Mission hospitals as vital capacity builders in the Majority World

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This Christian Journal for Global Health issue (June 2020) gives us a broad spectrum of insights into both the past and the present of how healthcare and medical missions have made an impact in our world. In the Commentary elsewhere in this issue, I propose that for the mission of the Church to be fulfilled, "healthcare mission" is the responsible party to engage the mainstream mission enterprise to bring about an integral approach, " . . . as the Father sent me . . . [Jesus]" (John 20:21).

But for there to be greater collaboration of healthcare in mission, capacity must be built to, " . . . send out more laborers." (Luke 10:12). This must come in many forms — community health, transformational development, and also more locally discipled medical "boots on the ground" in the Majority World who can also engage cross-culturally.

Engaging a Medical Education and Discipling Agenda

When our family arrived in Kenya in 1992, I joined three other missionary family physicians, two general surgeons, two nurse anesthetists, and a dozen nurses as the expatriate contingent serving with a staff of 300 at a 220-bed church-owned hospital. We family doctors took first call at night with an occasional Western medical student. The nursing school that had started in 1980 still had all missionary tutors who mentored well-trained and caring Kenyan nurses. When the Lord moved our family on in 2006, specialty physicians, business management, and nursing tutors were nearly all transitioned to Kenyan leadership.

By then, the hospital mission statement had clearly incorporated the desire to excel in education as well as its traditional clinical and chaplaincy services. The hospital became the focus of the training for HIV workers for the church-based, AIDS Relief PEPFAR program. The hospital has now grown to a 340-bed capacity, served by 30+ interns and residency trainees in four specialties spanning the breadth from family medicine to pediatric surgery. The majority of the nearly 30 physicians and surgeons are Kenyan, supplemented by missionary faculty and short-term, sub-specialty, teaching staff.

This transformation from an expatriate missionary-managed, secondary-care hospital to a tertiary level, teaching and referral hospital is one model of a mission hospital's future in the Majority World setting — embracing specialization with a blended faculty to fill unmet needs in the larger healthcare system. It follows the trajectory of Dr. Philip Woods's forecast in his third decennial review (2011) of a sample of African church hospitals.[1] Most hospitals within church health systems that had a majority of local doctors had transitioned to national ownership and leadership, and some had started formal residency training programs.

Do church hospitals in Majority World settings need to be involved in residency-level education into the future? And are Western medical educators needed? The short answer is, "yes:" 1) there are not enough positions for post-graduate training overall and few in family medicine and other primary care specialties; 2) what programs that do exist are not easy for church hospital junior staff to join; and 3) there is something important about being mentored within a wholistic approach that includes the spiritual dimension of healing.

The "Brain Push" Compounds the Brain Drain

Although resources have been invested to rapidly grow the number of medical schools in Majority World settings, post-graduate educational opportunities have not kept pace in Africa, and likely other areas.[2] Most African countries have from zero to 30% capacity for their graduates to follow on to specialty residency training, and what is available is mostly in large, big-city, national, referral hospitals. What happens when you are not the one in three or four to find a residency placement? I call it the "push factor" to add to the "brain drain," which is a "pull factor" that empties the brightest from their countries to seek after specialty training where it can be found. Most never return.[3]

The disproportion in the raw numbers of available residency positions is magnified by the huge disparity of their distribution. When Moi University began planning for its first family medicine residency in 2000, the statistics showed less than 25% of the district hospitals in Kenya had any specialists, even though the staffing plan intended each to have surgery, obstetrics & gynecology, pediatrics, and medicine specialists.[4] Over these past twenty years, this proportion has improved as the number of medical school graduates has increased, but long-term commitment to these district facilities by even the "core specialists" is still not the norm. Most move on to "greener pastures."

Another key need across all countries and sectors is the importance of professionalizing the broad generalist by providing a pathway for an internship-trained "medical officer/general practice doctor" to aspire to an equivalent specialty training. When a small group of family physicians come together, they can rotate the main call responsibilities in a small district hospital, something that cannot be done with single specialists in each of the other primary care specialties. Opportunities for primary care specialty training, especially family medicine, outside of the inappropriate huge tertiary referral hospitals, are few.

Disparity of Opportunities

Unlike most Western countries, funding for post-graduate *resident salaries* in specialty training in most Majority World countries is not channeled directly through training hospitals but catered for directly from the central Ministry of Health human resource system. Therefore, the salary follows the government-sponsored resident wherever they serve, district hospital or residency teaching position.

Therefore, when the mission hospital wants to sponsor their bright and enterprising medical officer, they must pay both the resident to go off to training *and* the salary of the doctor that must fill the now vacant position. For mission hospitals that operate on whisker-thin financial margins with (rarely subsidized) patient fees being their only source of revenue, it is difficult to attract the national doctors. Because of the additional financial burden, the mission hospital finds it doubly difficult to offer a path for professional advancement like the government Ministry of Health can do with the Exchequer to finance the bursaries. When they do return to serve in under-served areas with their often under-resourced (primary and secondary) schools, how will their children receive the same educational opportunity as their parents to follow in their footsteps at the top of the national exams?

Wholistic care must be modeled

Caring in Christ's name has a long legacy across the centuries. Coincident with the rise of scientific understanding over the last 150 years of how our bodies are fearfully and wonderfully made, missionary nurses, doctors and many other cadres established hundreds of hospitals, health centers, and dispensaries across Latin America, South and East Asia, Africa, and many other places. The number of these facilities has diminished in most countries as the responsibility for health care has been taken up by governments such as the UK's National Health Service or African countries' Ministries of Health. But the names of the hospital facilities they operate from (e.g., the St. Luke's and Baptist Hospitals in the US), and the continued presence of church-

sponsored health ministries started by missionaries across the world reflect the largely Christian heritage of providing healing and care to the sick from earliest times.

Church-sponsored health systems may seem anachronistic to some. But in a Kenyan study of how the poor try to pay for their healthcare, the rural church hospital outranked all others, even though the costs were higher.[5] Clearly, when the poorest vote with their feet to use a church-sponsored health facility, it speaks to something in the care that is worth preserving and growing.[6]

One of my career-long mentors and colleagues is Dr. Samuel Mwenda, General Secretary of the Christian Health Association of Kenya (CHAK) and founding CEO of the African Christian Health Associations Platform (ACHAP).[7] I once asked him, "Is there a continued role for health care in the mission of the Church?" There was a long pause and a quizzical look. He answered and in characteristically Christological form, responded with another question. "What would Jesus do? How would the church *not* be intimately involved in showing the love of Jesus in this way? Shouldn't the Church everywhere be directly involved in healing ministries across all domains; the physical, emotional, and spiritual?"

If mission hospitals are to continue, one important need is the training and discipling of national consultants who will themselves continue to model wholistic care and the humble service that patients are drawn to and which meets the healthcare needs of underserved areas. Although Christian faculty and residents within government medical education systems can and do emulate this care, I believe it can best be done within residency programs where faculty are unencumbered to integrate the skills of modern science and technology with mental health and spiritual healing that comes with ministering freely in the Spirit's power.

Standing on Shoulders of Giants

Many might be surprised to learn that starting medical schools and providing specialty physician education is not a new trajectory of medical missions. Christian medical schools have been producing national graduates that serve the under-developed and underserved areas of their countries and beyond as far back as the founding of Che Jung Wan Medical School (now Yonsei University) in Seoul, Korea in 1886.[8] Similar schools founded before 1920 are found in China, India, and Uganda (see Jansen's article in this issue). India's Christian Medical Centre Vellore (1900) [9] and Tanzania's Kilimanjaro Christian Medical Centre (1971, now Tumaini University) [10] are examples of health care leadership and education in their respective countries.

In more recent times, the Pan-African Academy of Christian Surgeons[11] has trained over 100 surgeons in twelve programs since 2000 who are technically excellent, yes, but who are also serving in under-resourced church and other hospitals for extended years where their skills are needed most. Similarly, the Christian Academy of African Physicians[12] is being formed to complement what PAACS has pioneered in surgery so that more mission hospitals can be supported to also train the primary care specialties; especially family medicine, which started in Nigeria in the 1980s. African Mission Healthcare[13] has gathered the Alliance; a group of organizations focused on expanding teaching centers of excellence in mission hospitals across Africa.

The distinct legacy of missionaries starting mission hospitals over the last 150 years is that they gravitated to the poorer, more rural areas where the majority (70 – 90% in most African countries) live and where health disparities are still the greatest. The PAACS experience is already showing that graduate physicians are staying to serve in these areas. If excellent training for a complementary specialty such as family medicine can also expand in these mission hospitals, their graduates also will be able to build capacity and continually improve services for the underserved populations who need it most; while also ministering to their spiritual needs and concerns.[14]

Looking Forward

As we look forward, we need to embrace a great hallmark of Jesus' ministry, both then and now — bringing together skills and gifts from

across the global Body of Christ to teach and disciple those who will facilitate the wholistic healing that only He can give. In the Majority World, and especially in the areas outside the capital cities, the disparities are stark. Expanded educational and discipling capacity of church health systems and ministries in these areas can lead to not only "better outcomes." We can, in the Spirit's power, and as a united, collaborative, mission enterprise, expect to fulfill Christ's charge to, " . . . do even greater things than these." (John 14:12).

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