Health systems strengthening through the faith-based sector: Critical analysis of facilitators and inhibitors of nationalization of mission hospitals in India

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Abstract

Introduction: The extensive network of Christian mission hospitals in India faced an abrupt loss of financing and supply of medical missionaries during and after independence in 1947. Many of the remaining went on to become indigenously owned Christian hospitals and prestigious medical colleges that maintained the heart for the poor and for spiritual care that was inspired by their founders. The aim of this critical analysis is to explore the literature to understand what helped these hospitals survive when others failed and lessons that can be learned to help direct future investment and programs for health systems strengthening.

Methods: A literature review was conducted utilizing PubMed and Google Scholar and combinations of keywords (mission, hospital, India, independence, indigenization, sustainability, history, health system). The initial list of 785 articles was filtered down to 28 that specifically address the research questions. Excerpts from these articles were annotated, coded, and evaluated for core themes.

Results: The following core themes arose as factors that contributed to their success: 1) shared mission, vision, and core values, 2) early emphasis on medical education, especially for women, 3) local champions, patrons, and governance, 4) strong community linkages, 5) strategic collaborations, and 6) healthy systems and infrastructure.

Recommendations: Most international investment in health systems strengthening has focused on short- and medium-term health outcome goals. While these have certainly saved the lives of millions, we must also consider what will be required to foster healthy healthcare systems. Long-term investment in building committed healthcare leaders and healthy institutions is challenging, but necessary, to meet long-term health goals. Faith-based hospitals are key allies in this endeavor.

Key words: India, mission hospital, indigenization, nationalization, sustainability, Christian.

Introduction

Since the time of Christ and the nascent Christian church, healing has been at the core of the Christian faith. Since the early church, Christians have repeatedly led the way, responding to the needs of the sick during the great plagues that ravaged the globe, often sacrificing their lives in the process.[1,2] Most early hospitals and medical schools in the west were started by Christian churches, both Catholic and Protestant, with the earliest arising from within Catholic monasteries.[3] Early missionary efforts to foreign lands did not consider formal medical work to be critical to their mission, as medicine prior to the mid-19th century had very little to offer.[4] "Medical missions" as a strategic approach to evangelism was likely first represented by the Medical Missionary Society in China in 1838. Its most famous representative, Dr. Peter Parker (1804-1888), led the movement of Christianity into inland China, capitalizing on his ability to use medicine to bring healing.[5]

In India, the East India Company (EIC) was a British joint-stock company founded in the 1600s to strengthen and control trade in the Indian Ocean Region. In the early 1800s, EIC controlled most of the trade in the Indian subcontinent. EIC's exploitation of basic commodity markets for silk, cotton, Indigo, spices, and even opium became critical to the growth of the British Empire.[6] Merchants were wary of including religious propagation in their agenda, fearing reprisals that would impact their trade activities. It wasn't until the early 1800s that the British Parliament enacted laws that would support missionary activities in India. The years that followed marked the beginning of what has been termed the *Great Century of Missions* as Christian churches and organizations in Europe and the United States increased their evangelistic efforts among the "heathen" tribes being encountered in expanding empires. Colonial India was central to British missionary strategy, and, by the middle of the 19th century, one quarter of all Protestant missionaries were in India.[7]

The explosion of scientific and medical knowledge and public health in the mid-19th century impacted the birth of what we call "modern medicine" and added an effective "instrument" to the expansion of the Christian missionary movement of that era.[8] During this period, the growing number of mission hospitals in India provided a significant proportion of health services and were generally located in rural communities serving the poor. By 1905, there were 280 medical missionaries in India, many being women.[6] Because of Muslim and Hindu prohibitions of physical contact between male physicians and female patients, female doctors and nurses were able to have greater impact than their male counterparts.

Early work training physicians and nurses further increased the impact of mission hospitals within communities as they generated additional health providers. As a result, by the time of independence, a number of healthcare leaders, including the Minister of Health and the Governor of West Bengal province, were female physicians trained at mission hospitals.[9] Through much of India, nursing was considered a lowly profession suited only for untouchables. Christian nursing education promoted the status of nurses to an honorable profession. Until just before WWII, 90% of nurses in India were Christian, and 80% were trained in Christian nursing schools.[10]

Core to medical missionary motivation was service to the poor and outcast. Because of India's pervasive "caste system," missionary efforts were therefore also directed at lower caste Indians. It was this group that most enthusiastically embraced not only the message of Christianity, but also Western cultural values and philosophies. Under British imperial rule, this Christianization (most evident in the South) represented a degree of liberation from the restrictions of the caste system that was more appealing for lower caste Indians than higher caste communities. By the end of the nineteenth century,

95% of Christians in Southern India came from the lowly Nadar caste.[11]

The admixture of Christian mission and colonialization left a mixed legacy.[12] In many settings, Western missionaries emulated the prevailing colonial models and had full control of Indian churches and hospitals. The most effective missionaries were those who mastered the local language and culture and lived humbly among the common people.[13] Many committed themselves to developing local leaders and supported aspirations of decolonization. Indeed, Indian Christians also played key roles in supporting Independence leaders and movements.[6,10]

In the decade following Indian Independence from Great Britain (1947), the Indian government became less and less tolerant of Western Christian missionaries, considering them to be guilty of cultural aggression.[14] A committee of the government declared that "evangelization in India appears to be part of a uniform world policy to revive Christendom, to re-establish Western supremacy and is not prompted by spiritual motives". This led to greater restrictions on Western missionaries and relationships between Indian churches and their Western counterparts.

Because of inadequate investment by Western mission agencies in developing local buy-in and building local leadership, many of the hospitals that missionaries planted failed when support from the U.S. or Britain failed, and Western missionaries were expelled following Independence.[15,16] Although precise numbers are not well documented, a number of these mission hospitals survived, and some have grown to become influential medical centers and training centers while maintaining their spiritual roots and commitment to serving the healthcare needs of the poor.[17] In areas where mission hospitals were planted, but later closed, improved health outcomes, when compared to similar areas without western missionary involvement, can be documented even decades later.[18]

The years that followed independence saw rapid expansion of private Indian hospitals that have increasingly improved the quality of their services. Many of these hospitals provide world-class services at a fraction of the cost in Western countries.[23] As a result, India has become a destination for "medical tourism" as patients come to India for advanced medical services that would not be affordable in their home countries. These private hospital systems were designed to meet the needs of the growing Indian middle class, leaving the public sector to care for the needs of the poor. This process of privatization has undermined resources that would have been available for the public sector which has therefore further restricted access to quality healthcare for the poor.[24] Developing high quality health services has taken significant investment in infrastructure, and the pressure to have a return on this investment has resulted in "profit-oriented," rather than "mission oriented," strategies.[19]

Specific Aims

The aim of this critical analysis project is to assess the factors that facilitated the emergence of these nationally led Christian hospitals at a time when most others failed. This analysis was guided by the following questions:

1. What are themes that emerged from the literature?
2. In what ways did "organizational culture" or "foundational principles" contribute to maintaining a commitment to spiritual care and service of the poor?
3. What other historical, cultural, or strategic factors may have contributed to the longevity of these hospitals?
4. From this body of work, what recommendations can be made regarding strengthening faith-based health care systems?

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Methods

An initial literature search was conducted using PubMed, Google Scholar, and Scopus. Search terms included India, mission, hospital, indigenization, nationalization, and sustainability. The search produced 785 articles that were reviewed for relevance. The World Council of Churches, the Christian Medical Association of India, and the Emmanuel Hospital Association were consulted for relevant articles, some of which were cited above, but not available online. As each article was reviewed, additional publications were identified through citations and added to the list for review.

The list was narrowed to those contributing to the research questions. Two lengthy publications were used for historical background only, and 28 were included for in-depth analysis. Some of the publications referred broadly to medical missions, but emphasized those that were focused specifically on India. Only four of these publications could be described as "studies" that applied systematic evaluations. There were three academic papers that covered history, as well as pertinent organizational principles. The majority of the papers were historical in nature, but also contained useful information about key characteristics of some of the major medical institutions as they were founded and during the transition to Indian independence. Case studies and biographies of early missionaries also shed light in these areas. The remainder could best be described as opinion pieces about what is needed in medical mission.

A database matrix was developed to capture key quotations and summaries that addressed the research questions extracted from the articles. Review of each publication included annotations that addressed the research questions. After review of these annotations, an initial list of *topical areas* from the research questions was expanded as recurring themes emerged. Each excerpt was then coded from this list. The coded excerpts were recorded in Excel where they could be grouped and sorted. Many excerpts addressed multiple areas and were included in each code area. Each topical area was viewed as a group to determine specific overall *themes* emerging from the stories (see Table 1).

Table 1. Themes

1	Creation and transmission of shared mission, vision, and core values
2	Business models that maintained emphasis on serving the poor
3	Early emphasis on formal medical education, especially for women
4	Fostering local ownership — Champions and governance
5	Mentoring local leaders
6	Strong relationship with and sensitivity to the community
7	Strategic Collaborations
8	Healthy systems and infrastructure

Results: Themes

Creation and Transmission of Shared Mission, Vision, and Core Values

Evaluations of failing mission hospitals in India clearly demonstrated a linkage with poorly defined goals and objectives, and a lack of planning, organization, and coordination.[16] By contrast, at successful hospitals, staff at every level were more likely to know the history and mission of the hospital and took seriously the spiritual nature of each person (made in the image of God) and their responsibility to show Christ's love in action.[20] Most of these hospitals had their mission statements clearly visible to staff and visitors and could state them when asked. It was observed that "*persons with such a high level of awareness of their institutional mission showed greater tendency to work toward the accomplishment of that mission.*"[21]

An important distinctive of effective mission hospitals was a strong linkage to Biblical mandates for justice and service of vulnerable groups (the poor, widows, orphans, homeless).

Hospitals with pervasive awareness of the institution's mission were also characterized by interdepartmental coordination, symmetric and systematic growth, and highly strategic use of limited resources. It is clear from biographies of the missionary founders of these successful hospitals that these values were evident from the inception of the ministry and were passed on not just through formal documents and administrative systems, but through modeling of sacrificial service to the poor, accompanied by great "thrift" and an entrepreneurial spirit that became, as it were, part of the DNA of the institution.[22]

Many missionaries were influenced by, and significantly contributed to the shifts of, the thinking that preceded and eventually led to India's independence.[10] Following independence, missionaries used their relationships and influence to hold accountable rich landowners who had exploited the poor.[14] There were cases when missionaries paid from their own resources the debts that poor people owed to oppressive landowners, further prompting conversions to Christianity.[6]

Business Models that Improved Sustainability but Maintained Service to the Poor

As the financial support and volunteer missionary workforce decreased around the time of, and just after independence, mission hospitals had to find new ways to make their work sustainable. Many mission hospitals started "private wards," offering a higher level of privacy and service as a mechanism for generating resources to fund service to the poor. The added benefit was that women of higher caste could finally access services (often from women providers) that met their need for healthcare.[Error! Bookmark not defined.]

As modern secular hospitals with high quality services expanded, their focus was generally on offering high quality care through a fee-for-service model. Indeed, many of India's hospitals could be ranked with the best hospitals in the world, with quality care at a fraction of the cost of equivalent care in the West.[23] However, the business model of private hospitals focused their services on wealthy Indians and the growing middle class, leaving the poor to continue to rely on under-resourced public hospitals and mission hospitals. Some mission hospitals followed suit by increasing their focus on fee-for-service care to improve hospital sustainability.

James McGilvray, the first director of the Christian Medical Commission (1968), observed that, "*hospital staff who, conscious that their Christian vocation directed them to serve the poor, were now forced to cater to the rich in order to do so and even that on a decreasing scale."*[16] While privatization of healthcare throughout India widened the disparity between the rich and the poor, mission hospitals that had a strong and shared commitment to serving the poor were able to find a better balance between equity and sustainability, though not without tension.[24] In his piece on the future of Christian health services, Dr. Steffen Flessa concluded that:

> . . . reliable health care services, where the dignity of human beings is respected under all conditions, are not a luxury, but a resource of unconditional reliability. Christian healthcare services have the unique calling to make this respect and love perceivable, irrespective of their clients' success or failure in life, or their ability to pay.[5]

Early Emphasis on Formal Medical Education, Especially for Women

Traditional social constructs in India during the early colonial period deepened the disparity and access to health services for women because they were not permitted to see male providers. Early female missionaries, like Ida Scudder, were

compelled to improve the plight of Indian women and were able to overcome these barriers as women providers. Many of the first medical schools, and essentially all of the nursing schools, were women-only. The female graduates from these early medical schools rapidly proved themselves to be some of the best doctors in the country.[26] Not only were they offering excellent education and patient care, but because of their history and value system, they maintained a commitment to serving the poor.[25]

These new institutions dedicated to educating and serving women were a new entity for male-dominated, foreign missionary agencies. As a result, they were able to operate with greater autonomy than other missionary endeavors.[22] Likewise, because the target beneficiaries of these hospitals were poor women, the colonial state powers did not consider them to be competition, further allowing freedom for growth.[22] The formation of medical colleges became one of the most salient contributions of medical missions. Not only did it improve access to medical services for Indian women (by female providers), it also produced some of the most influential early Indian leaders for healthcare, many of them women. This women empowerment was evident as India gained independence in 1947; a woman was appointed Minister of Health and another governor of West Bengal Province.[11]

Fostering Local Ownership-Champions, Patrons, Governance

Missionary women recognized the importance of establishing good relationships with local elites. These settings had complicated issues of gender, caste, and religion that missionaries had to navigate. The initial task was to develop credibility within the community, as well as established leadership structures. Because they removed some of the gender barriers to receiving care (i.e., prohibitions about seeing a male physician), women missionaries had close relationships with influential families. Many of these became local patrons and champions who not only supported hospitals financially but advocated for these institutions during the push for independence. Influential, reform-minded Indian men became generous philanthropists, enabling the founding of many schools and hospitals. In 1927, Mahatma Gandhi himself visited one of the more prominent of these hospitals, CMC Vellore (see case study) and encouraged the leaders of the hospital to continue their faithful service to the poor.[11]

Compared to Africa, India was more successful at replacing foreign missionaries with nationals in hospital care and leadership.[27] Reviews of missionary endeavors in India do include many settings where missionaries and mission agencies were the ones to make all important decisions. It was not that there were no qualified Indian leaders available, but there was a reticence to relinquish control.[6] Most of the important leadership decisions in these early hospitals were made by home mission offices, by leadership that was almost exclusively male and exclusively western. The hospitals that valued local input and empowered national leaders as they emerged were more successful when the forced transition took place during the process of independence.

As it became more difficult to send medical missionaries and it became more expensive to support growing mission hospitals, Western missionary agencies began handing over mission hospitals to local church leadership. This was often couched in the prevailing rhetoric of "self-governing, self-supporting, and self-propagating churches" or "partnership in mission."[16] The end result was a handover to national leadership that rarely had individuals with the training and experience required to run a hospital and were not able to attract the growing number of qualified Indian health professionals, and many of these institutions deteriorated and eventually closed.[19] By contrast, some of the enduring mission hospitals were able to maintain Western missionary engagement because of their strong relationships with local leadership and their balanced approach to empowering national ownership. Some institutions,

like Christian Medical College-Vellore, transitioned to national leadership with years of mentorship and empowerment from the founder.[12]

Institutions that were successful at transitioning from foreign-led mission hospitals to successful Christian hospitals were those that prioritized the development of indigenous leadership from the time of their founding. Intentional investment by medical missionaries in building technical skills was accompanied by modeling integrity and sacrificial service to the poor. The Indian leaders that emerged from these hospitals were the very ones who led them after independence and helped to form some of the key national organizations that guide Christian healthcare today. The Emmanuel Hospital Association (EHA) is a collaboration of 20 community hospitals, many of which were founded as mission hospitals, and is one of the largest non-profit providers of health services in North India.[28] The Christian Medical Association of India, the Catholic Medical Association of India, and the Seventh Day Adventist Health System of India collectively play a very significant role in provision of care, as well as national healthcare leadership.

A study commissioned jointly by the World Council of Churches and the Christian Medical Commission in the late 1990s described the importance of a qualified and empowered local governance body to the long-term sustainability of church hospitals.[20] A healthy board was one where its members were selected through a transparent and inclusive consultative process based upon their qualifications. It was also a board that had a healthy interface with the executive leadership and demonstrated an understanding of distinction between governance and management roles. These institutions also demonstrated a strong under-standing of the distinction between leader (CEO) and manager (COO).

Developing Strong Relationships with and Sensitivity to the Community

The earliest mission hospitals in India were initially birthed out of programs to meet the urgent needs of the communities identified for evangelical witness. Most early missionaries lived many years within the very communities they served. They experienced first-hand the struggles that the local population had in every aspect of life. They had to develop practical alternatives to Western medical techniques that were best suited to the local context and to limited resources.[22] These programs were initiated in the context of very little existing information in terms of what we now refer to as "best-practices." They developed organically and were customized to the unique needs, and often very limited resources, of the community.

During the 1950s to the 1970s, churches and mission agencies were re-evaluating the role that mission hospitals played in their overall strategy. Many concluded that the season of, and need for, mission hospitals had passed.[29] In May of 1964, leaders of protestant mission societies called a meeting in Tübingen, Germany to discuss the role of healthcare ministry in the overall work of the Church and missions.[30] This meeting, now called Tübingen I, was followed by a second meeting, Tübingen II, and a document called "The Healing Church." These meetings and this document played a vital role in shaping the World Health Organization's move toward primary healthcare and the Alma Ata Declaration of 1978.[31] Two physicians who had served as medical missionaries in India, Dr. James McGilvray (Christian Medical College Vellore and first director of Christian Medical Commission) and Dr. Carl Taylor (Christian Medical College Ludhiana and UNICEF), made significant contributions toward drafting this landmark declaration.[32,33]

Creating Strategic Collaborations

In 1902, as missionary efforts were opening up in India, the Conference of Missionaries met in Madras, India and drafted a resolution intended to avoid conflict and duplication. This resolution stated that mission communities were "prohibited from engaging in gospel works outside of their prescribed territories."[6] After WWII and Indian independence, foreign missionary staff and funding diminished significantly. These "lean times" had a positive impact as it fostered increased interdenominational collaboration and a "teamwork" approach to foreign mission.[22] It also set the stage for the formation of indigenous networks of health facilities. The largest of these networks are the Catholic Health Association of India, the Christian Medical Association of India, the Emmanuel Hospital Association, and the Seventh Day Adventist Hospitals.[34]

In addition to mission hospitals, Protestant missionary social activism became a foundation for Indian civil society organizations. A number of "mission-spurred" organizations became critical players in shaping non-governmental organizations.[14] As an indirect outgrowth of earlier work, NGOs became increasingly important players in governmental programs for health and development. Some health programs and public health service outlets are fully managed now by NGOs.[29,17] These organizational collaborations predated most current international and regional organizations and were also very organic and related to the context and relationships that existed at the time.

Developing Healthy Systems and Infrastructure

Early missionaries generally started out their healthcare work with only the resources that they had shipped with them. They offered healthcare services in people's homes or in small shacks that served as clinics. Many did regular mobile outreach work, often with just a donkey cart.[12] They utilized connections with churches and individual philanthropists in their home country to raise considerable resources to, bit by bit, grow these small clinics into hospitals and then medical and nursing schools. On limited resources, they had to establish water, power, wards, operating theaters, sterilization facilities, and housing. Many of these hospitals became like small cities as they attracted staff who lived nearby and other residents who valued living close to such resources.[22] The WCC/CMC study mentioned earlier identified a well-designed and well-equipped facility with limited or no debt contributing significantly to the sustainability of hospitals as they underwent nationalization.[20] The development of strong financial and management systems also helped hospitals thrive. Christian Medical College of Vellore has not only trained some of the country's best doctors; it has also developed strong, locally-relevant, management strategies, and even taken over the management of struggling mission hospitals and turned them around.[35] Hospitals with highly functioning boards and executive leadership also tended to be more strategic in their decisions and had business strategies that protected them against dependence on donor support.[20]

An Illustrative Example: Ida Scudder and the Christian Medical College, Vellore

Dr. Ida Scudder was born into a family of missionaries in India. Her father was a doctor and pastor and her grandfather, John Scudder, was one of the first medical missionaries to India. Despite her heritage, Ida had not planned on being a missionary or a doctor when she grew up. Her desire was to live in her home country, the United States, and enjoy all of the things that she'd missed out on while growing up in rural India. That was, until the "three knocks in the night." She had been at home studying by lantern when she had three separate visits from men

in her village asking her to help their wives who were having complications with labor in their homes. She was just a girl and not medically trained so refused their requests, saying that she would get her father to help. Each time that offer was refused because it was unspeakable in their culture to allow a man to attend a delivery. Each of these women eventually died in labor. This event so impacted her that she was determined to become a physician and return to this community to serve the women who had been neglected.

She did return to this rural village after her training and attracted other women health providers to be a part of her team. She started with a small, rustic clinic building and used a donkey cart to do her outreach clinics into surrounding communities. Recognizing the plight of women at that time in Indian history, and the lack of female providers to provide culturally-appropriate care, she set out to start the first all-women's medical college. With no money, no buildings, and no staff, she was able to mobilize resources to make this dream a reality. Christian Medical College of Vellore grew in numbers and in reputation. In 1922, her first graduating class of fourteen received the highest scores in the country and the Madras Presidency prize, competing against men from six other medical schools. Mahatma Gandhi made a special visit to Vellore in 1927 to honor them for the work they had been doing for the poor.

The hospital trained women who would go on to hold very influential positions in government and academia. CMC-Vellore opened up to male students as the government increased their requirements for numbers of staff, students, and patient beds for teaching hospitals. As India gained its independence in 1947, Dr. Hilda Lazarus took over the leadership of the hospital and the medical schools.

Dr. Ida Scudder's early commitment to raising the standards of education and health care for women set an example that many others would follow. Her heart of compassion for the poor and for her community is still felt in the continued commitment to serving the poor at Vellore today. Perhaps as much as any other founder missionary, Dr. Scudder successfully passed along her vision, mission, and values through her unswerving and humble leadership. Her early commitment to developing strong leaders, especially women, significantly contributed to her success and to the growth of Vellore. Medical education was central to her strategy and many others followed. Her entrepreneurial spirit and boldness in taking on seemingly impossible tasks allowed her to build an infrastructure that others could build upon. It also helped her respond to changing times and work collaboratively with others.

Discussion

While the paucity of rigorous research in the area of nationalization of mission hospitals makes the conclusions from this analysis less generalizable, it points to the importance of documentation of all experiences in frontier areas, like sustainable healthcare for the poor. Learning from past failures is even more challenging when there is no one left to tell the story, or when we don't really want the story to be told. This study only scratches the surface in understanding the contributions of individuals, especially early national leaders, whose lives were dedicated to serving the healthcare needs of India. It is a cursory view of the complex historical, cultural, and social factors that impacted India's journey to where it is today. It will hopefully serve as a call for the global health and medical mission community to tell stories, document failures as well as successes, and remain committed to a culture of learning and growing.

The transition from the Millennium Development Goals to the Sustainable Development Goals signals a growing understanding that population health is intricately connected to factors outside the health system. Poverty, gender inequality, poor stewardship of water and land, and unequal access to education and markets all

contribute to population health. An integrated, multi-sectoral, systems-based approach to health systems strengthening helps us identify tools that could possibly be employed to address the deep health disparities that our globe faces today. Yet, it is not enough. We must also reflect on the past and recognize the role that compassion, ingenuity, courage, and faith have played in the development of our current knowledge and practices. Faith-based hospitals and health programs still provide a significant proportion of healthcare to the poor, and they will continue to play a vital role in meeting the remaining gaps in development and health.

Quality, equity, and sustainability are all important features in a "healthy" healthcare system. However, in developing countries, it is difficult to impact one of these positively without negatively impacting one or both others. For example, generous external funding for programs addressing specific health outcomes (like HIV mortality) can enable significant improvements in the quality of services offered (free antiretroviral therapy), even to the poor. However, these programs would rapidly collapse if the funding waned because they are not locally sustainable. India has world-class hospitals that can compete with any hospital in the "developed world" and even turn a profit (high quality and sustainability), but these services are not accessible to the poor (low sustainability). What we often see in public sector hospitals in low-income countries is "poor quality care for all." In many countries, the healthcare system is so fractured that even the wealthy cannot find quality care. The wealthiest are medically evacuated to nearby countries for advanced care, and they take their healthcare dollars with them. While this is arguably "sustainable," it is hard to argue that it is "equitable" and impossible to argue that it represents "quality."

It is clear from this analysis that investment in missionary mentoring of national leadership had a significant impact on the long-term sustainability of mission hospitals in India. It is also clear that the prioritization of building leaders was really an expression of the values of some early missionaries who resisted the colonial model of top-down authoritative leadership. Instead, they adopted a servant leadership that went beyond the mere transmission of knowledge and skills to naturally emphasize modeling and discipleship.

This attitude also impacted their willingness to relinquish leadership and decision-making authority to those in whom they had invested. Much of the credit for the successful transitions in leadership must go to the capable and committed Indian nationals who stepped into these leadership roles. Their individual stories were not emphasized in this analysis, but often included backgrounds of tremendous hardship that was met with opportunities for education and social advancement. The true leaders were those who then translated that opportunity into grateful service for others. This represented a true reflection of their mentors, as well as their new-found faith.

A commitment to developing leaders must be a core component of organizational culture if it is to be realized. A colonial mindset results in an organizational culture that does not foster local ownership or accountability. Because of the cultural background of western missionary physicians and the methods that were being refined in allopathic medicine significantly shaped the nature of medical education. A critical value within medical education is *free sharing of knowledge and skills* from teacher to student. Indian medical ethics also adopted this principle that dates back at least to the time of Hippocrates. To some degree, this may have been because this principle is consistent with the teachings of Hinduism.[36,37] A strong *emphasis on formal medical education* by early medical missionaries was not only important in the sustainability of the institutions they birthed, but also had a significant impact on the progress that the country would later make in education (especially of women) and medicine.

Early missionaries came from protestant cultures that emphasized *thrift and reason*. They

adapted the standards of their home country to the needs and resources of their new community. They also held up standards of infrastructure, financial accountability, and organizational structure. The sustainable hospitals with *sound institutional management* and high standards for their hospitals, including esthetics, were able to continue operating by these standards after their expatriate founders left or died.

A common sub-theme in several of the themes listed above is the role of gender. Prevailing cultural prohibitions of physical contact between male providers and women patients had a very negative impact on healthcare access for women. Missionary women were able to provide healthcare to all ages and genders and recognized their important role in the care of women, especially related to pregnancy. Access to prenatal care and good intrapartum care improved health outcomes in women and strengthened local support for missionary work.

In addition to care for women, early mission hospitals also provided advanced medical education for women. Early missionary nursing schools helped break down the negative stigma associated with the nursing profession and opened up advanced education to women. Early medical schools clearly demonstrated that women could compete with men in higher education, and this impacted not only the health sector but also power dynamics in general. Advancement of women played an important role in assuring local support and leadership for mission hospitals.

Recommendations

A key strategy for medical missions is to respond to historical gaps in services that exist in settings in which it works. Through much of medical mission history, provision of health services to the poor was recognized as a very effective strategy for building credibility in Indian communities and breaking down barriers for the growth of Christianity. While the majority of India remains resistant to Christianity, seeing it as an extension of western domination, poor lower caste Indians saw it differently. For them, Christianity represented freedom from the entrenched caste hierarchy and placed them on more equal footing with their fellow Indians. They resisted "indigenization" of Christianity and were eager to adopt western practices and values. In this way, missionary efforts responded to a gap in services, as well as an equity gap for lower caste Indians, the poor.

The growth of private medical services in India has not closed the gaps of unequal access to healthcare for the poor; if anything, it has widened the gap. In most low- and middle-income countries, health outcomes are worse for rural citizens than for urban and are worse for lower income citizens than higher. There is still a role for church hospitals, most of which are located in rural areas where the majority of the poor live, filling the gap in service of the rural poor.

Train healthcare leaders

Existing data shows that there is a direct correlation between poor health outcomes and the ratio of health providers to population. High maternal mortality (pregnancy-related deaths) in much of the world is a reflection of inequities in access to healthcare.[38] The WHO projected that there will be a shortage of at least 12.9 million healthcare workers by 2035, and this number may be as high as 18 million by 2030.[39,40] Mission hospitals have always served as major training centers for nurses and physicians, and most have the capacity to increase their numbers with additional support. The past two decades have seen an increase in the number of post-graduate training programs in mission hospitals with the aim of increasing national healthcare leaders.[41,42] A 20-year follow up of the Pan-African Academy of Christian Surgeons (PAACS) program documented that 100% of their 67 graduate surgeons are still serving in 20 African countries with another 74 currently in training programs.[43]

In sub-Saharan Africa, Christian hospitals may provide as much as 40% of health services. These hospitals in low- and middle-income countries represent a rich resource for expanding and improving training of physicians and other healthcare providers. Training in rural, non-profit hospitals not only provides the unique set of skills required to provide cost-effective, compassionate medical care, it often comes with role models (instructors) who can model compassionate, whole person care. Investing in healthcare leaders of all cadres is an important long-term component of eventually having healthy, autonomous healthcare systems.

Balance short-, medium-, and long-term goals for global health

Global investment in health programs targeted at the most pressing health problems in low- and middle-income countries (LMICs) has already paid unprecedented returns. Between the years 1990 and 2015, global maternal mortality dropped by 44%, and the chance of dying before the age of 5 has decreased by more than half.[44,45] The global commitment to ending the HIV/AIDS epidemic has led to dramatic increases in the affordability of, and access to, antiretroviral therapy. A record 21.7 million people are receiving; HIV treatment and HIV-related mortality in sub-Saharan Africa decreased by 42%, and globally by 34%.[46] Despite these achievements and others, healthcare systems in many LMICs remain very weak and these "vertical" programs are fully dependent upon continuous financial and technical support from abroad.

There has been a movement in the WHO and donor community to support what has been termed a "sector-wide approach" (SWAp) to health systems investment. The SWAp directs funding to the broad priorities set by the local Ministries of Health and helps to balance the often "siloed" funding that focuses on a narrow set of health objectives.[47] This trend has improved funding streams for broad health sector investments, as well as resources to more fully engage faith-based hospitals and coordinating bodies.[48] What is still needed is intentional investment in developing the internal capacity and competent leadership of the Ministry of Health and leadership throughout the health sector. Some have found that investing in advanced training of national professionals abroad led to difficulty in getting them to return to generally low-paying and difficult jobs in their home country. Providing advanced training in-country does decrease this likelihood but some of the brightest and best are "poached" by the NGO or international sector. Building cadres of well-trained healthcare leaders will require a coordinated effort and interagency cooperation. The key to retaining these staff is not "bonding" but inspiring them and supporting them in their roles in government and institutions.

Invest in institutional strengthening

Training healthcare leaders also requires significant investment in strengthening training institutions. Training in a dysfunctional institution that offers poor quality care guarantees that these patterns will continue to exist. Most district hospitals in LMICs are run by physicians who have not even had specialty training, much less training in management or leadership. Investment in disease focused, or even health systems focused, intervention should be accompanied by investment in strengthening healthcare institutions of all types. Improving governance and leadership, strengthening financial and supply chain systems, improving health systems planning and public health, developing contextualized information systems and improving physical infrastructure are all long-term investments that must be made before we will truly see "healthy healthcare systems." Healthcare leaders that can transform broken healthcare systems need more than competence; they need character and commitment. The experience and modeling that takes place in rural Christian hospitals provides the environment that can create competent and committed healthcare leaders.

Capture the power of local solutions

Every country and every community have within them tremendous power for innovation. The poor are often the most resourceful because their very lives depend upon it. While guidance from WHO and other players in global health can be extremely useful in focusing resources and informing decisions, we must always create room for local solutions that capture local markets, meet local needs, and develop local livelihoods. Fostering innovation through creating awards and grants for entrepreneurs, coming alongside local champions and inspiring local genius, will likely spark solutions that, as outsiders, we could never have dreamed.

A new paradigm of cross-cultural, international partnerships

History teaches us that an authoritarian, colonial approach to building health systems does not inspire local ownership and leadership. While it is easy to criticize the self-serving and racially biased practices of the colonial era, many practices of bilateral donors and multi-lateral agencies still practice very top-down styles of leadership. Some give lip service to concepts like community empowerment, cultural humility, and mutual accountability but, when it comes to setting priorities and budgets, the "golden rule" still applies, "whoever has the gold, makes the rules." Vastly different values and worldviews can be difficult to navigate, especially when money and agendas are involved, but it is essential that the voices and minds of the "global south" are heard and included as equal partners in shaping the future of healthcare missions.

Whether in faith-inspired missions or international politics, neocolonialism can become the "default mode" in cross-cultural partnerships. Sometimes, it takes the form of, as Mary Lederleitner has said, "paternalism couched as accountability" or a political agenda couched as "protection of human rights."[49] The international development community must develop habits of preserving dignity and striving for mutuality in the way that we engage in "assistance" in developing country contexts. In many ways, we who come from task-oriented, highly individualistic cultures have a lot to learn from our brothers and sisters who come from highly relational, collectivistic cultures. Good relationships require an investment of time, as well as money. Paul Farmer describes his philosophy of "accompaniment."

> To accompany someone, is to go somewhere with him or her, to break bread together, to be present on a journey with a beginning and an end . . . There's an element of mystery and openness . . . I'll share your fate for a while, and by 'a while' I don't mean 'a little while.' Accompaniment is much more often about sticking with a task until it's deemed completed by the person or person being accompanied, rather than by the *accompagnateur*.[50]

"If you want to go fast, go alone. If you want to go far, go together." African proverb

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