



The changing landscape of mission medicine and hospitals in Sub-Saharan Africa

Samuel Adu-Gyamfi^a, Mariama Marciana Kuusaana^b, Benjamin Dompseh Darkwa^c, Lucky Tomdi^d

^a PhD, Senior Lecturer, Department of History and Political Studies, Kwame Nkrumah University of Science and Technology, Ghana

^b PhD, Lecturer, Department of History and Political Studies, Kwame Nkrumah University of Science and Technology, Ghana

^c MPhil(c) and Teaching Assistant, Department of History and Political Studies, Kwame Nkrumah University of Science and Technology, Ghana

^d MA(c) and Teaching Assistant, Department of History, University of New Brunswick, Canada

Abstract

Missions have played numerous developmental roles towards the achievement of economic and social advancement including the provision of healthcare. From their entry into Africa, they have employed numerous methods in order to introduce their Christian faith. The construction of schools and hospitals, engagement in public health campaigns, provision of relevant services for the poor, and spearheading the provision of formal education, among others, have been the most effective mechanisms. The activities of missionaries have taken different dimensions as their scope continues to change over time. Nevertheless, existing literature shows little data on the changing landscape of mission medicine and hospitals in Africa. Using a systematic literature review approach, the current study discusses the changing landscape of mission medicine and hospitals in Sub-Saharan Africa. This contribution dwells partly on the missionary theory of medical practice to define most of the services of these faith-based organization (FBOs) in Africa. Findings from the study have revealed that mission hospitals have established schools and training schemes that allow them to train medical personnel to complement the limited number of health personnel on the continent. In the twenty-first century, they have contributed to achieving the targets of the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs), especially aspects that focus on health. It is evident that while the focus, methods, and partnerships have changed, missions in healthcare have not diverted their attention from sharing the gospel of Jesus Christ.

Key words: Changing Landscape, Christian, mission, medicine, Africa, hospitals



Introduction

The humanitarian activities of missionaries over the years cannot be gainsaid. Throughout history, they have played significant developmental roles without necessarily shifting from their main goal of evangelizing lost souls. From exploration to medical care, missionaries like David Livingstone and Cardinal Charles Lavigerie, among others, have played significant roles in Africa to open up the interior and the people for the spread of the Christian gospel.¹

Missionary groups employed numerous mechanisms to make disciples. They constructed schools and hospitals, engaged in public health campaigns, provided charity for the poor, and contributed cheaper social welfare programmes as their most effective tools.^{2,3} The establishment of hospitals and dispensaries stood as the most effective soul-winning mechanism for many Christian missions.^{4,5,6} Their public health role has been crucial in incorporating the principles of biomedicine as a viable option in African pluralistic medical tradition. Since the colonial era, medical missions have been active in most former colonies.⁷ Among the motivations for engaging in the act of healing are spreading the gospel, making healthcare more accessible, and providing holistic care.^{7,8}

Missionary medicine and its role in Africa does not involve the treatment of physical ailments alone.⁹ Aside from that, missionaries have promoted and provided hope and encouragement for the sick.⁷ Also, medical missionaries have provided what Hardiman termed as an “all-round therapy” intended to civilize the so-called “primitive people,” getting them closer to Christian modernity.^{9,10} Thus, Christian missions resorted to treating both the physical problem of diseases and the spiritual problem of sin.⁸

The African belief in the social causative theory, which regards diseases as the actions of demons or as a result of a misdemeanor, has resulted in the acceptance of missionary medicine and its continuous utilization.^{11,12} Also, missionaries’ medicine has thrived in Africa due to their

intervention given to the poor and needy.⁸ The above, coupled with social changes in African societies, have informed various indigenes to embrace Christianity.¹³ Significantly, Christian missionaries have used Christianity as an alternative system of belief to meet both physical and spiritual needs for the sick and healthy.^{9,10,13} Their approach, however, has been described to be mostly curative. In the case of Uganda, Doyle is of the view that, at their inception, missionaries used diseases and their positive rush-in to offer counselling and support as bases to win converts for Christ.^{8,14}

Regardless of the above, medical missions are mostly regarded as the pioneers—and, in the early days, the only sources—of biomedicine in most areas of Africa, particularly in the rural centers.¹⁵ Also, since the colonial era, missionaries have made attempts, in collaboration with states, to bridge the healthcare gap between the rich and the poor.⁸ In effect, in Africa, missionaries’ strategies have, among other things, aimed at addressing the inadequacy of the state provision of healthcare.¹⁵

A survey of key literature on mission medicine has revealed that the major areas of interest for medical missions included treating diseases tagged as unclean among Africans: Hanson’s disease (leprosy) and blindness, among others. They also paid attention to maternal and child health as well as public health and hygiene. In colonial Tanganyika, medical missions provided vaccination campaigns, education for new mothers on hygiene, cleanliness, and the care for babies in addition to conducting research on sleeping sickness.⁴

Some scholars associate missionary medicine with the colonial state and activities arising within the same period.¹⁴ Other literature shows the various roles and motives of medical missions in Africa and other parts of the world. That notwithstanding, literature on the changing landscape of mission hospitals remains scant. There exist some data on current mission medicine and hospitals.^{16,17,18,19,20} Nevertheless, the literature has not been directed toward the changing landscape of missions and their contribution toward the attainment of Sustainable

Development Goals (SDGs) and Millennium Development Goals (MDGs), particularly, in the area of health. It is, therefore, imperative to re-examine missions' changing contributions toward health delivery in Africa.

Theoretical Underpinnings of Missionary Medicine

Theoretically, there is no monolithic approach to explain and understand the activities of Christian missions. Many scholars have propounded varied theoretical assumptions to define the activities of Christian medical missions. Nevertheless, the current discourse finds the missionary theory of praxis a best fit, which holds that missions engage in medical interventions as the examples of Christ in the Bible.^{5,21} Christian missions have always found it a necessary responsibility to inform people about the gospel before judgement day; Christians hold the belief that Christ would not return until the gospel reaches all people.²² In Africa, Christian missions resorted to employ strategies that would draw indigenous Africans and prepare them for heaven.^{15, 22} One of the major strategies employed was the provision of medical care. Theoreticians of mission medicine believe that missionaries, at inception, defined healthcare provision as part of Christianity and a responsibility of Christians arising from the Bible.²³ References to Jesus' holistic healing and caring for the sick, as evidenced in Matthew 25 and in the parable of the Good Samaritan (Luke 10:25–34),²¹ forms the underlying ethical rationale for their medical activities.⁵

The theory reckons that Christian missionaries have used teaching and healing, as Jesus Christ did, as a major prerequisite to spreading God's love.²¹ To a larger extent, the theory of missionary praxis emphasizes the welfare of children. The child is used as iconography, against which missionaries provide medical care for the child and the mother.²⁴ In Africa, it was evident, in the early days, of missions as the central place of children and their

mothers in Christian rhetoric manifested in the provision of maternal and child care.⁴

Within the theoretical framework, sin and suffering are intertwined.²⁵ African physical suffering, thus, reflected the sickness of their soul.^{5,25} Every sufferer was, therefore, regarded a sinner whose soul needed to be saved while being relieved from physical pains. This alludes to proponents' views on disease as misery and, hence, craving for missionary medicine.⁴ It can be suggested that medical missionaries used the above assumptions as justification for their commitment to healthcare. This, to a larger extent, is used as a premise by some scholars to argue that missionaries mostly used medicine to win converts.^{4,8} Following this view, a study on Uganda argues that the quality of care could be limited by the decision to attain the maximum number of potential converts.⁸ As a strategy, some medical missions were likely to focus mostly on "where most converts could be won," and not necessarily where medical provision was in dire need.⁴ Since their inception in Africa, the activities of Christian missions in the area of healthcare have undergone significant changes over time. As a result, this study contributes to the discourse on mission medicine by discussing the continuities and changes in medical missionary praxis.

The current study attends to Christian medical practice as missionaries' means of attaining a social intercourse with local people over time. Essentially, in this discourse, we regard missionary theory of medical praxis as an effective therapy for both sin and physical suffering and a means of acquiring recognition among the local people.

Materials and Methods

We conducted a systematic literature review in various journals, books, and databases related to missionary medicine and their roles as well as the changing landscape in Africa and other developing economies. Also, references of these studies were reviewed to identify other studies worthy of contact.

We used Google Scholar to search for data following these themes and keywords: such as “Mission Medicine,” “Mission hospitals,” “changing roles of mission hospitals,” “services of mission hospital,” “theory of mission medicine,” “ownership of mission hospitals,” “mission hospitals and SDGs and MDGs,” and “missions and state collaborations.” PubMed, Elsevier, Jstor, Brill, ScienceDirect, Wiley, and Emerald Insight were other databases that were utilized. Key words searched included “Africa.” Materials published in English that discuss missionary medicine were chosen. Manual search was performed in books such as Hardiman (2008),⁹ Twumasi (1975),²⁶ Good (2004),²⁵ and Karanja (2009),²⁷ among others. Also, data was taken manually from relevant journals.

We determined the praxes of missionaries and their roles in the delivery of healthcare as well as the

continuities and changes of their activities over the years. Information was analyzed thematically. We focused on missionary medicine and practice, ownership of mission hospitals, the kind of diseases treated, and changes in missionary medical activities and their activities which supported states to reach the MDGs and SDGs.

Results

We reviewed over 70 sources concerning the changing roles and other points of interests of mission hospitals in Africa. Our focus was on missionary activities since the era of their inception to contemporary times. For a fair representation of Africa, the materials are categorized under regional distributions of the continent. Table (1) below shows our findings from the literature and areas covered.

Table 1. Findings

THEME	RELEVANT MATERIALS	REGIONS COVERED
Theories of Mission Medicine	Vaughan, 1991; Hardiman, 2006; Doyle, 2015; Choi, 2017; Good, 2004; Jennings, 2006.	Tanzania, Asia, Africa
The Mission of Mission Hospitals	Spencer, 2016; Doyle, 2015; Karanja, 2009; Bhebhe, 2009; Mudzanire, 2017; Dirar, 2006; Calvi and Mantovanelli, 2019; Wilkinson, 1991; Adu-Gyamfi and Oware, 2018.	Zimbabwe, Tanzania, Kenya, Eritrea, Ghana
Services Provided by Mission Hospitals in Africa	Hokkanen, 2006; Covey, 2001; Ferngren, 1992; Wilkinson, 1991; Spencer, 2016; Addai, 1997; Doyle, 2015; McKay, 2007; Hardiman, 2006; Mohr, 2009; SNIS, 2010; Adu-Gyamfi and Marfo, 2018; Jennings, 2008.	South Africa, Ghana, Tanzania, Africa, Worldwide.
Changing Landscape of Mission Hospital	SNIS, 2010; Grundmann, 2008; Morgan, 2013; Olakanmi and Perry, 2006; Mudzanire, 2017; Fralick et al., 2019.	Tanzania, Ghana, South Africa, Togo, Zimbabwe
Staffing of Mission Hospitals	Green et al., 2002, Olakanmi and Perry, 2006; Forrest 2009; Wong, 2006; Kumwenda, 2006; Gilla and Carlough, 2008, McLennan, 2014; Katelyn, 2019; Kotzee and Couper, 2006; Vasanthakumar, 2006; Boulenger and Criel, 2012.	Zambia, South Africa, Sub-Saharan Africa, Africa, Cameroun.
Sources of Income for Mission Hospitals	Wood, 1991; Doyle, 2015; Wood, 2001; Green et al., 2002, Adu-Gyamfi 2019	Ghana, Rwanda, Sub-Saharan Africa, South Africa, Tanzania
Shift from the Emphasis on Sin	Delkeskamp-Hayes, 2006; Doyle, 2015; Hardiman, 2006; Fursdon, 2003; Dobbelaere, 1979; Morhee and Morhee, 2006; Henshaw et al., 2008.	Kenya, Ghana, Nigeria, Belgium, Africa, Asia
Extension of Services	Wood, 2001; Jehu-Appiah et al., 2014; Adu-Gyamfi and Oware, 2018; Loewenberg, 2009; Vaughan, 1991; Fursdon, 2003; Schmid et al., 2008; Mike and Makombe, 2018.	Ghana, Kenya, Zambia, Malawi, Zimbabwe, Africa, Worldwide
Change in Ownership of Mission Hospitals	Green et al., 2002; SNIS, 2010; Wong, 2006; Wood, 2001; Doyle, 2015	South Africa, Tanzania, Ghana, Liberia
State and Mission Hospitals	Schmid et al., 2008; SNIS, 2010; Loewenberg, 2006; Jennings, 2006; Doyle, 2015; Schneppen, 2000; Mike and Makombe, 2008; Prill, 2012, Boulenger and Criel, 2012, Anderson, 2017.	Ghana, Tanzania, South Africa, Nigeria, Zimbabwe, Namibia, Africa, Uganda, Chad, Cameroun, Madagascar, Liberia
Mission Hospitals and SDGs	Mike and Makombe, 2008; Grundmann, 2008; Munson, 2012; Omorogbe et al., 2012, Forrest, 2009; Gilla and Carlough, 2008; Johanson and Claypool, 2018; Calvi and Mantovanelli, 2019; Bath, 2018; Sharkey, 2002; Anderson, 2017.	Ghana, Tanzania, South Africa, Nigeria, Zimbabwe, Namibia, Africa. Guatemala, Northern Sudan, Madagascar

Discussion

The mission of missionary medicine

Aside from healing, missions have used various strategies to accomplish their goal of introducing Christ to Africa. Initially, they established contacts with the people to build

relationship before introducing them to Christianity. It has been reported that missionaries first established contacts by visiting and teaching children and women Bible stories and lessons.²⁸ Why women? Women and children were the most vulnerable group and were more likely to be



receptive to the initial stages of missionary activities. Vulnerability in this context does not necessarily reflect their propensity to receive the gospel; we use vulnerability to reflect conditions faced by women in an era of war, disease outbreak, and famine among other calamities.²⁹ Nevertheless, the teaching of women and children proved inadequate at this stage. Consequently, missionaries considered different approaches in fulfilling their goals which included the use of education and medicine.^{8,25}

The use of medicine was intended to draw people into medical centers where the gospel was shared.²⁷ In Zimbabwe, scholars reckoned that mission medicine was used as a bait to draw people to hospitals and medical centers to be evangelized.^{30,31} Curing diseases, therefore, was instrumental in acquiring new converts among the sick and their families.³² Though the use of women and children as first contacts proved inadequate, in some cases, for Christian outreach, it is noteworthy that the child as a symbol of helplessness and vulnerability prompted missions to regularly direct their attention toward children. A majority of missionary medicine focused on maternal and child health. The African Inland Mission (AIM) in colonial Tanganyika, for instance, put up a maternity home at Kola Ndoto to educate and provide “western” birth procedures and preventive and curative medicine for the sick.⁴ After independence, mission antenatal clinics in Tanganyika were twice the number of those constructed by the government.⁴ This enhanced missionaries’ contribution to maternal care.

Also, missionaries sometimes resorted to waiving or reducing fees for the vulnerable, needy, and the poor.⁸ For example, in 2003, Fursdon reported that in Kenya, mission hospitals had through time mainly targeted the poor, orphans, and widows within the community who were confronted with healthcare challenges.⁷ In Uganda, too, it was reported that missionaries, in their early years, reduced and waived most of their healthcare costs based on patients’ economic status.⁸ This was

partially attributed to a compassionate view of diseases as misery on one hand and the consideration of the poor as amenable to conversion. Since people generally want to avoid and remove sickness when it occurs, the sick have always created an audience for the word of God, hence intensifying missionaries’ goal of leading new souls to the house of God.^{4,33}

Scholars have argued that the quality of care, in some instances, was proportional to what was needed to reach the maximum number of potential converts.^{7,8} Specifically, Doyle (2015) reports that missionaries in Uganda provided second-grade services for Africans who were seen not to be prospective converts.⁸ The new Christian converts in Africa enjoyed the services of western medicine provided by the missionaries as they were devoid of paganism.¹⁴ In this respect, medical missions contributed immensely toward the introduction of a new medical system which suppressed African indigenous systems.^{4,13,26} In other words, African encounters with the missionaries alienated most of the former’s indigenous practices. In contemporary times, there has been a rush in Africa for what is foreign or exotic. In their current study among Ghanaians, Adu-Gyamfi et al. (2020) reported that Ghanaians in Kwawu still rely on indigenous medicine, but to a lesser extent. Due to the changing nature of culture, the indigenes, and especially the youth, utilize everything foreign, including biomedical practices, at the expense of indigenous practices.³⁴

Services provided by mission hospitals in Africa

Since time immemorial, Africans refer to certain diseases such as leprosy, convulsion, and epilepsy among others as unclean. Historically, people afflicted with such ailments were mostly marginalized within societies.³⁵ Mission medicine responded to the needs of these neglected patients—a role similar to that of Jesus’. In consonance with disease as misery, missionaries helped to relieve lepers, the blind, and the handicapped of their



maladies.⁶ As Jesus' healing paid attention to the lame, blind, lepers, the speechless, and the disabled, among others, missionaries resorted to the provision of hospitality care for these people to reflect Jesus' example which became the fulcrum around which soul-winning revolved.³⁶

The presence of the various medical missions in Africa ran concurrently with their activities of providing healthcare to the local populace. Significantly, they served as a source of spiritual encouragement to the sick and those who were grieving.^{7,33} Historically, some missionaries developed the view that offering any help—even if basic—was better than what the traditional medical practitioners (TMPs) could provide. Aside from the provision of healthcare, other medical missions trained local people to become practitioners. In Madagascar, the London Missionary Society (LMS) offered training programmes in biomedicine to local Malagasy.³⁷ In some fields, local people provided services including nursing, midwifery, and vaccination programmes.

Some missions refrained from the treatment of what they deemed incurable disease. Their inability to treat lunacy or mental health forced medical missions in Malawi to influence the government to put up asylums.⁶ In these circumstances, we infer that missionaries informed the colonial administration about some neglected health tasks.⁶ The goal was to treat common diseases as a means of establishing social intercourse with the local people. To that extent, mission medicine was twofold—serving as a means to converting the sick and promoting good health.

During colonialism in Africa, Ghana in particular, almost all the government hospitals were situated in urban areas.³⁸ Missionaries penetrated villages to set up clinics and dispensaries.⁸ In Sudan, missionaries were the pioneers of dispensaries in both rural and urban places.³⁹ Also, the scarcity of government medical services in rural areas compelled missionaries to supply medical care for government officials posted to these areas.^{6,40} In

colonial Tanzania, “it was the mission that became the driving force of maternal and child welfare in the territory that set the examples to be used by the colonial medical administration and allowed the colonial state to claim it was fulfilling its mandate.”⁴ Without the services of mission hospitals in Africa, the majority of the interior population would never have had a taste of and access to biomedical healthcare even to today.^{4,41} Put differently, missionary medicine was the only option for scientific medical care for most of the Africans in rural areas during the colonial era.¹ At the dawn of their establishment, the Agogo and Elim Mission Hospitals in Ghana and Tanzania, respectively, pioneered rural medical care directed mainly toward community and lay person's health.⁴²

Most sources argue that mission medicine, at its inception, was more curative than preventive.^{4,5,8,28} Why curative? Under Christian medicine, only the patient is viewed with sympathy and as the one who needs medical and spiritual assistance and not the one who has a high likelihood of getting afflicted. Until recently, missionaries mostly provided cure for the sick and not preventive mechanisms for the community as a whole. With reference to the missionary theory of praxis, the treatment of common diseases like malaria and eye and skin diseases were means to achieve their goals.⁵ This individualistic position is in contrast to public health laws found in the Bible. For example, Adu-Gyamfi and Marfo (2018) have argued that the Holy Bible serves as a health law.⁴³ Of seminal importance is the fact that “according to the Bible health laws, the simple principle of keeping the environment clean and avoiding the intake of items such as alcohol, fat, and blood is a powerful preventive measure for complicated and lethal diseases.”⁴³

The changing landscape of mission hospitals

The history of medicine in Africa has acknowledged the contribution of the activities of



medical missions prior to and during the colonial era.⁴² “Christian religion and care of the sick have traveled a long way together in the course of history; as a result, they are now inseparable.”²³ Specifically, scholars argue that missionary medicine in Africa began around the 1850s.¹ Since their inception, medical missions have been influential in the establishment of hospitals and the spread of Western medicine.⁴⁴ Starting always with minimal beds and equipment, mission hospitals have, over the years, acquired central stage in healthcare services across Africa.^{29,45,46} Historically, early Christian missionaries created Western medical centers in many African and Asian countries.⁴⁴ Over the years, mission hospitals and hospitals in general have witnessed changes in their modus operandi in the field of medicine. The following sections discuss the various transitions through which mission hospitals have gone. They include transitions in financing, staffing, shift from emphasis, extension of services, changes in ownership, and the relationship between states and mission hospitals.

Sources of income for mission hospitals

Missionaries have had varied sources of income. Around the 1990s, mission hospitals were reported to use resources, especially financial resources, more rationally than any other institution.¹⁶ These resources have assisted their social and medical interventions to complement the state’s healthcare resources.

Church hospitals in Africa now struggle to deliver quality healthcare due to less funding.⁴⁷ Medical institutions and hospitals are forced to charge to cope with funding shortfalls. In Congo, a majority of the in-patients of church hospitals faced considerable challenges concerning their medical bills.⁴⁷ Before the Second World War, most religious institutions relied on patients’ fees for their income.⁸ This discouraged the poor from attending their clinics.⁸ That notwithstanding, missions claimed patients were never denied treatments if they

lacked the ability to pay for their healthcare.⁸ Around the 1950s, in Uganda, the medical bills of disadvantaged people such as lepers, the blind, and crippled were waived.⁸ To address challenges of funding, most mission hospitals in contemporary times receive funding from Non-Governmental Organizations and International Non-Governmental Organizations.¹⁶ This idea is stressed by Green et al.:

... sources of funding have also changed, with a shift away from a structure where the majority of external income comes from those motivated to promote religious activities to one where there is a greater contribution from secular sources such as bilateral and multilateral donors, international NGOs, and national government as well as user charges.¹⁹

While outside agencies have been supporting these institutions financially and technologically, most of the African governments have provided little support.¹⁶ A study by the Swiss Network for International Studies in 2010 revealed that the Agogo Presbyterian hospital in Ghana and Elim hospital in Tanzania received funding from Swiss mission’s headquarters in Switzerland.⁴² Also, it has been suggested that most mission hospitals in Africa today receive subventions from government in either a formalized service agreement or on contract basis.¹⁹

Historically, church health services relied on the experience of user charges as the main mode of financing and generating revenue for their activities.⁸ In this contemporary era, an increasing number of community based prepayment schemes operated by both churches and governments provide a source of revenue for the wider health sector.^{19,48} An example of this scheme is the National Health Insurance Scheme (NHIS) in Ghana and the Community-Based Health Insurance Scheme (CBHIS) of Rwanda.⁴⁸ Kenya, Tanzania, and Ethiopia among other countries in Africa are following this example.

Staffing of mission hospitals

Staffing of mission hospitals has been a challenge since the inception of mission medicine. Despite the high levels of mortality among missionaries and the local population, most missionaries acted slowly in recognizing the need for training local medical personnel.¹⁹ In their earliest times, most missionary societies actively desisted from engaging medical workers not members of their society.¹⁹ Earlier, mission hospitals were mostly staffed by a single doctor and his/her assistant.¹

Over the years, mission hospitals relied on local people as staff to deliver healthcare services to the indigenous population. Certainly, as medicine has developed over time, mission hospitals have required more personnel.⁴⁶ In response, missionary doctors began training local practitioners to assist them.^{1,49} The increasing workload on the expatriate compelled missionaries to rely solely on local experts and volunteers in their medical activities.¹ In 1943, at Mgoro in Zambia, the Universities' Mission to Central Africa also employed local orderlies.⁵⁰ Some of these orderlies—including William Katumbi—injected, dispensed medicine, and used a microscope to diagnose patients.⁵⁰

In contemporary times, increasing demand for biomedicine and personnel have compelled missionaries to recruit national doctors not necessarily key members of their mission.⁴⁷ Expatriate doctors, mostly volunteers, still continue to be the backbone of most mission hospitals.^{20,47} The Tokombere hospital, a Catholic mission hospital in Cameroon, depends on expatriates as a source of both personal and financial resources.⁵¹ Recently, the number of long-term, expatriate, medical missionaries has declined.⁴⁷ In 2001, Wood reported that, after the 10-year civil war, Liberia had only one expatriate doctor, and most of the mission hospitals were planning to hand-over their operations and facilities to local churches.⁴⁷

One huge change in medical missions has been the transformation from medical missions into teaching hospitals. Currently, many mission

hospitals incorporate educational departments to train African doctors. In Cameroon, the Bansa Baptist Hospital and Mbingo Hospital provide training for health personnel.⁵² The Pan-African Academy of Christian Surgeons (PAACS) has been training African physicians and surgeons to beef-up the limited African medical personnel and surgeons, in particular.⁵³ The PAACS organize training programmes at several mission hospitals across Africa in countries including Gabon, Cameroon, Niger, Malawi, Tanzania, and Kenya.⁵³ Also, the Tenwek Mission Hospital in Kenya is among others that have established schools that train students in health-related programmes. The College of Health Science of Tenwek Hospital, which started as a nursing school in 1987, continues to train Kenyan Registered Community Nurses yearly.⁵⁴ The hospital still offers Chaplaincy training to students enrolled on health related programmes. The main aim is to complement the medical staff of Africa.⁵⁴

This notwithstanding, there are still skilled personnel who act as both leaders and laborers in mission hospitals and clinics.^{20,47} The low number of both national doctors and foreign personnel in mission hospitals undermines the goal of extending healthcare to majority of the African population.^{16,47} The lack of personnel in rural South Africa, where most mission hospitals in the country are located, adequately affects the delivery of healthcare.⁵⁵ Mission hospitals have fewer personnel because most secular hospitals receive comparatively higher remuneration.²⁰ Human resource shortages in mission medical institutions continue to pose threats to their operations. Across Africa, missionary health institutions find it challenging to hire experienced and well-trained medical personnel due to financial constraints and relatively higher remunerations taken by health workers in most secular hospitals.⁵⁶

A shift from the emphasis on sin

In the Christian scheme of things, the relationship between disease and sin provides a

framework for responding to the needs of the sick to enable him to understand himself as a “subject of his disease.”⁵⁶ Missions have resorted to treating both the physical problem of suffering and the spiritual problem of sin.⁸ This in itself reduced attendance and attention to mission hospitals and the activities of medical missions. The missions were largely unhappy about practices such as polygamy. This became a deterrent for polygamists and those who did that which the missions abhorred from seeking support from same.

In contemporary times, Christian hospitals have limited their emphasis on medical care as a remedy for sin. With an interest in the natural causation theory, diseases are not necessarily socially constructed. Scientific knowledge of disease, believed to emanate from God, needed to be applied; the indigenes needed to be disengaged from their old practices.⁴ Without an emphasis on sin, the attention of medical missions and hospitals have shifted to disease as misery. Increasing attendance at mission hospitals is taken as a positive response to this shift.⁸ Our findings have revealed that medical missions today do not rely on “spreading the gospel” as the basis to establish new hospitals.⁷ With increasing secularization, most mission hospitals have limited their evangelizing mission.

Mission hospitals have been controlled by the codes and ethics of their mother churches. Initially, these codes prohibited them from performing abortion, sterilization, artificial insemination, birth control, and family planning.⁵⁷ The literature notes a breach in some of these codes due to increasing secularization and medical rationality.⁵⁷ A study in Ghana has reported that mission hospitals now practice both medical and surgical abortion.⁵⁸ In Nigeria, mission hospitals provide treatment for the complications of either an induced or spontaneous abortion performed elsewhere, not by mission hospitals.⁵⁹

Extension of services and focus on new epidemics

After independence, mission hospitals in former colonies remained paramount in the provision of healthcare. Despite their challenges, specific missions have rapidly expanded community health services.⁴⁶ In Ghana alone, there are about 245 hospitals controlled and owned by faith-based organizations.⁶⁰ Ten of such mission health centers are situated in Kumase, in the Asante Region of Ghana.¹³

Church hospitals in contemporary times have extended their services to include the treatment of common diseases and the performance of surgical operations.¹⁷ Aside from expatriate missionary doctors, African mission hospitals have also deployed national doctors not necessarily from the denomination of the specific mission.^{47,16} Christian missions initially focused on treating the most common diseases like malaria, ailments of the eyes, and skin diseases. With sickness as an embodiment of misery, Christians in Africa have continued to ensure the treatment of the poor and the vulnerable who require medical attention.

By 2001, missionary facilities had diversified with mission hospitals treating about half of Africa’s total patients with HIV/AIDS.⁴⁷ Fursdon (2003) reported that missionaries are interested in the poor, HIV patients, orphans, and widows among other terminally ill patients as well as patients with chronic diseases and the outcasts.⁷ In 2009, in Tanzania, St. Joseph’s hospital focused on the top three causes of mortality in the country, namely, HIV/AIDS, malaria, and pneumonia.¹⁷ In Zambia and Malawi, missions have collaborated with other organizations in controlling the rise in HIV/AIDS epidemics.⁶¹ Powell (2014) described a coalition of seven churches that provided a sustainable programme for HIV prevention and care in Zambia.⁶² When Zimbabwe recorded her first HIV/AIDS case in 1985, missions and their hospitals advocated for behavioral change.⁶³ Many of South Africa’s AIDS

campaigns have been spearheaded by missionary groups.⁶⁴ In Ghana, the Christian Health Association of Ghana (CHAG) unified mission hospitals in Ghana and is second to the government as the largest provider of health care, catering for 35-40% of the nation's population.⁶¹ In Zimbabwe, mission health institutions are grouped under the Zimbabwe Association of Church-related Hospitals (ZACH). Over the years, ZACH has established partnerships with the government to run national programmes widening the scope of the state's provision of healthcare and has increasingly become the primary vehicle for preventive health programmes.⁶³

Over the years, missionaries and their hospitals have been delivering training schemes to healthcare professionals in response to the epidemiologic transition across the African region. In 2018, Cage and Rueda reported that around 1925, some 500 indigenous nurses across 116 hospitals and 366 dispensaries were trained across the continent by missionaries.⁶⁵ During the outbreak of the Ebola disease in 2014:

The Christian Health Association of Liberia (CHAL) partnered with U.S.-based International Medical Association (IMA) World Health to train healthcare professionals, community health volunteers, and religious and traditional leaders on the transmission, symptoms, treatment, and prevention of Ebola. The CHAL was also involved in procuring personal protective equipment (PPE) for health workers to prevent infection, critical to keeping healthcare centers operating . . . Many government hospitals in Liberia were closed due to the lack of equipment.⁶⁶

In the era of the Ebola outbreak, too, Christian mission hospitals in Liberia, Nigeria, Guinea, Senegal, and Sierra Leone pioneered mass education, treatment, and provision of medical supplies for the indigenes.⁶⁶

Change in ownership of mission hospitals

At the dawn of their establishment, most mission hospitals were managed by international missionary organizations.¹⁹ Most of these facilities today are owned, managed, and staffed by the national church and local committees.⁴² From the 1920s, various medical stations of the London Missionary Society across Africa were handed over to local committees.⁴² Management of many mission hospitals is a joint venture between the church mission and government.⁴⁷

Another contemporary concept of hospital management era is "twining." This explains the complex relationship between mission hospitals and their respective headquarters in Europe and other parts of Africa that allows technology, personnel, and financial resources to be transferred.^{19,47} Since independence, most medical missions have been supported by the state and further incorporated into national health systems.⁸

The state and mission hospitals

Most church hospitals have now been secularized and incorporated into national healthcare systems. The Christian Health Association of Ghana (CHAG), an umbrella organization that coordinates the activities of all mission hospitals, is in continual liaison with the Ministry of Health.⁶¹ About 23% of the available hospital beds in Kenya are provided by missionary hospitals.⁶⁷ In Cameroon, about 40% of the national healthcare is provided by missions.⁵¹ In the twenty-first century, the budgets of most missionary hospitals in Africa are now provided by the state, rendering the former as mere civil servants.⁴² This notwithstanding, most of the hospitals have to provide a significant amount of the budget on their own. The African states have adopted various regulations to take over the missionary hospitals. In South Africa, the government resorted to the relocation of mission hospitals.⁴² In 1961, the Swiss mission in Southern Africa was ordered by the government to transfer

their main hospital from the Elim village to a new area. Subsequently, the state negotiated for the takeover of the missionary hospital through formal purchase.⁴²

Around 1950s, the South African government started to increase its financial contributions to the budgets of mission hospitals to gain control over these institutions.⁴² Of all the missionaries in Tanganyika, the Catholics and the Lutherans over the years developed large medical institutions that have been subsequently integrated into the medical infrastructure of Tanganyika.¹⁷ In 1896, after recognizing the richness of their infrastructure, the French in colonial Madagascar established formal control over the hospitals built by the London Missionary Society.³⁷

Missions are gradually losing their authority as the sole owners and controllers of their hospitals to contemporary governments in Africa. There is a growing concern on the level of support provided by the state toward the mission medicine. Although governments in Africa appear to be supportive, many stakeholders of missionary medicine in Africa fear a government formal control over the medical sector hitherto controlled by the missions.^{8,24} In the 1970s, the government of Tanganyika massively nationalized most of the missionary medical centers.²⁴ Specifically, the state has transitioned the Ocean Road Hospital in Dar-es-Salaam to government dominion of the hospital's administration and operations.⁶⁸ In Nigeria, too, the Plateau State's government in 1975 started taking over the mission hospitals and schools.⁶⁹ Some states in Africa today have regulations that allow missionary doctors to be transferred to any hospital within the country.⁴² In Nigeria, most mission doctors were replaced with national doctors.⁶⁹ Although some missions still remain as the owners and sole controllers of their health institutions, they are contracted frequently to deliver public services that are financed by governments.⁴⁴ The Ministries of Health in countries such as Cameroon, Tanzania, Chad, and Uganda have contracted mission hospitals

to work in underserved areas.⁵¹ The contractual agreement in Cameroon started from the early 2000s.⁵¹ Mhike and Makombe (2018) argue that "since HIV/AIDs epidemics and its treatment became standardized in the 1990s, the governments have targeted mission hospitals to run awareness campaigns and dispense drugs in affected rural communities."⁶³

The governments in Namibia, South Africa and most countries within the region of West Africa have experienced increasing support from mission hospitals in the fight against HIV/AIDs.^{66,70,71} Commencing in the 1980s, mission health institutions in Zimbabwe have aided the state by spearheading the Zimbabwe Expanded Programme for Immunization (ZEPI), Diarrhoeal Disease Control Program (DDCP), and the National Nutrition Programme.⁶³

Mission hospitals and SDGs

Christian medicine in Africa has been changing in response to a changing world. Since the colonial era, the rural poor have been poorly represented in healthcare. The state's neglect of these people subjected them to poverty and a high rate of mortality.⁶³ In response, missionaries extended their medical activities towards the poor and often the rural poor.

Christian hospitals have transcended the idea of healing disease to promoting holistic health and well-being.⁷² Significantly, it has moved from being curative medicine to preventive care.²³ Currently, it appears intuitive that the inadequacy of public health systems across Africa, coupled with the change in disease epidemiology have cautioned Christian Missionaries and their hospitals to focus on preventive medicine. Missionaries also promote healthy living. Missions and mission hospitals, in particular, have played major roles toward the attainment of goal three of the sustainable development goals, promotion of good health for all.⁷³ This was necessitated by campaigns and the

creation of awareness of the need for good sanitary conditions and safe drinking water.^{23,49} The Namibia Evangelical Theological Seminary (NETS) engages in seminars on HIV/AIDs and its impact on society.⁷⁰ During the ethnic war of 1994 in Rwanda, missionaries in Goma, Congo (an area where about 50,000 people had died from cholera), introduced a water sanitation system to stem the spread of Cholera among the Rwandan refugees.⁷⁴ In Zimbabwe, the collapse of state-provided health services allowed mission hospitals to bridge the gaps within the healthcare sector.⁶³

Scholars argue that mission hospitals have greater access to both personnel and international resources than governments' healthcare centers in working towards the achievement of MDG 5 (improving maternal health).²⁰ This has enabled mission hospitals to develop training for infectious diseases.²⁰ Since its inception, they have paid special attention to training traditional birth attendants (TBAs) in safe methods of delivery in Africa.²³ The training of local midwives has produced a considerable reduction in maternal health challenges.^{4,24}

Scholars suggest that people proximate to the location of church-based [or faith-based] health centers and hospitals do better in terms of "health habits, such as hygienic practices, maternal and perinatal care, and disease awareness."²⁴ Mission hospitals champion proper nourishment and hygienic living conditions, "without which people would continue to become sick."²³ Missionaries have pioneered human resource training, drug provision, and healthcare funding toward the achievement of SDG 3.¹⁸ Churches in Africa and their mission hospitals continue to advocate for the provision of care, including access to reproductive care, which is in line with SDG 5.²³ Research in Kenya provides evidence that missionary hospitals advocate for behavioural change through periodic healthcare education aside from the provision of medical care.⁶⁷ Mhike and Makombe (2018) show how states in sub-Saharan Africa increasingly

deploy the services of missions and missionary hospitals to arrive at their SDG and MDG targets.⁶³

Conclusion

The landscape of mission medicine and hospitals in Africa is changing. Since inception, missionaries in Africa have deployed numerous methods for drawing members for their respective denominations. Education and medical services were among the measures which became successful in winning more souls for Christ. This study discusses the changing landscape of mission medicine in Africa with particular attention to missionaries' activities towards SDGs and MDGs as well as their relationship with state and African governments.

The study has revealed that medical missions at inception targeted the poor, women, and children who could not afford the cost of scientific medical services. With the changes witnessed, however, missions and their hospitals have now extended their services from being only curative to offering palliative, preventive, and public health programmes. Today, missionaries contribute immensely towards reduction of Africa's burden of HIV and non-communicable disease and other emerging epidemiology across the continent.

In contemporary times, upon the realization of African limited personnel and medical infrastructure, missionaries have developed schools and teaching hospitals to train local personnel to complement the inadequate African healthcare personnel. Their training schemes have over the years been important in the emergence of African medical and surgical personnel for both local and foreign needs.

Today, faith-based institutions still stand as major assets upon which most governments in Africa rely concerning healthcare. Funding, however, has become a major concern for these institutions as African governments provide little support for them. This notwithstanding, most mission hospitals



maintain ties with their founding boards, mostly overseas, for all forms of assistantship ranging from the transfer of monetary goods to technology and human resources.

In this study, it has been reported that some mission hospitals have been nationalized by local governments with government controlling major parts of their activities. Nevertheless, church health service priorities continue to be related to their mission statement and their community or denomination.

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Correspondence: Samuel Adu-Gyamfi, Kwame Nkrumah University of Science and Technology, Ghana. mcyamfi@yahoo.com

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