



On missional medicine: institution building, fragile places, and sheep among wolves

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Abstract

From the healing narratives of Jesus in the Gospels to the genesis of the first hospital to the practice of modern medicine, questions surrounding health and care for those who are sick and dying run through the heart of the Christian story. One way that individuals and communities have sought to live into their faith has been through missional medicine, that is, seeking to intentionally use the tools of medicine in step with and to bear witness to the life of Christ, particularly in cross-cultural and global contexts. In this commentary, we take up the incisive question of the late missionary physician Raymond Downing, “is there a distinctive Christian approach to global health?” Or, what sets (and should set) Christian approaches to global health apart from other interventions? Here, we argue that there are at least three distinctive Christian contributions to global health. First, missional medicine movements have been committed to the building of long-standing hospitals and academic medical institutions that have left indelible marks on long-term health outcomes for people and communities. Second, practitioners motivated by Christian convictions disproportionately serve and remain long-term in marginalized, rural, and underserved areas; many of which are connected to fragile or under-developed health systems. Thirdly, Christian medical missionaries and global health workers ought to be, in the words of Jacques Ellul: preserving salt, revealing light, and “sheep in the midst of wolves.” This is a theologically framed vocation that accepts suffering and sacrifice, embracing solidarity through accompaniment. This paper is not meant to be a comprehensive history of missional medicine nor a defence of its problematic manifestations over the centuries. Rather, we candidly explore examples of the distinctive contributions that have been made, and we hope will continue to be made, by medical missionaries and global health workers who are motivated by their faith.

Key words: missional medicine, mission hospitals, accompaniment, theology

*The church has been doing medical missionary work for 2000 years. These days it seems that people...don't realize the role that Christian mission doctors and hospitals play in most of the developing world. Anyway, self-promotion is a bit counter to the Gospel so perhaps not a bad thing.*¹

Introduction: Is there a distinctive Christian contribution to global health and healing?

From the healing narratives of Jesus in the Gospels to the genesis of the first hospital,^{2,3} to the practice of modern medicine, questions of health and care for those who are sick and dying run through the heart of the Christian story.⁴ Christianity itself has been described as a religion for the sick.⁵ In many ways, the above quote from medical missionary, Tom Catena, rings true — the church has been doing the work of healing since the earliest days of the faith. Yet, the “medical missionary” as a concept and medical missions as a whole largely developed in the 19th and 20th centuries in the wake of the expansion of European colonialism, significant developments in the fields of medicine, surgery, and pharmacology,^{6,7} as well as the significant growth of the modern missionary movement in the Western church.⁸

The work of medical missionaries and missions come under criticism as they are often linked with colonialism and Western hegemony.⁹ More recently, the enormous growth of short-term medical mission trips have only deepened this criticism. These generally one to two week-long endeavors, however well intended, often fail to account for cultural differences, the needs of the community, structural drivers of global health disparities, and the local health care infrastructure. They may cause more harm than good in the name of “serving the needy.”¹⁰ Many also are concerned that medical missions are often tied to proselytization. Is offering medical care simply a means for conversion or is the work of healing in of itself “good news?” Or, is it some mix of the two? These serious concerns (among others) invite

deep interrogation of all cross-cultural medical work, religiously-motivated or otherwise.

This leads to a provocative question asked by late missionary doctor Raymond Downing, “is there a distinctive Christian approach to global health?”¹¹ Bound up in this question are the various critiques of medical missions and the modern global health movement which has been named by Paul Farmer and others as a form of neoliberalism and Western imperialism.^{12–14} This question is both a practical and theological one, challenging Christian practitioners who engage in global health work to contend with the implications of the Gospel. What difference do the life and teachings of Jesus make in broken and needy individuals now and not just towards eternity or salvation? Is there any place for missional health care, including direct medical and surgical services, as well as community health and development work, that can be supported and embraced in view of the good news of Christ?

In this essay, we take up this question, arguing that there are at least three distinctive Christian contributions to global health. First, missional medicine movements have, over and above other global health interventions, been committed to the building of long-standing hospitals and academic medical institutions that have left indelible marks on long-term health outcomes for people and communities. Second, practitioners motivated by Christian convictions disproportionately serve and remain in marginalized, rural, and underserved areas; many of which are connected to “fragile health systems.”¹⁵ Thirdly, Christian medical missionaries and global health workers ought to be, in the words of Jacques Ellul, “preserving salt, revealing light, and...sheep in the midst of wolves...offer[ing] the daily sacrifice of their lives, which is united to the sacrifice of Jesus Christ.”¹⁶ This is a theologically framed vocation that accepts suffering and sacrifice and embraces solidarity, through accompaniment, or the intentional practices of being present and deepening relationships to do the work of the Gospel in the model of Christ.^{17–19}

This paper is not meant to be a comprehensive history of missional medicine nor a defense of its problematic manifestations over the centuries. Rather, we intend to candidly explore examples of the distinctive contributions that have been made, and we hope will continue to be made, by medical missionaries and global health workers motivated by their faith. To accomplish this, we will first briefly trace the parallel development of colonial medicine and missionary medicine. Then, we explore the institutional emphasis and impact of missional medicine movements with a focus on the lasting impact of mission hospitals in India and Sub-Saharan Africa. Finally, we explore Christian engagement in remote, unstable, and otherwise challenging contexts, concluding with a brief theological reflection on the work and writing of Raymond Downing and Jacques Ellul and the importance of accompaniment.

In Parallel: Colonial medicine and medical missions to global health, a brief history

Westernized biomedicine arose around the same time European colonialism was at its height in the 18th and 19th centuries. As evidence of its ties to extraction, racism, enslavement, and expansion of imperial power, medical care from the health care practitioners among the colonizers was only sparingly offered to locals. When the services of modern medicine were extended to indigenous communities, it was largely in the interest of the empire and to protect those serving in colonial outposts from tropical diseases and other maladies. Biomedicine was “often cited as one of the virtues of the imperial enterprise, even long after other defenses of colonialism had been discarded.”⁷ Colonial leader Hubert Lyautey said that “the only excuse for colonization is medicine,” for to him the “action of the doctor” both “ennobles” and “justifies” the brutality of colonialism.⁷ He and others viewed colonial medicine as the “most effective of our agents of penetration and pacification,”⁷ weaponizing biomedicine as a tool for domination.

Cross-national and cross-cultural Christian missions span back to the earliest iterations of the global church. Although there are significant examples of medical missionaries venturing into far-off lands before colonialist enterprises — including famously, Dr. Peter Parker (China) in the 1830s and Dr. David Livingstone (Congo and Zimbabwe) in the mid-1850s — European colonialism opened new opportunities for missionary activity. The adoption of modern medicine as a form of missionary activity is a complex story. The desire to share the goods afforded by modern medical, surgical, and public health interventions was a motivator for many at the time. Still others learned that scientific medicine could be a means for entry to difficult and distant locales, a “door opener” for proselytization.⁶ Some early missionary doctors viewed their work as part of “civilizing the savage,” a means for furthering Western domination not unlike the explicit aims of colonization, while others like Albert Schweitzer⁷ and Daniel McGowan²⁰ viewed medicine as a form of “atonement” for the atrocities of the colonial period.

It is important to note that although some aspects of the medical missionary movement were made possible by colonialism and have been deeply colonial in nature, most of the overarching aim was different than that of colonial medicine. Colonial medicine generally focused on the prevention and treatment of disease in the colonists and placed a greater emphasis on population-level interventions. Conversely, medical missionaries cared primarily for the indigenous population and invested in the health and clinical care of individuals, often outside the centers of colonial power.⁷ In short, although missionary medicine and colonial medicine broadly developed in the same era, they did so with largely different aims and outcomes, as well as the commitment and involvement of different groups of people.

From the end of the colonial period to the rise of “tropical” and “international” medicine to the current global health enterprise, there has been limited collaboration between “faith-based organizations” (FBOs) and “secular” health

initiatives. This persists despite the significant impact of FBOs on healthcare in resource-limited settings,¹⁵ as well as global health's shared focus on engagement with local populations.

Built to Last: The role of missions and institution building

Jon Fielder is a longtime missionary physician and chief executive of African Mission Healthcare.²¹ He cites the gap between grant-dependent large NGO global health initiatives and medical mission institutions (personal interview, October 2022). Fielder speaks of the reality of funding within large NGO global health programs, citing that most of the major funding goes towards discrete projects focused on water, sanitation, and hygiene, and generally neglect institution building and clinical care. The projects, though well intended, are often designed via top-down mechanisms funded by external private foundations and government agencies, resulting in unpredictable cycles of funding and recurrent personnel turnover in country. This work often feels distant from the stated and tangible needs of the local population. In addition, extractive research without local, tangible benefits as well as economic exploitation tied to large scale global health projects seems to be the latest iteration of colonial influence — now, steeped in neo-liberalism.¹²⁻¹⁴

Fielder also explains a phenomenon he has noticed in his context in Kenya. If health care workers from the hospital he has been involved with for years interact with locals, even far from the hospital, people immediately recognize and trust them. This is attributed to the longstanding presence of this institution in the region, for this mission hospital has been there for over 100 years. For example, locals can recall the time their mother was treated for ovarian cancer or uncle was cared for after an accident. This institutional presence shifts the entire area's health care seeking behaviors and fosters trust and solidarity between the hospital and community. It has a lasting and significant impact on the health care outcomes of the community.

This long-term investment, and the resultant outcomes, is also demonstrated in the Indian context in a recent paper from the field of developmental economics. In this study, the authors constructed:

a novel, fully geocoded dataset that combines contemporary individual-level data with historical information on Protestant missions in colonial India and their activities...to study the link between individuals' proximity to a Protestant medical mission (i.e., a mission equipped with a hospital or a dispensary) and their health outcomes today...[focusing] primarily on anthropometric indicators to measure health and use geocoding tools to compute the distance between the current location of individuals and the location of Protestant health facilities operating in early twentieth century India. Indeed, we find that proximity to a Protestant medical mission is positively associated with current individuals' health outcomes.²²

The authors controlled for many variables, including religious conversion, the location's relative prosperity/natural resources, missions *without* medical care or hospitals, level of urbanization, and presence of educational facilities. All demonstrated the most important factor for long-term impact on health was *proximity* to a medical mission/mission hospital. This effect was more significant in socially disadvantaged groups, namely women, the poor, and less educated individuals.²² The positive impact was more pronounced if the hospital offered surgical care.²² These improved outcomes persisted whether the hospital was still operational or not. The authors attribute this longstanding impact to 1) changes in health habits and practices, as well as health seeking behaviors and hygiene, and 2) a significant improvement in maternal and child health outcomes (likely tied to surgical obstetric care and other advanced maternal health care) that were the result of local medical mission impact. Further, this long-term effect is primarily

attributed to the generational memory of poor women and uneducated individuals. The “least of these” became a positive driver of the community’s health for generations, and hard-won trust left a lasting mark.

This study supports Fielder’s intuition. There is a tangible, long-lasting, durable impact on health outcomes associated with mission health care institution-building, particularly among the poor and marginalized in the surrounding communities. Building and maintaining institutions focused on delivering clinical care has been a distinctive contribution of Christian medical missions, ranging from larger teaching and referral hospitals like AIC Kijabe and Tenwek (Kenya), Kilimanjaro Christian Medical Centre (Tanzania), and Vellore (India), to district level hospitals such as Hope Kibuye (Burundi), Malamulo Adventist (Malawi), and Selian Lutheran (Tanzania), to smaller but geographically essential facilities such as Mother of Mercy-Gidel Hospital (Sudan) and the twenty EHA hospitals sprinkled throughout India — to name a few examples. At its best, this institution-building also includes the training of local nationals to build up clinical capacity and enable sustainability, a practice that traces back at least to the founding of the Che Jung Wan Medical School in Seoul, Korea in 1886. Starting with the training of nurses almost immediately after initiating any health program in a remote area, mission institutions continue to expand the breadth of their educational efforts to include physicians, surgeons, clinical officers, and other essential clinical staff. A paradigmatic example is the Christian Medical College (CMC) Vellore in India.²³ Founded by Dr. Ida Scudder in the early 20th century as a response to the dire need of Indian women dying in childbirth, CMC-Vellore still stands as a world-class training and research institute that offers advanced surgical care and community health interventions for the entire region. Today, it is known as one of the best medical schools and hospitals in all of India. The Pan-African Academy of Christian Surgeons and the similar Christian Academy of African Physicians for primary care are examples of local and international partnerships designed to share

knowledge and build local capacity for post-graduate, apprenticeship-focused training toward building local clinicians who practice excellent, holistic care.^{24,25}

Long-term investment in institutions and training local health care workers to high standards remains a distinguishing characteristic of a Christian approach to global health. This is not just good for short-term health outcomes of the patients they serve, but also seeks to empower individuals and invest in local capacity building. For this investment to remain appropriate, these health care workers would do well to understand theologies of health and suffering, the rich history of Christian involvement in healthcare delivery, and the important cross-cultural implications of engagement now being provided in a seminar course, Christian Global Health in Perspective.²⁶

Sheep Among Wolves: Suffering, accompaniment, and solidarity

There have been persistent gaps in understanding and collaboration between government, non-governmental organizations (NGOs), the more recently burgeoning academic global health world, and missional medicine. It is a much less common practice for missionary physicians to publish and publicize their work in academic journals or for mission hospitals to be integrated into or “counted” by governmental health systems. This makes the impact of medical missions difficult to quantify. One of the most notable academic engagements with faith-based commitments in health care was the *Lancet* series on Faith-based health care from 2015. One article from the series explores the impact of FBOs in Africa.¹⁵ In this piece, the authors acknowledge that faith-based institutions and communities provide a significant percentage of health care across Africa. Some estimate anywhere from 30%-70% of health care is provided by FBOs.¹⁵

Regardless of the overall magnitude of care covered by mission hospitals and other faith-based medical work, including large scale community health and development programs, the authors noted two key contributions that set them apart

from the public sector. First, available studies show that the “quality of the services provided is perceived as high because of a particular attention paid to the dignity of patients, sometimes articulated as more compassionate care than received elsewhere.”¹⁵ This is supported in a Gates-funded study of religious health care in sub-Saharan Africa that found that many people preferred to go to faith-based institutions over government hospitals.²⁷ Further, in several studies, mission hospitals were found to be preferred over other health care institutions.^{28,29}

Second, there is an emphasis on giving care to poor and vulnerable populations, which today has resulted in a disproportionate number of faith-based health care institutions in rural, remote, and hard-to-reach areas.¹⁵ This commitment can be difficult to sustain and often requires creative adaptations to survive in changing economic and social conditions, as well as sometimes necessitates continued external support from communities and churches to be sustainable.³⁰ Yet, it marks a particular contribution of medical missions to the landscape of health care globally. Olivier and colleagues conclude, “The slowly emerging evidence on faith-based health-care providers suggests that they are not simply a health systems relic of a bygone missionary era, but still have relevance and a part to play (especially in fragile health systems).”¹⁵

The reality that missional medicine has a distinctive role in rural, remote, unstable, or resource-limited health systems is almost a normative, distinctive marker of Christian contributions to global health, but is often underrecognized, even from within mission organizations who pride themselves on quiet consistent service and humility. Commitment to offering care in solidarity with those at the margins goes to the very roots of the historical missional medicine movement and is powerfully articulated theologically with the language of liberation theology and accompaniment.^{31,32} This theological imagination, stemming from mid-20th century grassroots movements in Catholicism in Latin America, is grounded in Scripture, including the Exodus narrative (Exodus 1-18), the book of Job,

and the life and work of Jesus as demonstrated in the Gospel of Luke:

The Spirit of the Lord is upon me, because he has anointed me to bring good news to the poor. He has sent me to proclaim release to the captives and recovery of sight to the blind, to let the oppressed go free (4:18, NRSV).

At its roots, liberation theology asks the question, “how does the life, death, and resurrection of Christ matter here and now, and not just for eternity?” Theologies of liberation, particularly as articulated in the Latin American experience, but also in Africa and parts of Asia, have put forward “accompaniment” as a theologically-based framework for ethical action.³³ Accompaniment, with its emphasis on listening, solidarity, and physical proximity to the poor, has been demonstrated to improve health outcomes not just for individuals, but communities. This stands in contrast to some global health programs that are directed from afar with limited relational commitments and long-term presence.^{18,19,33,34} Although many practitioners of missional medicine predate these theological frameworks, we believe that the values put forward in accompaniment articulate the commitments to proximity and solidarity prevalent in faith-motivated health care at the margins.

In one of his final books, *Global Health Means Listening*, Raymond Downing reflects on the concept of accompaniment and nearly 30 years of experience as a medical missionary in East Africa. In a chapter titled, “Is Suffering Necessary?” he asks, “Is there a distinctive Christian approach to global health, or do we simply draw from the myriad approaches already described, testing each piece for how well it reflects general Christian principles?”¹¹ Drawing from French philosopher and theologian Jacques Ellul, Downing contends that the three distinctive Christian contributions are to “be preserving salt, revealing light, and...sheep in the midst of wolves.” Regarding this “vocation,” Downing again quotes Ellul,

It is essential that Christians should be very careful not to be ‘wolves’ in the spiritual sense -- that is, people who try to dominate others. Christians must...offer the daily sacrifice of their lives, which is united with the sacrifice of Jesus Christ.¹⁶

Christians must be open to suffering as they draw near to those on the margins. There is no formula for this contribution or assurance of what the outcomes might be, but it entails a surrendering of our “need for control and the assurance of results and of change,” and a willingness to throw in our lot, as it were, with the weak and discarded of this world – to serve, teach, and befriend.¹¹ Taking up our distinctive vocation as sheep among wolves may not be a “winning” strategy as it is most typically construed. But, Christians follow a God in Christ who, “chose what is weak in the world to shame the strong” (1 Corinthians 1:27, NRSV). Perhaps such an approach is fitting.

Conclusion

We have proposed that there are at least three distinctive Christian contributions to global health. First, missional medicine movements historically focused on building health care institutions, a practice that has left deep and lasting improvements in health outcomes of proximate communities. Second, Christians serving in missional medicine are more likely to have a particular and lasting commitment to working in challenging situations, including underserved and impoverished areas and to being particularly committed to work with those who are poor and marginalized in society. Thirdly, those pursuing the fullness of a Christian approach to global health are to draw close in accompaniment and relationship. They are to offer their time and talents as “sheep among wolves,” refusing to dominate and willing to sacrifice and suffer alongside the communities they are accompanying. For those seeking to bring their Christian commitments to bear in global health, considering these distinguishing qualities might help motivate, sustain, and frame faithful engagement.

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medical missionary, was a practicing Catholic deeply influenced by core principles of liberation theology, including the preferential option for the poor and accompaniment. This framework motivated and sustained medical work in solidarity and advocacy alongside the poor in Haiti and all over the world. In a Sojourners piece titled “Sacred Medicine: How liberation theology can inform public health,” Farmer writes:

Over the course of my 20s, the slender, frayed thread of my own faith, which I had believed cut, slowly came back into view. There was a filament a bit stronger than imagined, made visible in part by my Haitian hosts and patients and friends, and in part by Catholic social activists working against poverty in settings as different as tough neighborhoods in Boston, the farms of North Carolina, and the slums of Lima. Some were nuns or priests, some were engaged laity, from many professions. Most were people living in and struggling against their own and others’ poverty. Their activism taught me a lot about a space in the Catholic Church I’d not seen clearly before, and about the promise of long-term engagement in the monumental struggle against poverty and discrimination in all its forms.

To read more, see

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