners



When asked about causes of illness, they stated physical factors, stress and behavioural factors as main causes of illness. Other causes to choose from include wrath from God, disregarding taboos, not appeasing ancestors, witchcraft, and lack of protection from God, the devil and evil spirits and the curse of God. Based on the findings, according to health practitioners, causes of illnesses are predominantly physical, psychosocial and psycho emotionally inclined. This suggests that for health to be achieved, the whole person should be addressed. Bircher (2005) argues that health should include bio-psycho-social dimensions. He contends that, "[h]ealth is a dynamic state of wellbeing characterised by a physical, mental and social potential, which satisfies the demands of a life commensurate with age, culture, and personal responsibility."

It is important to note that the model that had been introduced by Bircher lacks the spiritual or religious dimension. The model that could be efficient is bio-psychosocial-spiritual. This dimension has to be included in medical and theological conception of health.

Integration of Religion and Health

As the table above shows, medical practitioners affirm that there is a connection between religion and health. The general view of medical practitioners is that faith motivates medication adherence; spiritually helps with the healing process; influences good behaviour and health. This is represented in the following verbatim responses,

'I place God above in the sense that I will encourage patients to take treatment fully while also praying to God for healing' (Interview, FRMP008).

'Psychologically, someone has to have faith that a medical drug can cure, therefore that can motivate the person to take drugs' (Interview, TSMP001).

Most of the medical practitioners acknowledged the power of God in health and healing even though they stick to medical diagnoses and treatment. Based on the findings

of the study, medical practitioners were adamant that they only address physical illnesses. This disregards the connection between faith, religion and illness. The World Health Organisation also recognizes religious and spiritual dimensions of care by medical professionals and organisations. It is found in the report published in 1998:

> Until recently the health professions have largely followed a medical model, which seeks to treat patients by focusing on medicines and surgery and gives less importance to beliefs and to faith-in healing, in the physician and in the doctor patient relationship. This reductionism or mechanistic view of patients as being only a material body is no longer satisfactory. Patients and physicians have begun to realize the value of elements such as faith, hope and compassion in the healing process. The value of such 'spiritual' elements in health and quality of life has led to research in this field in an attempt to move towards a more holistic view of health that includes a non-material dimension (WHO: 1998).

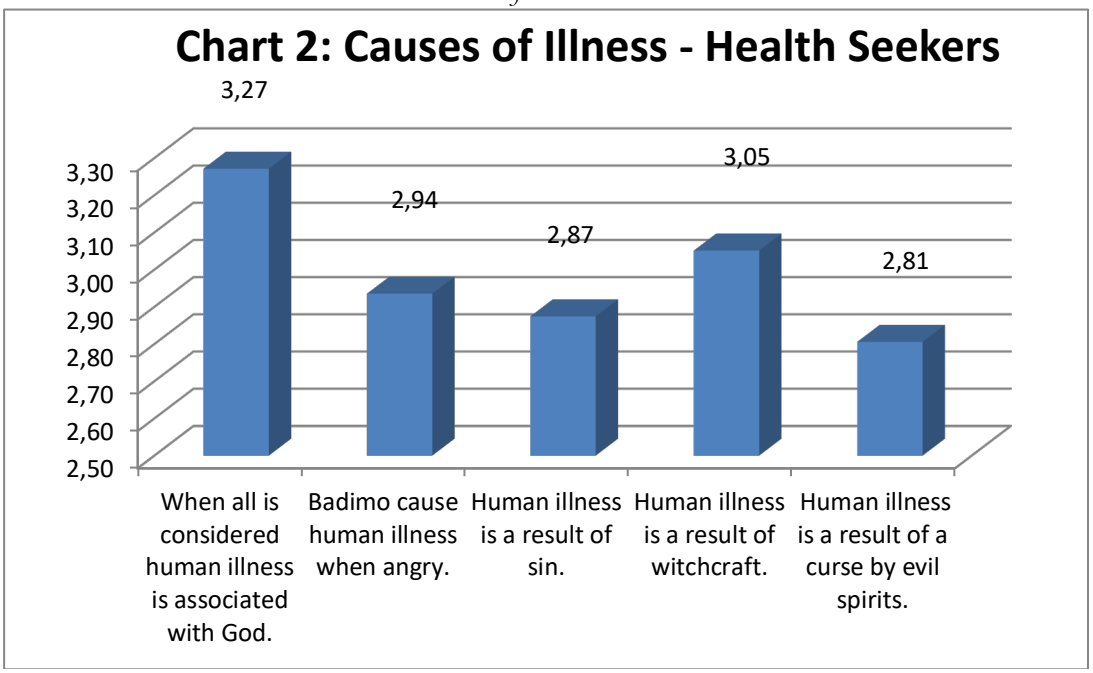
Data collected from medical practitioners' shows that there is an increasing recognition and sensitivity to religious and spiritual caregivers to minister to the needs of patients. This is represented in the following verbatim extract:

'I do respect their spiritual beliefs, but I deal with the physical aspects using whatever medical approach that I have. I can counsel them depending on what I think the condition is' (Interview, MAMP009).

Meanwhile, the findings from health seekers too emphasize the importance of the pastoral care to the healing process among patients in Botswana and suggest the need for medical staff to work with pastoral care givers in hospital care.

Table 2 below shows the responses of care seekers on causes of illness:

Table 2: Causes of Illness – Health Seekers



Based on the above chart, health is understood in terms of the relationships which appear to be an important component of human identity. Firstly, there is a relationship

with God, ancestors or supernatural entities. It would seem from the foregoing graph that there should be that harmonious relationship between an individual with a transcendental entity for them to enjoy health and wellness. Further, the graph suggests that the harmony might be destroyed by sin and be restored differently by different people.

From the in-depth interviews, health seekers, like faith healers identified behavioural factors as common causes of illness. This is represented in the following verbatim response,

> "…….Illness can be caused by different things such as lifestyle, the kind of food, and reckless lifestyles" (Interview, TSHS002).

Within this view, there should be functional relationship among the individual, God, others and the environment. The quality of life and peace is assured in the context of good relationships with the self, God, others and nature. Failure to have a good life means that one has failed to keep harmonious relationships.

Health seekers also expressed their views on the African cultural conception of health. Their reflections show that spiritual realities play a significant role in the issues of sickness and restoration to health. Lack of spiritual observance as a cause of illness was popular among health seekers. The following was stated:

> My belief teaches that instructions should be followed. There is a problem with new generation who wants to know the gender of the baby before the baby is born; immediately the baby is born at the hospital, they will take pictures and put them in Facebook. But there are illnesses such as *thibamo*, which come because of seeing an un-cleansed baby (FTHS007).

Speaking from African perspective, Louw (2008:44) maintains that health should not be separated from existing cultural contexts. The majority of health seekers indicated that religion and spirituality are essential factors, especially when they are sick. Basically, for them the quality of life is characterised by religious and spiritual support. Unfortunately, the religious and spiritual needs of care seekers are often neglected at a clinical setting. Studies reveal that within a hospital setting, religious and spiritual needs assessed for less than 10% of sick, elderly persons (Balboni, Sullivan et. al 2013).

According to the findings of this study, pastoral care with its tools of religious and spiritual engagement could be a feasible vehicle for providing spiritual care within the hospital environment in Botswana. Moreover, religio-cultural assumptions and personal experiences are significant and could contribute towards wholeness, healing and a better coping process. Medical practitioners are becoming aware that the biomedical model is not sufficient for holistic hospital care. This calls for the accommodation of complementary and alternative approaches.

Pastors and Health

During interviews with medical personnel, some physicians reported that some patients visit religious leaders when they are ill. They also reported that some health seekers in hospitals sometimes demand the services of pastors. When hospitalized, some raise spiritual concerns which medical practitioners find difficult to deal with. This is when they

require the assistance of pastors with the belief that they would get to understand what is going on with the patients. Sometimes pastors encourage them to go to hospital. Demanding the services of pastors while at the hospital shows that some health seekers want their pastoral needs to be addressed. "Patients turn to what they hold sacred because they want help with their spiritual struggles during illness. These struggles, however, can contribute to spiritual deterioration or become chronic if they are not resolved" (VandeCreek 2010:5).

Medical professionals in Botswana are not trained to address all dimensions of human existence. Neither are they trained in pastoral care in hospital care nor in recognising the importance of including pastoral care in hospital care. They cannot even handle all the needs of patients (Hill and Smith 2010:175). Medicine is unable to mediate spiritual healing and wholeness. This is where it becomes apparent for the medical practitioners to consult with pastoral caregivers who have competence to provide authentic and appropriate spiritual intervention.

Holistic Pastoral Theological Approach and Collaboration in Hospital Care

The history of modern medical practice in Botswana reveals that there was collaboration between medical care and religion during the missionary era. Responsibilities for pastoral care rested on the same individual who was both a priest and physician. Some hospitals and clinics in Botswana owe their existence to the mission work. Therefore, the health sector is called to rebuild the fallen foundation now with a stronger structure of care. This article realizes that the fragmentation of health systems in Botswana makes it possible for the failure to attend to the health needs of patients and proposes a holistic framework. This framework takes into consideration the physical as well as the non-physical and spiritual components. The complex reality of illness therefore necessitates a collaboration of medical care professionals with Pastoral Care professionals within a team approach. Therefore it could be argued that the pastoral caregivers and the medical personnel need to collaborate for holistic healing.

Intercultural perspective of pastoral care could be of greater use for the effective implementation of Pastoral Care in the hospital context. This perspective emphasizes on the person of care, the message of Scripture and the context in which the person is embedded. Lartey (2003) uses the term intercultural, to describe an approach to care and counselling that responds to a dynamic complexity of cultural pluralism around the world. Intercultural care also seeks to correct the problematic consequences of Eurocentric cultural and political hegemony. It values the rich, dynamic, interpretive complexity of interactive cultures and rejects typologies that reduce such complexities.

Lartey's (2003) intercultural approach draws attention to African worldview, culture, customs, beliefs and views of the people it serves. According to Lartey, authentic pastoral counselling takes the culture of the people and African psychology seriously. This means that pastoral caregivers need to take it into account the underlying factors, including the in-depth knowledge of the individual. Transformation in this context should be dual; it should have an individual therapeutic effect and socio-political transformation. This approach to Pastoral Care takes on issues of advocacy, justice, development and empowerment as well as moral and bioethical issues rather than focusing on prayers, physical healing and being present. It is in this sense holistic.

Conclusion and Recommendations

In conclusion, the paper argues that the inclusion of pastoral care and the appropriate holistic approach to the care of health seekers in a hospital context could contribute towards quality care of the people in Botswana. Given the limitations of medical care and pastoral care working independently, the paper revealed that care requires the combined efforts, skills and expertise. This paper, therefore, recommends:

- The need to assess the religious and spiritual needs of care seekers in a hospital or clinical setting. There should be guidelines that address spiritual issues.
- An approach that acknowledges that there are needs that are specific to health seekers. Improved understanding of religious and spiritual care provision can positively lead to interventions aimed at improving the psychosocial wellbeing of care seekers.
- An educational programme for both health practitioners and pastoral caregivers that aim at equipping them to help people deal with meaning questions in the context of suffering.
- A need of policy making that gives dignity to the patient through considering unique identities of patients in Botswana.

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