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A Kairos for mental health: Intercultural pastoral theology and transformative action for elderly well-being in Botswana

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Amid contemporary crises of social fragmentation and healthcare inequity, older adults in Botswana endure heightened mental health struggles because of societal isolation, stigma and systemic neglect. This article interrogates how the prophetic urgency and ethical imperatives of the Kairos Document can inform intercultural pastoral theological interventions for elderly mental health. Through a critical literature review, the study analyses cultural perceptions of mental illness and evaluates the role of faith-based initiatives in mitigating stigma and fostering inclusive care networks. Drawing on the Kairos Document's demand for transformative praxis, the proposed framework integrates pastoral care, traditional healing and biomedical services to address spiritual, cultural and structural dimensions of the crisis. By centring Botswana's communal values and the Kairos ethos of contextual solidarity, the research advocates for culturally grounded strategies that bridge theological ethics and public health.

Contribution: This article emphasises the enduring relevance of the Kairos Document in mobilising faith communities towards justice-oriented responses to contemporary societal ruptures, particularly for marginalised elderly populations.

Keywords: Botswana; elderly well-being; intercultural pastoral theology; Kairos Document; mental health stigma.

Introduction

The world's ageing population is facing increasing mental health issues because of the factors like social isolation, long-term illnesses, and a lack of proper care. This problem is even bigger in low-resource areas, where cultural stigmas and poorly organised healthcare systems make things worse (Lima & Ivbijaro 2013). Studies show that a large percentage of older adults in low- and middle-income countries experience depression and loneliness. There is a need for public health actions that prioritise prevention and management of geriatric depression in low- and middle-income countries (Brinda, Rajkumar & Enemark 2016). In Botswana, however, these vulnerabilities intersect uniquely with rapid urbanisation, shifting familial structures, and entrenched beliefs that often attribute mental distress to supernatural causes (Tapera et al. 2020; Onen et al. 2019). Older adults, particularly in rural areas, grapple with scarce access to geriatric mental health services, while ageism and colonial-era healthcare disparities perpetuate cycles of marginalisation (Clausen et al. 2000; Sidandi, Opondo & Tidimane 2011). These compounded factors signal a Kairos moment; a critical juncture demanding urgent, justice-oriented action to address what the Kairos Document (1985) termed a 'moment of truth' in the face of societal rupture.

Building on this context, the study draws on the Kairos Document (1985), which is a theological manifesto born from South Africa's anti-apartheid struggle to reframe Botswana's mental health crisis through a lens of prophetic urgency and transformative praxis. Originally a call to dismantle apartheid's dehumanising systems, the Document's principles of contextual solidarity and disruptive compassion transcend their historical roots. It offers a framework to confront the spiritual, cultural and structural dimensions of elderly neglect. By integrating this ethos with intercultural pastoral theology, which emphasises communal ethics [*botho*] and relational well-being (Lartey 2003), the research bridges Botswana's indigenous healing traditions, faith-based initiatives and biomedical care. This synthesis challenges the hegemony of Eurocentric models, aligning instead with decolonial theories that prioritise epistemic justice and health sovereignty

(Silverman 2005; Link & Phelan 2001). In the context of mental health, Eurocentric models typically emphasise individualism, rationality and a biomedical approach to diagnosis and treatment (Galderisi et al. 2015). Decolonial theories challenge the dominance of Eurocentric models by prioritising epistemic justice and health sovereignty. Epistemic justice addresses the unfairness in how knowledge is valued and who is considered a legitimate knower. In an area of health, communities are to define their own health priorities and practices, free from external control or imposition. Therefore, Western medical models should not be imposed on people, and traditional healing systems should not be undermined. It is important therefore to incorporate indigenous knowledge into research and practice. It is even more important to be particular with centring the voices and experiences of those who have been historically marginalised by colonial systems (Lartey 2002).

It is, however, unfortunate that existing scholarship on elderly mental health in Botswana is still fragmented. While clinical studies highlight healthcare gaps (Olashore, Frank-Hatitchki & Ogunwobi 2017), and anthropological work critiques cultural stigma (Sidandi et al. 2011), few studies integrate theological ethics or explore the potential of faith communities as agents of systemic change (Motsamai & Mhaka–Mutepfa 2022). This oversight perpetuates siloed interventions that neglect the interconnectedness of ageing, spirituality and structural inequity. For instance, faith communities, despite their moral authority and grassroots reach, are rarely mobilised to combat stigma or co-design care models with elders (Brooks et al. 2021). Similarly, traditional healing practices, although culturally resonant, remain marginalised in national health agendas. Such gaps highlight the need for an interdisciplinary framework that centres communal values and prophetic action.

In response, this study addresses a central question: *How can the ethical imperatives of the* Kairos Document *inform an intercultural pastoral theology framework to address mental health stigma and systemic neglect of elderly populations in Botswana?* To unpack this, four sub-questions guide the inquiry: (1) *How do cultural perceptions of ageing and mental illness intersect with structural inequities to perpetuate stigma?* (2) *What role can faith communities play in bridging biomedical, traditional and spiritual care?* (3) *How might the Kairos principles of contextual solidarity reshape pastoral theology to prioritise elderly well-being?* and (4) *What practical strategies integrate botho, traditional healing, and biomedical care into a holistic model?*

Guided by these questions, the research employs a critical literature review and decolonial methodology to synthesise theological ethics, public health and indigenous epistemologies. It argues that the Kairos mandate of 'costly discipleship' (Bonhoeffer 1959), a theologically driven call for radical justice that actively opposes complacency, offers a clear ethical way to respond to the marginalisation of the elderly.

This article further argues that churches, traditional healers and clinics can improve access to mental health services,

especially where it is limited. This can also help rebuild community support for elders that has been weakened as people move to cities. Traditional and faith healers are often more accessible and affordable, especially in low-resource areas. By including them, along with churches, mental healthcare can be decentralised and cultural views on mental health issues can be addressed (Ngamaba, Panagioti & Armitage 2018). For these partnerships to work, they need to be rooted in the community and supported by policies and actions that address social, spiritual and medical needs. In Botswana, for example, the government has a policy of recognising traditional healers and promoting collaboration between them and modern medicine (Sidandi et al. 2011).

The following section deliberates on the background of the study, providing foundational context before diving into specific analyses. The article then analyses cultural narratives that stigmatise ageing and mental illness in Botswana, exposing how these narratives intersect with healthcare inequities. It then examines the transformative potential of faith communities, drawing on case studies where Kairos-informed advocacy has reduced stigma in other African contexts. Ultimately, this article proposes a model of intercultural pastoral care that integrates *botho*, traditional healing practices, and biomedical services. This model promotes systemic changes that honour the dignity of elders. By situating theological ethics within public health discourse, the work contributes to a growing body of African scholarship that reframes ageing as a communal vocation of reciprocity and care, rather than a burden. Echoing the Kairos Document's persistent call, the study emphasises that moments of crisis are opportunities for radical solidarity and participation in the struggle of the poor and oppressed (Kairos Document 1985), particularly Botswana's marginalised elderly people, whose well-being depends on culturally grounded, justice-oriented action.

Background

After the introduction's overview, this section examines Botswana's mental health crisis through the dual lens of global ageing trends and local socio-cultural realities. By anchoring the study's Kairos-driven framework in the intersecting challenges of ageing populations, systemic inequity and the exclusion of traditional knowledge systems, it highlights the urgency of culturally grounded, justice-oriented action. Taking a comprehensive and culturally sensitive approach is key to understanding mental health. Mental health is more than just the absence of mental illness; it is a dynamic equilibrium that encompasses cognitive and social skills, emotional awareness, coping abilities and a harmonious connection between mind and body. It is important to recognise that culture shapes the very definition of mental health (Galderisi et al. 2015). Therefore, it is crucial to recognise that mental health is influenced by emotional, psychological and social factors.

Older people generally refer to individuals in the later stages of life (Lusambili, Nyakundi & Ngaruiya 2023). In Botswana, approximately 5% of the population is aged 60 years and

above (Mhaka–Mutepfa & Shaibu 2022). Individuals aged 65 years and above are typically eligible for a monthly pension (Mhaka–Mutepfa & Shaibu 2022). When considering the definition of 'older people', it is important to look beyond just chronological age. Health, social roles and cultural context all play a significant role (Galderisi et al. 2015).

The world is undergoing an unprecedented demographic transformation, with the population aged 65 and older projected to double by 2050 (Mhaka-Mutepfa & Shaibu 2022). While increased longevity marks a triumph of modern medicine, it also unveils a paradox: older adults, particularly in low- and middle-income countries, face heightened risks of depression, anxiety and social isolation. These conditions are worsened by societal ageism and inadequate healthcare (WHO 2022). Globally, 15% of older adults experience mental health disorders, yet fewer than 10% receive treatment, a disparity starkly pronounced in sub-Saharan Africa (UN 2020).

Botswana exemplifies this paradox. Although known for its economic stability and progressive social policies, the nation struggles to reconcile its rapid demographic transition with systemic inequities. By 2050, nearly 20% of Batswana will be over 65 years, a surge driven by rising life expectancy (70 years) and declining fertility (UN 2020). However, this demographic shift has outpaced socio-economic development more so that 91% of elderly Batswana live below the poverty line, surviving on monthly pensions of BWP 1400, while rural communities face acute shortages of geriatric care (BIDPA 2023; Brooks et al. 2021).

Botswana's mental health challenges are made more complex by cultural beliefs that create stigma around ageing and illness. While older people were traditionally respected for their wisdom, this has changed because of urbanisation and Western influence, which have weakened family connections between generations (Ngwenya et al. 2020). Mental health problems are sometimes blamed on supernatural forces or unhappy ancestors, leading people to seek help from traditional healers [*dingaka*] rather than doctors (Sidandi et al. 2011). Meanwhile, clinicians often dismiss symptoms of mental health as 'problems of old age', reflecting a systemic bias that pathologises ageing itself (Motsamai & Mhaka-Mutepfa 2022). Those symptoms include, but are not limited to, loss of bladder control and memory impairment.

These cultural tensions are compounded by colonial-era healthcare hierarchies that sideline indigenous knowledge. Apart from cultural tensions, Botswana's mental health system, governed by the outdated *Mental Disorders Act of 1969*, distributes less than 2% of its health budget to psychiatric care, with only 0.29 psychiatrists per 100 000 people (WHO 2022). Rural areas, home to 40% of the elderly, lack specialised services, forcing families to travel hours to clinics or rely on understaffed facilities (Olashore et al. 2017). Moreover, this systemic neglect perpetuates what decolonial scholars term *epistemicide* – the erasure of traditional healing practices, despite their cultural resonance and historical efficacy (Santos 2014).

Botswana's faith communities and traditional healing systems appear as underutilised, yet culturally resonant resources. Churches and mosques, which serve as moral and social anchors for 80% of Batswana (Madigele, Moeti & Moeti 2024), have historically bridged spiritual and practical needs: a role mirrored in global contexts where religious institutions pioneered mental healthcare (Koenig, McCullough & Larson 2001; Moreira-Almeida, Neto & Koenig 2006). Similarly, traditional healers [*dingaka*], trusted by 70% of rural populations, employ holistic practices that align with the Tswana philosophy of *botho* [relational personhood], addressing spiritual, communal and physiological dimensions of distress (Msimanga & Mberengwa 2015). Yet policymakers and clinicians often dismiss these systems, reflecting a broader epistemic clash between modernity and tradition.

This confluence of ageing demographics, cultural stigma and structural neglect creates a Kairos moment, a critical juncture demanding transformative praxis. The Kairos Document's call for 'contextual solidarity' and prophetic action against dehumanising systems resonates profoundly here. For Botswana, this means rejecting colonial binaries and forging an intercultural pastoral theology that harmonises *botho*, biomedical care, and indigenous healing. Such a framework not only addresses immediate mental health needs but also reclaims ageing as a communal vocation – one where elders are honoured as living libraries of cultural wisdom, and their well-being becomes a sacred collective responsibility. The article now turns to an in-depth analysis of cultural narratives stigmatising ageing and mental illness, interrogating how these narratives intersect with systemic failures to marginalise elderly populations.

Cultural narratives stigmatising ageing and mental illness

The mental health crisis among Botswana's elderly people, as mentioned in the background, is deeply entangled with cultural narratives and structural inequities that shape societal attitudes towards ageing and illness. This section directly engages Research Question 1 (*How do cultural perceptions intersect with structural inequities to perpetuate stigma?*) by dissecting how shifting traditions, colonial legacies and systemic neglect converge to marginalise elders.

The first narrative to explore is the 'burden' narrative. In Botswana, traditional norms emphasise the importance of productivity and contribution to the family. Historically, elders played vital roles in caregiving, household chores, and as reservoirs of wisdom. They often cared for grandchildren, shared their knowledge of traditional practices, and provided guidance to younger family members. However, as elders age and potentially become dependent on their families for care, they are sometimes perceived as a burden (Ingstad 2004; Onen et al. 2019), especially if they are also experiencing mental health challenges. This shift can create tension, as the traditional reciprocal relationship between generations is disrupted. This is further complicated by modern definitions

of mental health that emphasise productivity. While some definitions of mental health consider internal equilibrium and the ability to use one's abilities in harmony with society, there are limitations. For example, if an individual is unable to work productively, they may not be considered in good mental health under such a definition (Galderisi et al. 2015). This framework, however, can inadvertently exclude those unable to work because of age or physical condition. Therefore, it is important to recognise that elders can still offer valuable contributions to their families and communities, even if they are no longer able to engage in traditional forms of labour; their wisdom, experience and presence remain invaluable.

The second narrative worth exploring is the 'witchcraft' or 'spiritual affliction' narrative. Mental illness is indeed compounded by marginalisation, often stigmatised not as a medical condition but as a moral failing, spiritual affliction or ancestral punishment (Mhaka-Mutepfa & Shaib 2022; Sidandi et al. 2011). Mental health challenges are attributed to supernatural forces rather than biological or psychological factors. Younger generations, influenced by globalised norms, increasingly dismiss traditional frameworks as archaic, widening generational divides. This dismissal contributes to the erasure of indigenous knowledge systems. In Botswana, witchcraft is endorsed as a predominant causal belief, in addition to drug abuse and effects of human immunodeficiency virus (HIV). This can result in people with mental illness being stereotyped as dangerous, untrustworthy and cognitively impaired. This, in turn, can lead to discrimination in employment, relationships and sexual interactions, increasing their vulnerability to HIV (Becker, Ho-Foster & Yang 2019).

Moreover, in many African contexts, including Botswana, misfortune, illness, and even death can be attributed to witchcraft or spiritual affliction (Manala 2004).

Accusations of witchcraft can, however, lead to social isolation, stigma and even violence against the accused elder. This further diminishes their social standing and reinforces the perception of them as a burden on the family and community. If mental illness is perceived because of spiritual causes, the affected individual may be ostracised from the community for fear of contagion or spiritual impurity. If elders are accused of witchcraft, their property can be confiscated, and they can be assaulted or even burnt (Kotzé 2018). This can lead families to seek help from traditional healers or religious figures to address the perceived spiritual affliction, potentially foregoing practices supported by medical and psychological evidence, and thus prolonging the elder's suffering.

Furthermore, witchcraft accusations can severely damage intergenerational relationships, leading to mistrust, fear and resentment. This can further isolate the elder and undermine the traditional support systems that are crucial for their well-being. The imposition of Western biomedical models of mental health can overshadow and devalue traditional healing practices and understandings of mental well-being. When traditional knowledge is dismissed or suppressed, it can lead to a loss of cultural identity and a sense of alienation, particularly for elders who hold this knowledge. Furthermore, it can create barriers to accessing culturally proper mental health care, as individuals may be hesitant to seek help from Western-trained professionals who do not understand or respect their beliefs (Becker et al. 2019).

The third narrative popular in the country is the 'shame' and 'secrecy' narrative. Mental illness is often seen as a source of shame for the family, leading to secrecy and concealment. Families are normally reluctant to discuss the issue openly or seek help for fear of social stigma. Shame and secrecy are often attributed to a lack of awareness and understanding of mental illness (Evans–Lacko, Baum & Danis 2011). There is a general lack of knowledge and awareness, which leaves people with no choice but to rely on stereotypes and misconceptions, which further perpetuate negative attitudes. Meanwhile, there are structural factors which lead people to popularise the 'shame' or 'secrecy' narrative. Negative historical views of mental illness in Botswana (Pheko et al. 2013) manifest in several ways. For instance, mental health is often given low priority compared to other health concerns (Olashore et al. 2017; Opondo et al. 2020). One study found that mental health receives an exceedingly small part of the overall healthcare budget in Botswana (Olashore et al. 2017).

Botswana's healthcare system, still structured like colonial-era systems, focuses on immediate and infectious diseases, often neglecting the mental health needs of the elderly (Clausen et al. 2000). Specialised services are scarce in rural areas, where over 40% of elders live, forcing families to travel far or rely on inadequate local clinics (Brooks et al. 2021). Even when elders do access care, ageism often leads to their concerns being dismissed as 'just old age problems'. This systemic neglect is rooted in outdated policies like the *Mental Disorders Act of 1969*. The *Mental Disorders Act of 1969*, while intended to provide care, has been criticised for being mainly procedural and not adequately protecting the rights of individuals with mental disorders (Maphisa 2018). The system overlooks the potential contributions of traditional healers [*dingaka*] (Maphorisa, Poggenpoel & Myburgh 2002) who have historically played a role in mental healthcare within the community. The current system is not set up to provide fair and effective mental healthcare for all, especially elders, because of outdated laws, limited resources and a failure to integrate traditional approaches.

The fourth narrative is the 'irreversibility' narrative. Mental illness is sometimes viewed as a chronic, irreversible condition (Becker et al. 2019). This perception normally leads to a sense of hopelessness and a reluctance to invest in treatment or care. If people believe that mental illness cannot be improved, they may be less likely to seek help or adhere to treatment. Families and communities may be less willing to invest resources in the care and support of individuals with mental illness if they believe that recovery is impossible (Pheko et al. 2013). Becker et al. (2019) highlight that some

respondents describe mental illness as occurring 'when the trees blossom', highlighting a conceptualisation of it as seasonal, chronic, and often incurable and as worse than HIV. This understanding perceives mental health as long-term, persistent condition. This perspective highlights the importance of addressing these negative beliefs and promoting more hopeful and correct understandings of mental health and recovery.

Having dissected the cultural and structural forces perpetuating Botswana's mental health crisis, the analysis now turns to the transformative potential of the Kairos Document and intercultural pastoral theology.

The Kairos Document and intercultural pastoral theology

Born in the crucible of apartheid South Africa, the Kairos Document (1985) is not merely a theological text, but a thunderous cry for justice. It is a manifesto that dared to unmask the heresy of neutrality in the face of systemic oppression. Its authors, a collective of theologians and activists, rejected the hollow piety of 'church theology' that preached reconciliation without justice, and the brutal pragmatism of 'state theology' that sanctified tyranny. Instead, they proclaimed a third way, *prophetic theology*, rooted in what they termed the *Kairos* – a Greek concept denoting a decisive, God-ordained moment demanding urgent moral action. 'The time has come', they declared. 'The moment of truth has arrived'.

This ethos transcends its historical moment. The Kairos Document's searing critique of power, its insistence that faith must 'take sides' with the marginalised, resonate with piercing relevance in Botswana's mental health crisis. Just as apartheid reduced black South Africans to disposable bodies, Botswana's elderly people endure a quieter violence: their pain made invisible by cultural stigma, and their dignity eroded by healthcare systems that privilege biomedical hegemony over indigenous wisdom. The Document's condemnation of 'cheap reconciliation' challenges us to reject superficial solutions such as tokenistic policy reforms or half-hearted interfaith dialogues and instead embrace disruptive compassion: a praxis that dismantles oppressive systems while co-creating alternatives grounded in the lived realities of the oppressed.

At its core, the Kairos Document is a theology of embodiment. It refuses to spiritualise suffering or outsource justice to abstract eschatology. 'God does not want his people to suffer', it insists, condemning apartheid as 'a sin, and a heresy'. Similarly, Botswana's elders are not called to passively endure stigma or poverty as 'God's will', but to demand systems that honour their intrinsic worth. The Document's call for contextual solidarity, action shaped by local histories and epistemologies, aligns seamlessly with Tswana ethics of *botho*, where personhood is realised through reciprocal care. This demands more than clinical interventions; it requires a pastoral theology that sees mental health as inseparable from spiritual wholeness, communal belonging and economic justice.

Critically, the Kairos Document challenges faith communities to move beyond charity to liberative praxis. In apartheid South Africa, this meant boycotts, civil disobedience and underground networks of care. In Botswana, it might manifest as churches partnering with *dingaka* [traditional healers] to destigmatise mental illness, or mosques lobbying to revise the *Mental Disorders Act of 1969*. The Document's rejection of 'neutrality' is particularly salient here: to still be silent as elders are marginalised by ageism and epistemicide is to become complicit in their oppression. Yet the Kairos Document is not a relic of the past but a living text, its radicalism rekindled in movements for health equity and decolonial justice. Its vision of prophetic imagination envisions a world where ageing is revered, care is collective, and healing is holistic. It offers Botswana a path forward. To heed its call is to recognise that the crisis facing elders is not merely a healthcare failure but a moral emergency demanding theological courage. As the Document implores: 'We cannot remain silent. We cannot remain idle. The Kairos will not wait'.

In this spirit, the study now turns to intercultural pastoral theology, a framework that amplifies the Kairos mandate by bridging Tswana wisdom, prophetic action and biomedical care. For Botswana's elders, this synthesis is not optional; it is the lifeline that transforms survival into sacred vocation. In *In Living Color: An Intercultural Approach to Pastoral Care and Counselling* (2003), Lartey dismantles the myth of a 'universal' pastoral theology, critiquing Western-centric models that pathologise non-European ways of knowing. Drawing on postcolonial theory, he argues that effective care requires epistemic humility which is a willingness to decentre dominant frameworks and engage with local cosmologies (Lartey 2003:47). For example, he contrasts the Western emphasis on individual autonomy with the African ethic of *Ubuntu* ('I am because we are'), showing how communal relationality can reshape therapeutic goals (Lartey 2003:89). This aligns with his critique of 'clinical pastoral education' (CPE) models, which he views as complicit in colonial legacies by privileging biomedical individualism over communal healing rituals (Lartey 2006).

Emmanuel Lartey's vision of intercultural pastoral theology therefore is more than just an academic concept. It is a call to dismantle old, colonial ways of thinking about care, particularly in how it separates the spiritual, physical, ancestral, communal and individual aspects of a person. He pushes beyond simply being 'sensitive' to other cultures, advocating for a dynamic exchange between diverse ways of understanding the world. This is particularly relevant in places like Botswana, where respecting the wisdom of elders and traditional practices is essential. In Botswana, Lartey's framework calls for embedding *botho*, the Setswana ethic of relational personhood, into mental healthcare. This approach, aligned with the Kairos mandate, decolonises mental healthcare by dismantling hierarchies that privilege Eurocentric approaches over Tswana cosmologies (Maluleke 2020).

Lartey's intercultural hermeneutics (Lartey 2006:112) guides caregivers to understand suffering through local histories of oppression and to co-create solutions with communities, avoiding the imposition of external 'best practices'.

This intercultural hermeneutics involves prioritising marginalised voices, including the recognition of indigenous spiritualities often dismissed in mainstream approaches. For instance, Lartey highlights that Akan rituals for ancestral reconciliation (*Nnoboa*) in Ghana can offer therapeutic benefits for collective trauma, an aspect sometimes overlooked or underemphasised in conventional Western psychotherapy (eds. Mucherera & Lartey 2017). Aligning with Frantz Fanon's critique of colonial psychiatry, Lartey's work contributes to a broader anti-colonial discourse. He critiques 'theological imperialism', the neglect of African spiritual resources (Lartey 2013).

He argues that practices like communal lament, ancestor veneration and oral storytelling have untapped therapeutic potential. The Ga people's *Homowo* festival, a ritual mourning period that encourages communal catharsis, shows how African traditions normalise grief as a collective, spiritually integrated process, which is different from Western models that often isolate bereavement (eds. Mucherera & Lartey 2017).

Lartey also rejects superficial 'multiculturalism'. Instead, he advocates for 'dialogical solidarity', a deep engagement where different worldviews mutually transform each other (Lartey 2013). This requires caregivers to engage in critical self-reflection on their cultural biases, share power in therapeutic relationships by, for example, inviting traditional healers as co-facilitators and advocate against systemic inequities that disproportionately harm marginalised communities.

A Kairos moment for justice

Botswana's mental health crisis among elders is not merely a healthcare failure, but a moral and theological emergency. In Botswana, where ageing populations face cultural stigma, structural neglect and epistemic injustice, this framework compels a radical reorientation of care. Intercultural pastoral theology, as advanced by Lartey (2003), amplifies this call, insisting that healing must emerge from dialogue between Tswana wisdom and global insights. Together, these frameworks expose the colonial roots of Botswana's crisis and chart a path towards emancipatory care. Ageist narratives that reduce suffering to 'problems of old age' mirror apartheid's dehumanising logic. Lartey's intercultural theology challenges this stigma through dialogical solidarity, urging caregivers to centre elders' lived experiences. For instance, when a *ngaka* [traditional healer] attributes depression to ancestral displeasure, she articulates a holistic epistemology that biomedical models often ignore (Sidandi et al. 2011). By validating such narratives, intercultural theology disrupts the epistemicide Santos (2014) warns against, reclaiming Tswana cosmology as a resource for healing.

Botswana's healthcare system, governed by the colonial-era *Mental Disorders Act of 1969*, perpetuates what the Kairos Document terms 'neutrality in the face of injustice'. Allocating less than 2% of health funding to mental health (WHO 2022), it enacts 'biomedical theology', a hierarchy privileging Western epistemologies over indigenous practices like *dingaka* healing. Lartey's *intercultural hermeneutics* (2006) reframes this neglect as a site of decolonial struggle. His methodology, which involves contextualising suffering within colonial histories, co-creating solutions with local communities, and centring the voices of the marginalised, directly calls for policy reforms. For instance, formally recognising *dingaka* [traditional healers] as licensed healthcare providers (Baloyi & Olehile 2021) would not only affirm Tswana epistemologies but also address persistent rural healthcare gaps. Building on this, the Kairos Document's call for 'prophetic praxis' finds tangible expression in Botswana's faith communities, which are uniquely placed to bridge the divide between spiritual and clinical care, given that they are trusted by over 80% of Batswana (Pew Research Centre 2015). The success of the Molepolole collaboration, where Lutheran pastors partnered with *dingaka* to address *boswagadi* [bereavement distress], leading to a 40% increase in clinic attendance and reduced stigma (Mogobe, Tshiamo & Bowelo 2007), further demonstrates the potential of such partnerships. This resonates with Lartey's analysis of Ghanaian *Nnoboa* rituals, highlighting how culturally rooted practices can transform trauma care. Ultimately, these intercultural partnerships embody *botho*, the Tswana ethic of relational personhood, and enact the Kairos mandate to 'side with the oppressed' through concrete, justice-oriented action.

Towards a decolonial future

Botswana is at a turning point, with an opportunity to move beyond colonial divisions and embrace a vision of care that embodies justice. This involves recognising local values, beliefs and traditions when addressing mental health issues. Community-based care, emphasising citizen involvement and collaboration, is essential (Seloilwe & Thupayagale–Tshweneagae 2007). To address the root causes of mental health problems, it is crucial to acknowledge and tackle systemic issues like family problems, stigma and cultural beliefs. Integrating traditional healing practices with modern medicine, recognising the potential benefits of traditional approaches, is also important (Sidandi et al. 2011). Particular attention should be paid to the mental health needs of older adults in Botswana, considering the unique challenges they face. More research is needed on mental health in the geriatric population (Motsamai & Mhaka–Mutepfa 2022).

Policy revolution requires action, entailing the implementation of mandatory geriatric training for healthcare professionals, funding partnerships with traditional healers [*dingaka*] and revising the outdated *Mental Disorders Act*. It also requires communal reckoning. This entails restoring elders to their respected positions in community leadership and public discussions. Action must also facilitate epistemic justice. To achieve such, clinicians will be trained in understanding

diverse cultures, fostering respect for Tswana beliefs. It is time to move beyond passive compassion and actively create a future where healing is collective, care is decolonial, and ageing is revered as a communal blessing.

Conclusion

The mental health crisis among Botswana's elderly people highlights a global issue: longer lifespans are not always met with adequate care and respect. While Tswana culture traditionally honoured elders, urbanisation and Western healthcare systems now often reduce ageing to a list of problems. This is made worse by underfunded mental health services and a lack of recognition for traditional healers. Faith communities in Botswana can play a key role in addressing these challenges. Rooted in the culture, churches and mosques can connect modern healthcare, traditional wisdom and spiritual comfort. By embracing the Tswana value of *botho* [relational personhood], these partnerships can challenge negative views of ageing and push for changes like recognising traditional healers and fighting the financial exploitation of older women. Inspired by the Kairos Document's call to support the oppressed, faith leaders can transform pastoral care into a force for justice. This means challenging the dominance of Western medicine, giving elders a voice in their own care, and seeing ageing as a sacred calling. Practical steps include changing outdated policies, incorporating traditional rituals into grief support and using religious networks to advocate for fair pensions. Botswana's experience offers a lesson for the world: honouring elders is a moral duty, not just a financial one. We must listen to ancestral stories, advocate for justice and recognise that a society is judged by how it treats its oldest members. By weaving *botho* into global health, we can answer the call for dignity with compassion, creativity and love, fulfilling our shared responsibility to care for one another.

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Tshenolo J. Madigele: Conceptualisation; Methodology; Investigation; Formal analysis; Resources; Data curation; Supervision; Writing - original draft; Writing, review & editing; Validation; Project administration. The author confirms that this work is entirely their own, has reviewed the article, approved the final version for submission and publication, and takes full responsibility for the integrity of its findings.

Ethical considerations

This article followed all ethical standards for research without direct contact with human or animal subjects.

Data availability

The author declares that all data that support this research article and findings are available in the article and its references.

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