Missionary Medicine and Primary/Universal Health Care: The Case of Uganda

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Healthcare for all?

• Can effective healthcare be provided at low cost to the bulk of the population even in poor countries?
• Do mission institutions have a role to play in the provision of universal elementary healthcare and preventive services?

 Recovering children with mothers in a pediatric malaria ward in Butare. Photograph: David Evans/National Geographic/Getty Images
Was missionary medicine primarily ‘a tool for evangelization’ (J. McCracken)

- Medical mission:
- ‘used as heavy artillery . . . in the less responsive fields (H. Lankester)
- ‘has to treat the physical problem of suffering and disease, and it has to deal with the spiritual and moral problem of sin’ (A. Cook)
Or was medical mission penitential?

• For Albert Schweitzer medical mission was a means of righting ‘the injustice and cruelties that in the course of centuries [Africans] have suffered at the hands of Europeans’
Is missionary medicine compatible with universal and primary healthcare?

Mission healthcare may seem to policy-makers to provide a structural obstacle to the integration, coordination and consistency implied by universal health coverage. Whereas Universal and Primary Healthcare have a focus on the community, on prevention, mission medicine by reputation focuses on the curative, on the individual, and on its own adherents.
Medical mission focused on groups which were defined as particularly vulnerable, or especially important to the religious aims of the mission.

• Missions concentrated on relief for disadvantaged groups such as lepers, the blind and the crippled, ‘biblical manifestations of disease and misery’.

Maternal and child health was another area pioneered by missions across Africa. In Uganda missionaries began training indigenous women as midwives and nurses in 1918. By 1932 the CMS alone had established 23 maternity and child welfare centres, mostly in Central Uganda. These clinics were tasked with improving local morality, and serving as ‘a beacon light of hygienic village life’.
In Central Uganda the proportion of women giving birth in hospital rose from 21% in 1947 to 41% in 1967. 4% of mothers and 5% of babies who left hospital alive in 1950s-1960s would have died a generation earlier, before penicillin, blood transfusion and caesarean section.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>1924-1949</th>
<th>1950-1969</th>
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<tbody>
<tr>
<td>Maternal mortality</td>
<td>2%</td>
<td>4%</td>
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<tr>
<td>Neo-natal mortality rate</td>
<td>10%</td>
<td>12%</td>
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<tr>
<td>Stillborn</td>
<td>3%</td>
<td>5%</td>
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Mortality and stillbirth data from Mengo and Nsambya Hospitals, Uganda’s largest maternity units
Seemingly the distinctive concerns that shaped mission medicine in the first half of the 20thC made it an unusually good fit with some of the core principles of primary/universal healthcare:

• the equitable provision of medical guidance and treatment irrespective of gender, age, disability or place of residence;
• the development of an indigenous health workforce;
• a multi-sectional approach that engaged local communities in the transformation of health-related attitudes and behaviours in order to improve people’s lives.
• Some scholarship suggests that medical missions often associated leprosy with damnation.
• Missions in Uganda cross-subsidised maternity provision by deliberately grossly overcharging STD patients (whose condition, it seems likely, was often misdiagnosed).
• In some areas it appears that quality of care was limited by a determination to reach the maximum number of potential converts, so that a second-rate service deemed adequate for Africans typified much mission provision.
• And community engagement often depended on the coercive assistance of local chiefs, commercial interests or colonial officials.
Missionary medicine has not gone away...

A Spanish missionary infected with ebola arriving in Madrid. Photograph: Reuters.
Postcolonial missionary medicine has built on its strengths...

• It has pioneered rural health centres, focusing on child health
It filled gaps left by a retreating state due to political instability and economic decline (Nsambya RC Hospital Kampala during Amin and Obote II)
Nsambya outpatients rose sixfold as Mulago state hospital declined 1971-84
In 1987 Rev. Sr. Dr. Miriam Duggan started the “Home-Based Care Service” (now CHBC) at Nsambya Hospital and Sister Ursula Sharp founded Kitovu Mobile, a home-based care program, which together transformed the model of palliative care for AIDS in Uganda.