

**A historical survey of a failed medical venture?
The attempts of the London Missionary Society (LMS)
to establish a mission hospital in Sefhare 1934–1952**

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Abstract

Using primary sources from the Botswana National Archives (BNARS) as well as secondary material, this article argues that the efforts to establish mission hospitals in Africa in general and in Sefhare in the Batswapong district of Botswana in particular were designed to provide the much-needed medical services in mission areas of operation as exemplified by the Batswapong area. Secondly, the article argues that mission endeavours to achieve such noble goals were not without challenges and that, often, such good intentions failed to produce the intended results. Thirdly, the article argues that the establishment of the Sefhare Mission Hospital was a way of competing with other mission bodies in the country so that the London Missionary Society (LMS) should not be misconstrued as being passive in the provision of medical services. Lastly, the article argues that the LMS's failed venture to achieve its goal of a successful mission hospital was on account of unsound financial capabilities and that it was trying, as it were, to live beyond its means in order to stay in the competition with other mission bodies.

Introduction

Western mission bodies together with their respective missionaries came to labour in Africa not only for the purpose of converting the African people to the Christian religion, but also to introduce literacy and medical services for the Africans. The introduction of medical services by the mission bodies into the various African societies increasingly became a luring weapon for potential converts to the Christian fold.¹ As a result, mission bodies not only

¹ For details of the use of western medicine to attract potential converts see J Comaroff and J Comaroff, *Of Revelation and Revolution: The Dialectics of Modernity on a South African Frontier* Vol. 2; p. 325; R Elphick, TO Beidelman, *Colonial Evangelism: A Socio-*

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vied for spheres of influence over conversion and literacy, but also competed for the establishment of medical services in order to reach their goal of being holistically accepted by their African hosts.

The use of western medicine to woo potential converts was not peculiar to the missionaries labouring in the Bechuanaland Protectorate or to Sefhare. In colonial Zimbabwe, for example, Gelfand has noted that many missionaries made attempts at taking what was termed “tropical medical courses” before venturing to come to the African continent² so that while genuinely trying to assist in the eradication of diseases and ailments they could use this strategy, among others, to win converts. After all, it had become a given that “medical mission was usually an integral part of the Church ...”³ Comaroff and Comaroff state that, in the present North West Province of South Africa, Robert Moffat of the London Missionary Society adopted a philosophy of linking the healing of the body with conversion to the Christian religion. They further note that Robert Moffat did in fact confide that he took every opportunity to use medical aid among the Batlhaping to impress the Word of God upon those he treated.⁴ Ranger has also observed that, in parts of East Africa, western medicine became increasingly used as a “weapon in a more direct and militant confrontation with heathenism”.⁵ While not all mission medical doctors were in agreement with this assertion as evidenced in Masasi, Tanzania, where a mission doctor was adamant that a “Christian hospital was not a bait to catch converts nor an institution that will impress patients that they ask to become Christians,”⁶ the crux of the matter is that western medicine played an integral role in Christian conversion and had a substantial effect on the winning of converts. Mission bodies therefore played a significant role not only in the introduction of literacy, but also in providing medical services. The establishment of the Sefhare Mission Hospital among the Batswapong by the LMS fell within the rubric of this broad general conversion strategy of mission bodies in Africa in general and in the Bechuanaland Protectorate in particular.

Historical Study of an East African Mission at Grassroots, (1982) pp. 110–111; also see F Nkomazana, “The First Missionary Encounter Among the Batswana: A case study of the Bangvato of Shoshong 1857–1871” in F Nkomazana and L Larner (eds.), *Aspects of the History of the Church* (Pietermaritzburg: Cluster Publications, 2007), pp. 70–74, also see P Landau, *The Realm of the Word: Language Gender and Christianity in a Southern African Kingdom* (London: James Currey Ltd, 1995) pp. 117.

² See M Gelfand, “Medicine and Christianity in Rhodesia 1857–1930” in A Dachs (ed.) *Christianity South of the Zambezi*. (1973) p. 109.

³ M Gelfand, *Christian Doctor and Nurse: The History of the Medical Mission in South Africa from 1799–1976* (1976) pp. 19–20; also see A Merriweather, *Desert Doctor: Medicine and Evangelism in the Kalahari Desert* (Cambridge: Lutterworth Press, 1969) pp. 18–21.

⁴ Comaroff and Comaroff, vol. 2, p. 325.

⁵ TO Ranger, “Godly Medicine: The Ambiguities of Medical Mission in Southeast Tanzania 1900–1945” in *Social Science and Medicine* 15B, p. 263.

⁶ *Ibid*, p. 274.

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Associated with the establishment of mission hospitals by the various mission institutions was the competition among the various missions themselves. The competition was a healthy one, designed not only to alleviate health problems but also to win more converts in a given area. In pursuit of this venture, the missions also aimed at gaining respect and credibility. From this desire emerged what became known as areas of operation or spheres of influence where missions laid stakes and claimed niches among the groups in which they laboured.⁷

Areas of operation or spheres of influence did not begin with the missionaries. They have been a common feature throughout human history. The many conflicts that raged in Greek and Roman epochs and all through medieval times were largely about spheres of influence. The partitioning of the African continent by the European powers in the 1880s was associated with areas of operation.⁸ Mission societies, which usually preceded colonial occupations, did not deviate from this norm; they in fact set the pace for the acquisition of spheres of influence.

Missionaries who came to labour in Africa and the then Bechuanaland Protectorate in particular hailed from Europe and belonged to various denominational societies. Competition among the missions was inevitable as these vied for the control of spheres of influence. It is not surprising therefore that the LMS carved out its sphere of influence from the Kudumane area in the present North West Province of South Africa through to the Bangwaketse, the Bakwena, the Bangwato, the Batawana and the northern regions of Bokalaka, and the eastern parts of Batswapong and Babirwa stretching all the way to present southern Zimbabwe.⁹ The Hermannsburg (Lutheran) Mission

⁷ For specific details on the competition among the mission societies in Botswana see PT Mgadla, "Who Used Whom in the Establishment of Medical Spheres of Influence in the Bechuanaland Protectorate? The Case of the Seventh Day Adventist Church in Kanye, 1922-1959" in F Nkomazana and L Larner. *Aspects of the History of the Church in Botswana*. pp. 115-153; also see O Gulbrandsen, "Missionaries and Northern Tswana Rulers: Who Used Whom?" in *Journal of Religion in Africa* Vol. 23 pp. 49-56. The Bangwaketse, Bakwena and Bangwato were used as case studies in this article.

⁸ See JD Hargreaves, *A Prelude to the Partition of West Africa* (London: Macmillan, 1966); also see J Mackenzie, *The Partition of Africa and European Imperialism in the Nineteenth Century* (London: Methuen 1983).

⁹ For details on the LMS activities and its sphere of influence see TJ Theal, *Livingstone* (Nrk: Dell, 1974) pp. 107-109; I Schapera, (ed.) *Livingstone's Private Journals* (London: Chato and Windus, 1960); J Ramsay, "The Rise and Fall of the Bakwena Dynasty of South Central Botswana 1820-1940" (PhD thesis, Boston University 1991) ch. 2; J Mackenzie, *Ten Years North of the Orange River* (Edmonton and Douglass, 1871) p. 375; A Merriweather, "Molepolole Mission History" in *Botswana Notes and Records* 1968, pp. 15-17; and LH Burns *One Hundred Years of Christianity Among the Bangwato: A Historical Account Published for Shoshong Centenary Committee* (Lobatse: Bechuanaland Book Centre, 1962) p. 1.

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laboured among the Balete¹⁰ of present-day Ramotswa, while the Wesleyans (Methodists) laboured among the Barolong¹¹ and the Dutch Reformed Church worked among the Bakgatla¹² both in Botswana and in South Africa. The late arrivals, the Seventh-day Adventists (SDAs) arrived in Kanye and Maun respectively (see map), areas that had been the preserve of the LMS until then. The Catholics also arrived late in the protectorate. The two late-comers were received and accepted more for their offer of their educational and, more importantly, their medical services. However, the acceptance was not smooth as the established mission societies, especially the LMS, resented and opposed the presence of other denominations, viewing them as intruders in what they considered their sphere of influence. Consequently, the colonial government found itself in the position of arbiter,¹³ settling differences by taking into account, among other things, the financial capabilities of the mission bodies, spheres of influence and the magnitude of the medical services needed in the various areas. The Sefhare Mission Hospital in the Batswapong area was the result of such mediation and negotiations involving the protectorate administration and the two mission societies, both of which vied for the same sphere of influence.

Background to the establishment of the Sefhare Mission Hospital

It ought to be stated from the onset that Sefhare, in Tswapong, was under the jurisdiction of the Bangwato, one of the principal ethnic groups in the central district of Botswana. Usually the paramount Kgosi (Chief), in this case Kgosi Tshekedi Khama of the Bangwato, sent a representative to be a resident overseer of the Batswapong since they were regarded as a subject group. At the time therefore, the Batswapong, like other minority or “subject” groups,

¹⁰ For more information on the Hermannsburg Mission Society see W Prosker, “*The Political Significance of Early Hermannsburg Mission in Botswana*” in *Botswana Notes and Records*, Vol. 22, 1990, p. 43; R Ojang, *The Impact of Christianity Among the Balete of Ramotswa 1935–1965* (BA research essay, University of Botswana, 1987) p. 3.

¹¹ See Broadbent, “*A Narrative of the Introduction of Christianity Among the Barolong Tribe of the Bechuana* (1865); also see J and J Comaroff, *Of Revelation and Revolution: Christianity, Colonialism and Consciousness in South Africa* vol. 1. (Chicago: University of Chicago Press, 1991); J Potter, “*The Origins and Development of the Methodist Mission Work Among the Barolong of Present day of Botswana* in *studies of the Church in Southern Africa* Vol. VI, 1995.

¹² M. Schiele, “*Notes on the History of the Dutch Reformed Church in Mochudi*” in *Botswana Notes and Records* Vol. 4 1972, p. 282; B. Moitsoi, “*The History of the Dutch Reformed Church in Mochudi*” (BA research essay, University of Botswana, 1994; WL Maree, *Botswana: 1877–1977: A Centenary of the Dutch Reformed Church in Botswana* (Silverton: Promedia Publikasies, N.D.)

¹³ See PT Mgadla, “*Who Used Whom in the Establishment of Medical Spheres of Influence in the Bechuanaland Protectorate?*” pp. 128–129.

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owed allegiance to the “principal” ethnic groups,¹⁴ in this case the Bangwato. Virtually all developments that occurred among any “subject” group had to have been sanctioned by its overlord. It was in vogue at the time to assume that such developments had been carried out by the “principal” ethnic group.

Negotiations leading to the establishment of the Sefhare Mission Hospital started in earnest in the early 1930s, but they did not come to fruition until 1937. The LMS had a health post in the Maun, Ngamiland, northwest of Botswana, its sphere of influence since the days of Dr David Livingstone.¹⁵ The health post, inadequately financed, staffed and built, fell short of providing the much-needed medical services in the area. The Seventh-day Adventist Church, which had successfully secured a foothold in Kanye among the Bangwaketse ethnic group in the southern part of the protectorate by providing medical services in the form of a hospital,¹⁶ wanted to do the same in Ngamiland despite the fact that this was not its sphere of influence.

It was generally acknowledged by all parties involved, the administration, the LMS, and the SDA Church that the area of Ngamiland, with its large population, needed medical services. Also, the proposals for the building of hospitals in needy areas of the protectorate were in line with, and had been recommended by, Sir Alan Pim in his report.¹⁷ C Rey, the Resident Commissioner, had communicated with the mission bodies about this venture with a view to securing their cooperation along the lines, possibly, of a joint medical venture.

It goes without saying that the LMS and the SDAs were headed for a major confrontation. The LMS was steadfast in its argument that the Ngamiland area fell within its area of religious jurisdiction and that therefore the priority of a joint medical venture with the protectorate administration

¹⁴ On minorities in relation to “principal” ethnic groups, see IN Mazonde, *Minorities in the Millennium: Perspectives from Botswana* (Gaborone: Lightbooks, 2002).

¹⁵ Dr Livingstone had visited the Ngami area after he had left Sechele’s country on his visitations to Central and parts of East Africa. Subsequently, other missionaries in the 1860s, such as the Rev Roger Price and Rev Helm also made visitations there though their journeys were catastrophic. They had visited the Linyanti area in Ngamiland with the aim of proselytising in the area. See T Jill, *Livingstone* (New York: GP Putman’s Sons, 1973; U Long, *The Journals of Elizabeth Lees Price* (London: Edward Arnold (Publishers) Ltd, 1956) pp. 44, 434, 458, 553. EW Smith, *The Great Lion of Ngamiland*, T Tlou. *A History of Ngamiland*, (Gaborone Macmillan Publishers, 1985), B Morton.....

¹⁶ See PT Mgadla, “Who Used Whom ...” Also RKK Molefi, *A Medical History of Botswana* (Gaborone: The Botswana Society, 1996).

¹⁷ Sir Alan Pim was a protectorate government’s consultant for the three High Commission Territories tasked with the responsibility of finding out and making suggestions on how best the administration could tackle the economic and social problems that beset those territories. See BNARS S316/2 1933, *The Financial and Economic Commission of Sir Alan’s Pim Report*, 1932. Also see BT Mokopagosi and GB Gumbo in PT Mgadla and BT Mokopagosi (eds) *Forty Years On: Essays on the Fortieth Anniversary for Botswana’s Independence* (Gaborone: Department of Information Services, 2008).

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should be given to it. The SDAs and the administration, however, held a contrary viewpoint. They argued that the preference should be given to the medical needs of the people in the area and that a deciding factor should be whether or not the mission body in question demonstrated sound financial capability. Rey advised the LMS “to abandon the idea of establishing a hospital in Maun and that they leave that to the SDAs, which had the funds to establish a hospital, and that the LMS should consider establishing theirs in the Botletle district¹⁸ of the chief”.¹⁹

Rey’s position regarding which of the two mission bodies was to establish the Maun hospital was subsequently discussed with the High Commissioner, representatives of the mission bodies and Kgosi Tshekedi Khama of the Bangwato. The result was that all the parties amicably resolved that LMS would confine itself to the establishment of a smaller hospital at Rakops in the Botletli area. In a 1934 interview with Kgosi Tshekedi Khama about the establishment of a medical venture in his district, the LMS grudgingly accepted the reasoning of the protectorate administration although it preferred that the offer be made to its sister society, the United Free Church of Scotland (UFCS).

However, the LMS Botletli-Rakops medical venture hit a snag and could not take off. Agreeable to the establishment of the medical venture in Botletli though Tshekedi Khama was, he reminded the protectorate administration “that a considerable proportion of the population of the Botletli River area would be moving to the new land, ceded to the Bangwato as Crown land”.²⁰ In view of this development Tshekedi Khama had proposed that the hospital be relocated to areas that were more densely populated and had abundant water resources. These were the Batswapong, Babirwa; Bakalanga and Bateti areas. It would appear that population density, among other considerations, contributed to the choice of the site for the hospital. In a letter to the Secretary of State for Colonies in London the High Commissioner noted that:

... The Principal Medical Officer, the Resident Magistrate and the Chief (Tshekedi Khama) consider it a great benefit for the hospital to be established in the Tswapong area where there is a dense population of 140,000 in the vicinity of Seolwane.

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ BNARS 365/11, Hospital and Medical Mission: Ngwato Reserve, Rakops General and the Sefhare Hospital: G Nettleton, Resident Magistrate in Serowe to Resident Commissioner Charles Rey, 26 April 1934.

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Representatives of the mission bodies were all in concert to change the site to the Tswapong area.²¹

By 1935 all indications were that the considerations for the site of the proposed hospital had pointed to the Batswapong area.



Map of Bechuanaland Protectorate showing the position of Sefhare

The Sefhare Mission Hospital

The establishment of the LMS medical mission hospital in Sefhare was a long process. It took three years to plan, survey, consult, seek funding, drill for water, have the land tenure issues sorted out, build and provide the

²¹ Ibid, Hospitals in the Bechuanaland Protectorate: High Commissioner, Pretoria to Secretary of State, London, 13 November 1934.

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hospital with both the necessary equipment and the staff. Furthermore, the venture involved several parties, the protectorate administration, the LMS and the paramount *Kgosi* Tshekedi Khama, under whom the area fell, as well as the people for whom the hospital was intended, the Batswapong. All these parties had to agree on the exact location of the hospital. Before the final decision to construct the hospital at Sefhare, several places were considered along with factors such as the availability of water resources, accessibility, population, and infrastructure.

All indications were that Sefhare would be ideal for the mission hospital despite the fact that it was not necessarily central to the Batswapong area. "Sofala," as the protectorate officials and the missionaries alike wrongly pronounced *Sefhare*, was seen as an alternative to other places considered. Dr Dyke, the then Principal Medical Officer of the protectorate, and Mr Burns of the LMS had preferred "Sofala," arguing that it was more convenient from an administrative point of view and that it served a fairly large "native" area in the Batswapong region. Furthermore, it was argued that it was fairly close to the government camp and that it would also serve the interests of the Tuli Block.²²

Water, land and construction issues

A comprehensive survey of the availability of water in the Batswapong area was undertaken in 1936. It involved all concerned parties.²³ The team concentrated most of its work in Sefhare. Its findings, which were based on the use of a water measuring instrument known as a "triangular notch weir," indicated that Sefhare would generate 11 000 gallons per day and that a conservative estimate of the overall generation of water would be 14 000 to 15 000 gallons per day.²⁴ The Chadibe water measurement from the two water channels indicated that 31 000 gallons per day would be yielded, not taking into account numerous other streams of water existing in the precincts of Chadibe. If these were to be considered, "40 000 to 50 000 or even 60 000 gallons per day"²⁵ could be generated. For the most part the water was used for the irrigation of several acres of citrus fruits, guavas and many kinds of vegetables belonging to *Kgosi* Tshekedi Khama.

Because of the objections of *Kgosi* Tshekedi regarding the use of surface water, the LMS and especially the protectorate administration had

²² BNARS 365/12 Interview with Tshekedi Khama on the Occasion of the Visit of His Excellency the High Commissioner to the BP, Mahalapye, 15 June 1935.

²³ BNARS S 365/15/2, Hospital and Medical Mission: Ngwato Reserve: Establishment of, by LMS with Government Aid, 28 August 1936. Memorandum by JC Hawkins, District Commissioner, on water supplies at Sofala, Chadibe and Maleti.

²⁴ Ibid.

²⁵ Ibid.

little option but to drill a borehole for the hospital. By 1936 the borehole had been drilled at the expense of the administration as the LMS lacked the financial capabilities. However, two problems emerged after the borehole had been drilled. First, the water was found to be inadequate to supply the hospital. Second, samples of the borehole water had been sent to Pretoria, South Africa, for testing, and the report indicated that it was not potable and therefore unfit for domestic consumption.²⁶ The Principal Medical Officer explained in a meeting that the chemical and bacteriological analyses were both submitted for inspection by those present and it was agreed that the “the supply is of no value for hospital purposes”.²⁷ So serious was this discovery that government water experts were requested to determine if sufficient quantities of the water supply in Chadibe could be piped to the hospital in Sefhare.²⁸ Some protectorate officials even suggested that, because of the water problems at Sefhare, the whole medical venture at Sefhare should be put in abeyance and that a new site should be identified east of the railway line and funded by the protectorate administration itself.²⁹

The unsuitability of the water for domestic consumption necessitated the drilling of a second borehole near the site of the hospital. The LMS, which was anxious for the project to succeed, had requested the government for this second borehole. The government was therefore compelled to drill for water elsewhere, quite unnecessarily, and at great expense.³⁰ Since the administration had already lost money in the drilling of the first borehole, it now wanted the second one to be recognised as the property of the administration.³¹ However, this was not to be as the subsequent memorandum of agreement nullified any property ownership, in the event of closure, by either the LMS or the administration of the land on which the hospital was built.

More and more officials lamented the regrettable state of affairs concerning water problems at Sefhare, with the LMS, cap in hand, expressing some regret that its London Board had difficulties in providing more capital for financing the scheme. The LMS further expressed some confidence that it would manage the whole scheme in view of the fact that it was a cooperative

²⁶ BNARS S 365/13 Hospital medical Mission: Ngwato Reserve (Sofala, Tswapong, areas) Establishment of, by the LMS, 1936.

²⁷ Ibid; Memorandum of Meeting held in the District Commissioner's Office at Serowe on Wednesday, 12 August 1936 on the subject of the Sofala hospital site.

²⁸ BNARS S 365/15/1, Hospital and Medical Missions.... Burns of the LMS to Dr Sterling, Serowe, 22 August 1936.

²⁹ Ibid, District Commissioner in Serowe to the Principal Medical Officer, D Meams, 15 August 1936. In that memo, the District Commissioner pointed out that “Sofala” hospital had a water problem, and advised that whole venture be put in abeyance and that a different site, east of the line, be considered and funded by government itself.

³⁰ Ibid; Memorandum from the Resident Commissioner, Charles Rey in Mafikeng, 14 August 1936.

³¹ BNARS S 366/3 Hospital and Medical Mission at Sofala: Agreement with Acting Chief Tshekedi re: Land and Water, 1935. Reilly to Captain Nettleton 1935.

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effort involving the administration, Chief Tshekedi and the mission itself.³² A second borehole was therefore drilled at the cost of the administration, with the LMS, as usual, promising that its financial situation would soon stabilise.

Land

Kgosi Tshekedi Khama gave ample land for the building of the hospital, enough to include a site for the mission house as well as nurses' and medical doctors' living quarters. By providing land for the LMS and the administration Tshekedi Khama was not selling the land nor giving it away on a permanent basis. Some protectorate officials mistook Tshekedi's gesture as giving away "tribal" land to the mission. The Principal Medical Officer, for example, stated that: "the Chief having given this tribal land to the Mission, the matter would have to go before the High Commissioner for approval of the transfer of the grant of land to the LMS ..."³³ It has been fairly documented that the land tenure system among the Batswana and the Bangwato in particular was not based on the principle of selling as demonstrated by the Tiger Kloof land saga.³⁴ What Tshekedi Khama did when he permitted the LMS to build a hospital in Sefhare was to guarantee the retention of the land by the LMS for as long as the latter required it for the purpose of the hospital.³⁵ In point of fact, Tshekedi Khama wanted a lease agreement drawn up and sent to him for perusal and signature. In an undated letter regarding the Sefhare Mission Hospital Tshekedi Khama stated that for as long as the LMS conducted itself and its operations in a manner satisfactory to all parties concerned, it would not be disturbed in the occupation of the hospital site. Ending his undated letter, Tshekedi Khama clearly stated that: "should the

³² Ibid; AJ Haile to Principal Medical Officer in Mafikeng, 4 August 1936.

³³ BNARS 365/15/2 Hospital and Medical Mission ... Meeting held in Mafikeng (now called Mahikeng) on 31 August 1936.

³⁴ The LMS had wanted to start a high school in the Bangwato Territory as there was none in the whole territory of the Bechuanaland Protectorate. While Khama III welcomed such a development he made it clear to the LMS that he would not sell the land to the missionaries for such a purpose and that such a school would necessarily have his influence. Following protracted arguments, the LMS decided to buy land in the Cape Province on a farm called Tiger Kloof near Vryburg in the present North West Province of South Africa. For details see PT Mgadla, 'The Relevance of Tiger Kloof to Botswana' in *Pula Journal of African Studies*, Vol. 8 no.1 pp. 30–52; also see Lekhela, 'The Origin, Development and Role of Missionary Teacher Training Institutions for the Africans of North West Cape: A Historical Survey of the Period 1850–1954 Vols. 2' (PhD thesis, University of South Africa, n.d.) and QN Parsons, 'Khama III, the Bangwato and the British with Special Reference to 1885–1923' (PhD thesis, University of Edinburgh, 1973) p. 242.

³⁵ BNARS S 366/3: Hospital and Medical Mission in Sofala: Agreement with Acting Chief Tshekedi re: land and Water 1935: Reilly acting in the Resident Commissioner's Office to Captain GE Nettleton. In this letter Reilly was reporting the outcome of the meeting he had held with Haile, the Principal of Tiger Kloof, Gavin Smith, the LMS's treasurer, and HL Burns, secretary of the Bechuanaland District Committee.

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LMS relinquish its interest and cease its activities in the hospital or should the hospital be closed down and abandoned ... then in such an event land upon which the hospital was built would become the property of the tribe".³⁶

The issue of land for the hospital was finally resolved in 1936 with a Memorandum of Agreement "Entered Into Between the LMS for the purpose of establishing a hospital at Sofala, Bangwato Reserve, and to make provision for the said hospital to be taken over by the Bechuanaland Protectorate Government in Certain Eventualities".³⁷ Briefly stated, the memorandum of agreement stated that the *Kgosi* and the *morafe* (ethnic group) had agreed to hand over to the Mission *on loan and for use*, an area of land in the Bangwato Reserve at Sefhare measuring approximately four acres for the purpose of establishing and maintaining a hospital. The agreement further stipulated that the land was lent to the mission *gratuitously* [my own emphasis] for an indefinite number of years as long as the land was used for the purpose for which it was intended. The agreement also made it crystal clear that the *Kgosi* and the *morafe* would retain ownership of all property on the land that had been lent to the administration and the mission in the event that the mission and the protectorate administration became unable, for whatever reason, to continue with the operations of the hospital.³⁸

Construction

It is worth noting that each of the three parties mentioned thus far was expected to contribute in one way or another to the building of the hospital. While the LMS and the administrations contributed in monetary, technical and advisory terms, Tshekedi Khama and his *morafe* (mainly Batswapong and some Bangwato) contributed in the form of labour. Virtually every official and missionary associated with the Sefhare Mission Hospital gave accolades to the people of Sefhare for the role they played in the building of the hospital. When the hospital opened, A.J. Haile of the LMS congratulated *Kgosi* Tshekedi and his *morafe* and thanked "Kgosi Tshekedi for the great help you have given us in this work and this is the hospital you have helped to build. There are men who made the bricks and there are men who

³⁶ Ibid, an undated letter from Tshekedi Khama about the erection of a hospital by the LMS at Tswapong.

³⁷ Ibid, Notes of Conference held at Mafikeng in the Office of his Honor the Resident Commissioner, 17 August 1936. Present at this meeting was Captain CAN Clarke, Assistant Resident Commissioner, Dr JW. Stirling, Principal Medical Officer, AJ Haile, Gavin Smith, JHL Burns, JW Brind, Government Engineer, and WT Thompson, Contractor.

³⁸ Ibid, Draft memorandum of Agreement Entered Into Between the LMS, the Bangwato and the Protectorate administration, August 1936.

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transported materials from the station”.³⁹ His speech was noteworthy because it included substantial and liberal words considering the era and prevailing negative attitudes. He continued: “We cannot forget the women who carried water from the spring before the water tank came to be used”. Few would have acknowledged the role women played in a venture of this nature as the attitude of the time tended to be one of domination by men at the exclusion of women. The other official who acknowledged the labour of the Batswapong was Resident Commissioner Charles Rey, who said that the “tribe” of the Batswapong in Sefhare⁴⁰ had made the bricks of the hospital and that they ought to be praised for the good job they had done.

Another authority that recognised the role of the *morafe* in the building of the hospital was the Kgosi Tshekedi Khama himself, who mobilised regimental labour to mould the bricks for the building of the hospital. In his 1936 notes to the Resident Commissioner in Mafikeng, Tshekedi Khama emphasised the role played by the *morafe* labour.⁴¹ District Commissioner Nettleton added his commendation on the Batswapong at Sefhare and other villages in its precincts noting that they had contributed to making some 15 000 bricks which had to be transported to a distance of a mile and that transportation was by “tribal” wagons.⁴² The above discussion underscores the role played by the residents of Sefhare and the surrounding villages in the building of the hospital.

Grants and funding of the hospital: a joint venture

Plans for the hospital were initially formulated so that a joint venture involved the LMS, the protectorate administration and, to a lesser extent, Tshekedi Khama and his *morafe*. The LMS pledged 1 500 pounds towards the establishment of the hospital while the administration would contribute an amount of 1 150 pounds for capital costs. The administration was also expected to pledge an annual grant of 1 050 pounds. “Acting Chief Tshekedi Khama would cooperate in the work and thus reduce the Government’s

³⁹ BNARS S365/11 hospital Medical Mission: Ngwato Reserve Rakops General (Sefhare Hospital Opening of) 12 October 1938. The Principal of Tiger Kloof, AJ Haile of the LMS, making a speech at the opening of the Sefhare Mission Hospital, 29 June 1938.

⁴⁰ BNARS 365/15/1: Hospital and Medical Mission: Ngwato Reserve: Sofala Site Unsuitable: question of new Site in Machaneng, Seolwane, Maletse, Chadibe or travelling Dispensary... 12 August 1936. Memorandum from the Resident Commissioner Charles Rey in Mafikeng, 14 August 1936.

⁴¹ BNARS S 365/15/2 Hospital and Medical Mission: Ngwato Reserve: Establishment of, by LMS with government aid. 28 August 1936. Notes of a meeting with Chief Tshekedi Khama at Mafikeng on 31 July 1936.

⁴² Ibid, GE Nettleton, District Commissioner in Scrowe to Government Secretary, Mafikeng, 5 October 1936.

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contribution.⁴³ Also worth noting is the fact that the administration was not only in a joint venture with the LMS in Sefhare, but it subsidised all the mission hospitals in the country by providing capital funds where there was a dire need for doing so as well as providing annual grants-in-aid. Thus, the SDA Church both in Kanye and in Maun, the Dutch Reformed Church in Mochudi, the Balete-Lutheran Hospital in Ramotswa, the United Free Church of Scotland and the Sefhare Mission Hospital all benefitted from the administration's subsidy.

It would appear that the *modus operandi* between the mission societies and the administration in the Bechuanaland Protectorate was not quite in sync with what was happening in other parts of British Africa as far as relations between mission societies, mission hospitals and the government were concerned. In 1933, for example, the General Secretary of the LMS at its headquarters in London, AM Changwin, observed that in other parts of Africa the doctors and nurses belonged to the mission body but served the people in the areas in which they operated as well as the Europeans and government employees. He observed:

In other parts of British Africa, where the Society cooperates with the government in rendering medical services to the people, the doctors and nurses are full missionaries of LMS appointed by the Society and serving under the regulations that apply to all the missionary workers. The government thus receives services of qualified and reliable men and women whose missionary vocation with a well-known Society are a guarantee of the faithfulness and standard of their work, and in addition the government usually receives annual reports or in other ways satisfies itself of the value and quality of the work that is being done. In such cooperation with the government, the Society medical missionaries render services gratuitously to members of the government staff, but receive fees from other Europeans while they sometimes receive small fees or voluntary gifts from African patients. All such fees and gifts are wholly devoted to the medical work. This society would be glad to cooperate with the government of the B.P. on terms of a similar character.⁴⁴

⁴³ BNARS 391/3: Hospitals and Medical Missions in the B.P. Resident Commissioners Survey of various Offers made and Recommendations that SDA in Maun and that of LMS in Rakops (later changed to Sefhare in Tswapong area) be accepted.

⁴⁴ Ibid, AM Changwin, General Secretary of the LMS to the Resident Commissioner, 30 December 1933.

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Be that as it may, the LMS had always been known in the protectorate for being financially unsound and not having enough financial muscle to carry out major projects of the magnitude of schools and hospitals, prompting its Secretary Changwin to observe further that: "... the LMS was financially strapped and was committed to other mission fields, had to cut missionary personnel as well as other drastic cuts. In view of this, it is not possible for the Society to achieve this unless the government chipped in".⁴⁵ It is not surprising, therefore, that the administration's contribution towards the LMS's mission hospital was quite substantial.

The LMS was so desperate for the support of the administration that it requested the grant of 1 050 pounds to be regular and to come in a lump sum instead of on a quarterly basis. In that way, the LMS would cover the developmental projects of the hospital as soon as the funds were available rather than piece-meal. The inadequacy of LMS's funding contributed to the demise and eventual closure of the hospital. As early as 1936, Rey reported that "the Batswapong hospital had reached an unsatisfactory stage because of a variety of causes, chief among which was financial".⁴⁶ It was clear that, although the LMS had noble and ambitious plans to provide medical services in the needy areas, such as those of the Batswapong, it certainly did not have the financial capabilities to do so. It could not stay on par with other mission hospitals, whose endeavours clearly eclipsed those of the LMS in the provision of medical services. Finally, this financial lacuna burdened the administration, which itself could not boast of a healthy financial position and thus lent itself to criticism by other mission hospitals that were not receiving the same assistance.

Operations of the hospital

The Sefhare Mission Hospital was officially opened on 29 June 1938. Amid pomp and fanfare, many dignitaries⁴⁷ were invited to the "Cinderella" of the LMS. The first doctor of the hospital, Barnett, encouraged the people of Sefhare to come to the hospital for help if they were sick. He also touched on

⁴⁵ Ibid.

⁴⁶ BNARS 365/15/1: Hospital and Medical Mission; Ngwato Reserve...Memorandum from the Resident Commissioner, Charles Rey in Mafikeng, 14 August 1936.

⁴⁷ BNARS 365/11, Hospital and Medical Mission: Ngwato Reserve: Rakops (Sefhare Hospital Opening of) 12 October 1938. Record of the Proceedings at the Opening of the Sefhare Hospital on 29 June 1938 at 11 am. Present were the Resident Commissioner, Arden-Clarke, the Principal Medical Officer, Dr Sterling, the District Commissioner for Serowe, VF Ellenberger Esq., the Reverend AJ Haile, Principal, Tiger Kloof Native Institution, of the LMS, Dr E Barnett, the first doctor of the Sefhare Mission Hospital of the LMS, H Palphramand, Esq., Storekeeper, and many other European residents from Mahalapye, Tuli Block, Palla Road etc, as well as Chief Tshekedi Khama of the Bangwato Tribe, the Reverend J Tibape, the Reverend Mmonwa, and the schoolchildren.

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the running of the hospital noting that, "We are going to run it together and every first Tuesday of every month there would be staff meetings to consider suggestions to improve the running of the hospital".⁴⁸

Kgosi Tshekedi harped on the same tune as did other dignitaries who spoke at the opening, observing that the medical venture was a sign of great progress in the country, particularly in those areas that were far from major villages where a modicum of development had taken place. He noted that:

there are many things the government is doing for us in the country, but most of these great works are taking place in places like Serowe. The Bangwato tribes living outside Serowe have not seen anything like this for a long time. I wish to say that this should not only be the beginning, but the continuation of the work to be done outside Serowe. There are many villages in the country that wish to be given the same assistance as this.⁴⁹

He thanked his own people for the role they played in the building of the hospital and encouraged the self-help spirit to continue in other developmental projects. He also advised people to use the hospital when sick despite the pervasive strong belief in "witch doctors".⁵⁰

The Principal Medical Officer, usually a doctor, of a given term of office oversaw the operations of health care in the country, the Sefhare Mission Hospital included. The executive committee of the LMS in the southern region, commonly known as the Bechuanaland District Committee (BDC), in consultation with its secretariat in London, monitored developments at the hospital and consulted with the administration and its secretariat. The day-to-day operations of the hospital were, however, left to the doctor in charge, who acted as a superintendent, and to the nurse(s), who acted as his assistant(s) or manager(s). On paper, the doctor and the nurses were supposed to work closely with the chief and the people of the village through consultations.⁵¹ In reality, however, conflicts later surfaced between the hospital and the leadership of Sefhare's inhabitants that contributed, in no small measure, to the eventual demise of the hospital.

Among others the hospital had an outpatient department, a small operating theatre, and a mortuary that was rather big considering the fact that there appeared to be no known epidemic that threatened people's lives at the

⁴⁸ Ibid, Dr Barnett making some remarks at the opening of the Sefhare Mission Hospital.

⁴⁹ Ibid, Kgosi Tshekedi making some remarks at the opening of the Sefhare Mission Hospital.

⁵⁰ Ibid. Also see S Volz, *African Teachers on the Colonial frontier: Tswana Evangelists and Their Communities During the nineteenth Century*, p. 101.

⁵¹ See BNRS S 365/11: Hospital Medical Missions ... Sefhare Hospital, Opening of. Dr Barnett making remarks during the opening of the hospital.

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time. It was designed to have twenty “native” but no European beds.⁵² However, Europeans could be admitted to the hospital in emergency cases. Such an arrangement reflected the prevailing situation of the time in southern African colonies, where prejudice on the basis of colour was rife. The situation at Sefhare was therefore not peculiar to the protectorate, or the region for that matter. After all, there were European hospitals in the urban centres of Lobatse, Francistown, Athlone and Jubilee, and these did not cater for Africans.⁵³

The situation at the hospital appeared to be under control and the people of Sefhare and its environs appreciated its existence and utilised it as expected. However, there were signs of dissatisfaction and instability when its first doctor, Barnett, resigned and left in 1939, having served for only one year. He cited, among other reasons, arduous conditions at the hospital, inhospitable living conditions and the frustration of being away from urban life. He also cited the lack of cooperation with the people of Sefhare and a lack of support for the goals of the LMS and its endeavours to promote the mission hospital. The officials of the administration and the LMS noted that Dr Barnett became “tactless and unacceptable to the people of Sefhare so that the initial work of the hospital was therefore prejudiced”.⁵⁴ A couple of years later, the first nurse, Ms Mary E Dunn, who had become a matron, also left the hospital on furlough never to return after she had had a breakdown and an operation due to stressful duties.⁵⁵ There were rumours, however, that Sister Dunn frequently absented herself from Sefhare leaving her position unattended, a contravention of the rules and regulations put in place by the LMS and the administration.⁵⁶

Dr Barnett’s successor was a young woman doctor from England by the name of Winfred Tribe. Enthusiastic and energetic, she made a great effort to try to put the hospital back on track, win the confidence of the people and overcome the prejudices created by her predecessors. She started to initiate the building of dispensaries in the remote parts of the Tswapong. By 1940, just after she took over from her predecessor, the number of outpatients in Sefhare rose to over 11 000 and the number of patients in the hospital grew to 107. The following year “the figures were respectively 12,000 and 131”.⁵⁷ Under her, a programme for training local staff and hiring African nurses started in earnest but under very trying conditions because

⁵² BNARS 365/11, Hospital and Medical Mission ... 12 October 1938. Burns to Resident Commissioner, Arden Clarke, 6 April 1938.

⁵³ See Mgadla, *Who Used Whom*.

⁵⁴ BNARS 366/2/1, Hospital and Medical Mission: Ngwato Reserve at Sofala(Tswapong) Agreement with the LMS and BP Administration in 1935. GE Nettleton to Dr Priestman, Principal Medical Officer, 1 September 1942

⁵⁵ Ibid, AJ Haile, to Principal Medical Officer, 2 December 1942.

⁵⁶ Ibid, Government Secretary to J Anderson, Principal Medical Officer, 30 September 1942

⁵⁷ Ibid, Nettleton to Dr Priestman.

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classrooms, books, teachers and examiners for these nurses were hard to find. Despite these odds, the relevant authorities regarded her work as sterling. Dr Tribe's responsibilities must have taken a toll on her for she soon requested furlough as well as support for starting dispensaries in the remote areas of the country upon her return. Records do not show whether the request was ever acceded to. Neither did she return to Sefhare.

The demise of the Sefhare Mission Hospital

Between 1939 and 1942 there is a dearth of correspondence regarding the Sefhare Mission Hospital, presumably because of World War II. After the replacement of Dr Winfred Tribe with another doctor, Dr Dorothy Entrican, the Sefhare Mission Hospital appeared to have simmering problems of discontent, general malaise and financial insecurity that subsequently led to the demise and eventual closure of the hospital. Nurses began to resign citing working relations, working conditions, and the fact that the hospital was forced to go for weeks on end without the drugs so badly needed in the dispensary. Staff problems culminated in the dismissal of some members as evidenced, for example, by a "notice of dismissal of the dispenser and the African nursing staff".⁵⁸

From a report prepared by Dr Entrican it appeared that ever since she took over at the Sefhare Mission Hospital, she had encountered problems with the dispenser, a certain Mr A. Senthope, who allegedly exhibited obstructive attitudes by refusing to cooperate in the duties that he was supposed to perform. There was also trouble with the African nursing staff that revolved around matters of discipline.⁵⁹ The trouble with the nurses came to a head over a change of regime that became unpopular because of adherence to strict discipline.

The issue of staff discipline was further compounded by the intervention – rightly or wrongly – of the headman of the village, Mr Ramosamo. It would appear that Mr Ramosamo's strategic approach to the problem lacked professionalism. After a ward-maid had reported to him about the situation at the hospital, he confronted the doctor and the matron on a busy hospital day and began to lecture them publicly on matters of discipline at the hospital.⁶⁰ The doctor and the nurse were put in an embarrassing and humiliating position. It was concluded that "the headman meddled in an officious manner with matters of staff which were the prerogative of the

⁵⁸ Ibid, memo of discussion with Dr Entrican on 10 March 1945: Staff position at Sefhare from Dr Mackenzie. Dr Entrican to the Deputy Director of Medical Services, 8 March 1945.

⁵⁹ Ibid.

⁶⁰ BNARS Med. 2/1, Hospital Mission...A.J. Haile to Dr John Mackenzie, Deputy Director of Medical Services, 16 March 1945.

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Doctor and the Matron".⁶¹ Ramosamo was reprimanded by Kgosi Tshekedi Khama for his unprofessional behaviour and later removed as headman of Sefhare.⁶² By 1946 Dr Entrican was ready to leave the Sefhare Mission Hospital as she was needed in China. Matron Sharpe retired the following year.

So serious was the state of affairs in Sefhare that a sort of commission of enquiry was instituted. The commission was headed by Mr Andrew Kgasa, one of the best known and most respected African ministers in the country. After being appraised of the situation, Mr Kgasa took it upon himself to spend some time with the people with a view to getting first-hand information. He urged them to support the hospital and the church and to appreciate the privilege of having a hospital in their midst, saying that it needed their support to succeed.⁶³ After all concerns had been raised, it was concluded that the challenges that had occurred had done the hospital some good and that the people and the hospital administrators should learn from what had transpired and look forward to building the future of the hospital.

The LMS was made quite aware of the deteriorating situation in Sefhare. By 1947 the position of the Sefhare Mission Hospital was so unsatisfactory that the officials began to talk seriously about its closure. Some even doubted that the venture should have been undertaken at all. Instead of coming clean about its lack of financial capabilities, the LMS shifted the blame first to the lack of personnel at the hospital and then to the community of Sefhare itself. It blamed the population of Sefhare for being "backward" and said that it was uncooperative and that it resented "all attempts made to help them medically". In a surprising turn of events, the LMS expressed doubt about whether the establishment of the Sefhare Mission Hospital should have occurred in the first instance.⁶⁴ The LMS's argument was not convincing as most people in the protectorate would have welcomed medical services as they were in dire need, just as they are today. The crux of the matter is that the LMS did not have enough money to run and maintain the hospital.

Closure of the Sefhare Mission Hospital

The Sefhare Mission Hospital was finally closed on 17 September 1947 after operating for 10 years. However, while the hospital was declared closed there

⁶¹ Ibid.

⁶² BNARS 366/2/2, Hospital and Medical Mission Ngwato Reserve at Sefhare: Agreement between LMS and BP Administration and General District Commissioner to Government Secretary, 10 April 1945.

⁶³ BNARS Med. 2/1 Hospital Mission: London Missionary Society, at Sefhare.

⁶⁴ Ibid.

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were numerous attempts to resuscitate it or to find alternative ways of redeeming its present state of dilapidation.⁶⁵

Meanwhile, others suggested that the only way to resuscitate the Sefhare Mission Hospital was for the “tribal” administration to take it over.⁶⁶ Kgosi Tshekedi Khama had in fact made this suggestion, which was viewed as palatable by the administration provided it could be established that “the tribe can afford to buy the hospital and run it thereafter”. The suggestion could not have come at a better time for the LMS. In yet another dramatic turn of events, the LMS was now talking about selling the hospital.⁶⁷

The LMS felt the financial pinch because all along it had been cushioned by the preferential treatment offered by the administration with regard to subsidies, which other mission bodies did not receive. After World War II the administration gave six months’ notice to the LMS of its intention to terminate the existing grant as it was proposing to bring into operation a new uniform schedule of grants to all missions.⁶⁸ The LMS was worried about this change as it would have an adverse effect on its finances.

The issue of the reduction of subsidies needs some brief discussion. It contributed in no small measure to the LMS’s inability to continue running the hospital at a credible and respectable standard. The purpose of the change of agreement regarding mission subsidies from the administration was an attempt to bring uniformity among missions and in line with the government subsidies to missions in former Southern Rhodesia and Basotoland.⁶⁹ The LMS complained that it was disastrous for the administration to bandy about colonial development and welfare and yet it was reducing its grants so drastically towards welfare work that missions had to close down their ventures.

The administration was, however, not persuaded by the argument advanced by the LMS that, as it was, medical treatment for Africans varied in mission hospitals. Kanye and Mochudi charged for hospitalisation but at other *merafe* centres, such as Sekgoma Memorial in Serowe, treatment was available at a minimum fee at dispensaries and hospitalisation was free.⁷⁰ Clearly the need for uniformity was desirable, and if an equitable arrangement was agreed on, the disparities would not arise.

⁶⁵ Ibid, notes on Dr Chargwin’s talk with Dr JM Mackenzie and Reverend AJ Haile, 27 July 1948.

⁶⁶ Ibid, Director of Medical Services to District Commissioner in Serowe, 22 October 1948. Tshekedi wanted to know the position of the LMS if his *merafe* took the hospital over.

⁶⁷ Ibid, AJ. Haile to Tshekedi Khama, 14 March 1949.

⁶⁸ BNARS s 366/2/2, Hospital and Medical Mission Ngwato Reserve at Sefhare: Agreement between the LMS and BP administration; Ufs: Government Secretary, LMS meeting with their representatives to discuss their advance proposals for post-war development, 17 March 1945.

⁶⁹ Ibid, Deputy Director of Medical services to Government Secretary, 29 November 1945.

⁷⁰ Ibid.

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In point of fact, the Kanye and Mochudi hospitals had made protestations concerning subventions made to them by the administration. They complained that the rates of the administration's assistance should be equal. To address the issue, the government issued a memorandum terminating subsidy agreements with all mission hospitals and stipulating that henceforth the subsidies would all be uniform. In the end the LMS had no alternative but to plead with the administration to be given a little more time with the current subsidy so that it could adjust to the change. The plea was acceded to, but only for the 1946/47 financial year.

By 1946 the administration had seriously considered the termination of what it termed "differential treatment" that existed in relation to the LMS's hospital at Sefhare and other missions.⁷¹ The LMS was therefore being asked to adhere to the new model. The enforcement of the agreement in regard to mission subsidies therefore put paid to annual grants that the LMS had hitherto enjoyed from the administration throughout its 10 years of existence.

The LMS and the administration were anxious to put the buildings to some use rather than let them waste away. At one point it was considered that the buildings of the Sefhare Mission Hospital might be turned into a teacher training college.⁷² However, this was found to be not feasible because the idea of a tertiary institution, when Sefhare and its environs did not have even a primary school, appeared to defy logic.

By 1952 the buildings at Sefhare were in a sad state of affairs. At the same time, the Bangwato wriggled out of their earlier promise that they would buy the hospital citing the breakdown of their administration⁷³ as a factor contributing to their inability to do so. The breakdown of administration referred to here was the political crisis following the matter of the Seretse Khama marriage. The "tribal" administration became paralysed and projects and other developments were halted. Be that as it may, the idea of putting the buildings to some good use was consistently pursued. In 1952 the hospital buildings were turned into a primary school.

By 1953 the Bangwato District team had reiterated its earlier position of not buying the hospital but renting it instead. The LMS must have been delighted at this turn of events as it was assured of a monthly income that could not have come at a better time. In 1953 the Sefhare Mission Hospital became the Sefhare Primary School, which still stands there today. Record searches have not been able to ascertain whether the Bangwato or the now Central District council is still paying rent to the LMS, now the United Congregational Church of Southern Africa (UCCSA).

⁷¹ Ibid. Government Secretary to Administrative Secretary of the High Commissioner, Mafikeng, 19 February 1946.

⁷² Ibid, WAW. Clark to RE. Turnbull, 10 July 1962.

⁷³ Ibid.

Conclusion

In an attempt to maintain a sphere of influence, winning converts and competing with other mission bodies in the provision of medical services, the LMS undertook a noble medical venture by establishing the much-needed medical services in needy areas such as Sefhare in the eastern parts of the protectorate among the Batswapong. The LMS also wanted to maintain its credibility as a society that was not only concerned with conversion and literacy, but also wanted to keep pace with the other mission bodies, which had been successful not only with the introduction of literacy and conversion, but also in the establishment of medical services in their areas of operation.

In the venture of establishing the Sefhare Mission Hospital, the LMS was encouraged and indeed buoyed by the protectorate administration through grants and annual subsidies. The mission body itself was not as financially sound as other mission bodies were. It had similar ventures in Kanye and Maun respectively, but both had eventually closed down because of a lack financial capability. It was not surprising, therefore, that its third venture of this nature in Sefhare eventually faced a similar fate.

Once the administration stopped the preferential treatment accorded to the LMS's Sefhare Mission Hospital for purposes of achieving uniformity regarding subsidies for all mission bodies in the country, as was the trend in other countries, the LMS felt piqued by this move because such a policy meant a reduction of the administration's grants and subsidies, which it had enjoyed for 10 years at the exclusion of other mission bodies.

Finally, this article takes the view that the venture, desirable as it was, failed to achieve its intended objective, that of providing sustained medical services among the Batswapong. On the other hand, the venture demonstrated the challenges and rigours faced by mission bodies in their proselytising endeavours.

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