

Research Project ‘History of Health Systems in Africa’

SNIS Executive Summary

1. The research plan

The history of health systems in African countries remains neglected. Health reform has always tended to be informed by the challenges of the immediate situation and has given little importance to longer-term studies on the evolution of health systems. Early studies looked at administration, and sometimes at concepts of health delivery; but they seldom applied historical methods to this research. Our study of health care delivery at the local level will contribute to a wider understanding of the development of national health systems and of their capacity to provide equitable health care. We believe that this is where our project, based on a long time span and comparative framework, makes its strongest contribution.

The following aims and key topics guided the comparative analysis:

1. Identification of actors in health systems and their perspectives

The project gave priority to the actors on the ground and to their conceptions of health. It looked at their motives and aims, together with their ideological and scientific backgrounds.

2. Characterisation of health care concepts and delivery in rural Africa

The characteristics of health care delivery developed at the various mission stations were examined. Particular attention was directed at whether health delivery at certain times and places leaned, for instance, towards a) an approach targeting specific groups of the population or a broad public health approach, b) a highly technical, expert-driven health delivery system focused on specialised hospitals in urban centres or a primary health care approach encompassing rural areas, and c) a focus on curative measures and techniques or an emphasis on preventive health care and hygiene.

3. Assessment and explanation of success and failure in a historical perspective

To assess success in health delivery, three steps were planned: a) to judge the outcome of health delivery at least partially in terms of the experiences of recipients; b) to find out whether the health care providers were satisfied with the results of their work, and c) to describe the effect of health delivery in terms of mortality, life expectancy and distribution of disease.

4. Characteristics of mission medicine

To examine the characteristics of the medical mission work developed by the Swiss in the twentieth century, it was considered whether mission medicine had specific strengths that other health providers did not have. Another aspect of interest was the way gender concepts structured the provision of missionary medical services. A key concern was to compare mission medicine as it was practised by different religious denominations in different localities marked by different cultural backgrounds.

To study these key topics from a comparative perspective, three case studies were carried out in Elim Hospital (South Africa), Agogo Hospital (Ghana) and St. Francis Hospital (Tanzania).¹ Each case study carefully examined written sources including archives, patient records and personal correspondence. They also collected oral histories from key actors involved in shaping and providing mission medicine, from the local population who were potential beneficiaries, as well as from elders and other key informants who could provide historical context knowledge.

2. Results and Analysis

2.1 Main actors

Even though Swiss missions were important actors as founders of the three hospitals, the project documents great variation in terms of their role, involvement and influence. This variation is partly attributable to the fact that the hospitals were founded by different Swiss missions at different periods in three different British colonies in Africa. The Swiss Romande Mission of Free Churches opened Elim Hospital in 1879, when Northern Transvaal was still part of the South African Republic (1852-1877 and 1881-1900) and just before it moved from Boer to British hands in 1902. The Basel Mission inaugurated Agogo Hospital in 1931, when the Gold Coast in West Africa was a British crown colony. And the sisters of the Franciscan Baldegg congregation, as well as the Capuchin Bishop of the Archdiocese of Dar es Salaam, supported an Austrian medical doctor in the construction of the St. Francis Hospital in Ifakara which opened its doors in 1960, a year before Tanganyika (a British mandated territory) reached independence in East Africa.

A closer look at each site provides insights into its specific history; something that was in turn influenced by larger changes at home and in Africa. At Elim, the Commission of Missions created within the Free Church of the Canton de Vaud first provided medical care at a mission station in 1879. In Switzerland, delegates from Geneva and Neuchâtel joined the Vaudois Commission of Free Churches in 1883, and soon afterwards, the Mission Vaudoise changed its name to Swiss Romande Mission of Free Churches. In the late 1890s, this new and expanded Swiss mission began to plan a hospital and turned its attention to the health needs of the rural population around Elim. The colonial government, in fact, granted permission only on condition that the hospital would serve both black and white patients. The Transvaal government even offered to fund the construction of the hospital. However, the Swiss Mission doctor at Elim, Georges Liengme, decided to raise funds back home to keep the hospital independent from the local administration. The hospital construction was financed by money raised in Switzerland, but over the next decades, the Transvaal administration and later the South African state gradually extended grants to the hospital.

The Basel Mission started discussions about the establishment of a ‘medical mission’ (Ärztliche Mission) in the 1880s. The physician Rudolf Fisch left Basel for the Gold Coast in 1885. He first opened a sanatorium for Europeans and later a small clinic for Africans north of Accra. With the outbreak of the First World War I, the British government expelled the Basel Mission from the Gold Coast, and the Scottish Mission as well as the Presbyterian Church of the Gold Coast took over its activities. After its return in 1926, the Basel Mission had to search for a new area and moved to the Ashanti region further north where it built Agogo Hospital in 1927. Soon after the

¹ The comparative research project History of Health Systems in Africa (2008-2011) was financed by the Swiss National Science Foundation, and SNIS contributed funding for two PhD students for two years (2008-2010).

opening, however, financial questions led to a severe conflict between the mission leadership in the Gold Coast and Basel, and the mission doctors in Agogo. The former expected the hospital to be financially self-supporting and, later, even to generate revenue that could be invested into other missionary activities, while the latter aimed at improving and expanding the services (see below). By the early 1950s, the colonial state in the Gold Coast had started to financially support mission health care activities. This led to a significant increase of health institutions run by missions: the number of mission hospitals in the Gold Coast grew from three in 1951 to thirty in 1960.

In East Africa, the Swiss Catholic missionaries from the Capuchin Order and the Baldegg Sisters took over from German missionaries of the former German colony, soon after the League of Nations formally gave the mandate over Tanganyika to the British in 1920. While the Capuchins first concentrated their activities on the government hospital in Mahenge, the Franciscan Baldegg congregation built a small dispensary in Ifakara in 1929, which gradually developed into a maternity hospital with 30 beds (1944). The first mission doctor arrived in 1951, followed by Karl Schöpf in 1953. The latter started the construction of a new hospital in 1955 and remained in service at St. Francis for 17 years. The mission and its friends became more and more financially supportive and engaged up to the mid-1960s, when they handed over St. Francis Hospital to the local Roman Catholic Church.

What all three sites have in common is that Swiss missions not only founded the hospitals but funded their construction. Elim Hospital was financed by ‘Société Immobilière’ in Lausanne, Agogo Hospital by the Union Trading Company of the Basel Mission and St. Francis Hospital through various mission and medical support networks. Over the decades and up to now, various and internationally-expanding support networks which have been formed by missionaries, their relatives and/or supporters in Switzerland, Germany and other countries, continue to provide financial, material, medical and managerial support. In addition, the Service for Technical Cooperation of the Swiss Government and, increasingly, also overseas donors, have become important partners of these hospitals, including church, private and government organisations mainly from Germany, the Netherlands, and to some extent from the USA.

Many of these actors have to be taken into account in the comparative historical analysis of the three mission hospitals. To examine their changing relations over time, the project pays, for instance, particular attention to the changing constitution of the management boards of the three hospitals.

Elim Hospital had from the beginning a *Commission de l'Hôpital*, led by the hospital director, but this “board” was dependent on the decisions taken by the missionary conference in the Transvaal as well as by the ‘Comité Médicale’ in Neuchâtel. Non-medical missionary staff of European origin was in the majority in this board. In the early 1940s, local representatives were invited to join the board which now consisted of members of the Swiss mission, the Swiss superintendent of Elim Hospital, a delegate of the Transvaal local administrator, and representatives of white farmers. In 1976, the decision of the South African government to take over all missionary hospitals became effective at Elim Hospital. Since then, the management board has consisted of the local administrator, community members and the superintendent of the hospital, as in any other hospital of the South African health system. The mission then had officially nothing to do with the management of the hospital, even though the superintendent and the medical doctors were Swiss or of Swiss descent.

At Agogo Hospital, the “Stationskonferenz” was in the hands of the European hospital staff. This board represented the hospital’s concerns about the mission leadership in Kumasi and Basel. Due to the financial questions mentioned above, the relations between the board and the mission leadership became strained shortly after the hospital opened and the dispute finally led to the resignation of a physician. More fundamental discords have been identified as underlying the financial questions: the autonomy of the Agogo medical doctors vis-à-vis the mission house, and their relationship to the missionaries on the ground; the role of the Union Trading Company; and also the ideological closeness to German National Socialism of some of the (German) hospital staff. From the early 1950s onwards, senior staff from Ghana, mainly qualified nurses, had a regular meeting, but this meeting was subordinate to the management board. From the late 1950s, the board consisted of the church moderator (national level), the pastor of Agogo (local level), and the European staff of the hospital. The District Commissioner as a state representative joined the board in 1965, and since then, the church, medical doctors and the government collaborated in the management of the hospital. In the early 1990s, the newly formed Area Board was introduced as the decision-making body of the Presbyterian Health Services Agogo (later Ashanti Akim) of which the hospital formed part. Apart from the hospital management and staff as well as the Presbyterian Church of Ghana, the Agogo Traditional Council, the Regional Health Services, the Ebenezer Presbyterian Church of Agogo and the Christian Hospital Association of Ghana were represented in this body.

At St. Francis Hospital, a board was formed when Mahenge became an autonomous diocese within the Tanzanian Catholic Church. Opened shortly before Independence in 1961, St. Francis Hospital became the flagship of the church and was visited by the late President Julius Nyerere on a number of occasions. Scientists from what later became known as Swiss Tropical Institute (now Swiss Tropical and Public Health Institute) initiated and supported the building of a field laboratory and a training school for medical staff, and the leaders of these institutions joined the hospital board. In 1976, the hospital was integrated into the national health system and government representatives became members of the hospital management board. In the early 1990s, the Swiss Development Cooperation as major donor was invited to join the board, and there was a discussion about including a community representative in the board.

This short comparative analysis clearly shows that medical missionaries were not merely foot soldiers of colonial expansion, as was often assumed. Mainly with money raised through trans-national links, they built hospitals which became important nodes in power relationships between the mission/church, medical professions and the government. These nodes constituted social fields in which broader societal, political and economic changes were not only reflected but also negotiated or fought over and, at the same time, the hospital management boards became institutional agents in their own right.

In all cases the local communities have been excluded from playing an active role in these nodes of power, except for educated elites (see below) and the white settlers in South Africa. A special case is the prominent role of the local leadership in Agogo in bringing a mission and hospital to their territory, according to the official oral history. However, the voice of the patients is not heard in the history of all three hospitals – and this probably reflects the everyday reality throughout the decades. The hospital administration produced huge piles of patients’ files and records (especially at Elim and Agogo Hospital), but the hospital records say nothing about the perceptions and experiences of patients or the socio-economic, ecological and cultural contexts in which they lived. The actors who played a key role in the hospital management boards shaped

and dominated the development of the three mission hospitals over the years and, together with the broader forces which influenced them, defined mission hospitals' direction and policy orientation.

Nevertheless, several important insights were gained with regard to local communities. First, the word itself has to be unpacked in order to be used as an analytical term. "The community" encompasses not only users of the health care services in the strict sense (sick people/patients) but also many more members of social groups, often – but not necessarily – living in the vicinity of the hospitals who were actively involved in shaping mission medicine. In all three studied hospitals, for instance, family members did – and still do – most of the cooking and are actively involved in providing care, while health professionals are responsible for clearly defined nursing activities. With their manual and supportive work at the hospital, family members either contributed to the cost of treatment or generated a small extra income. Other community members were employed by the hospitals or used their infrastructure and material basis, although not always driven by the same medical, legal, bureaucratic and ethical rationalities. Secondly, for many members of local communities, hospitals served as discursive containers in which to negotiate access to development, welfare institutions and trans-national networks. A third insight is that individual persons and social groups of the local communities played an important role in translating, transferring and transforming missionary medicine, inside and even more outside the hospital walls, for instance in lay movements like the Blue Cross Movement (South African case study) or the Legio Mariae (Tanzanian case study).

Health care concepts and delivery

The voice of patients', their relatives and "ordinary villagers" was not heard. It seems plausible that the staff of the three mission hospitals rejected understandings of health and illness which had non-Christian and/or roots they considered 'unscientific'. The combination of a Christian sense of mission and a biomedical claim for truth may have led to a biased and distorted attitude which ignored or discredited health-related social practices like witchcraft or healing rituals. However, although the project made special efforts, it was difficult to gain deep insights into the relationship between Christian hospital staff (e.g. doctors but also nurses, lab staff, secretaries, cooks, drivers, or guards) and villagers and their efforts at translating, reconciling or even transforming health-related ideas and practices of different sources and origins (see above).

In the decades following the Second World War, the three mission hospitals had to reconfigure and realign their services and policies due to increasingly rapid changes in the field of health but also with regard to their legitimation and role in colonial and later independent governments. The mission hospitals were confronted with new diseases (e.g. diverse persisting tropical infectious diseases and increasingly with non-communicable illnesses), changing health profiles (due to class and race and to migration and seasonality, Elim Hospital), newly emerging health priorities and needs now formulated by national ministries of health (such as a nationwide coverage with vertical programmes of infectious diseases eradication in Tanzania), and finally the emphatic focus on WHO's Primary Health Care programmes (e.g. in Tanzania and Ghana). The hospitals were further confronted with new political constraints and pressure (such as Apartheid in South Africa) and with new political ideologies (such as the African Socialism in independent Tanzania and partly in Ghana). These important transformations affected the three hospitals to varying degrees and are mirrored in debates about free treatment versus user fee, clinically oriented hospitals with high European medical standards versus community-based preventive and promotive social medicine, self-sufficient versus profit-oriented hospitals and charitable medical

services guided by religious and spiritual values and norms versus secular-technical, highly professionalized treatment and diagnosis. For example the discussion about the introduction of user fees in St. Francis Hospital (Tanzania) is intrinsically linked with the greater political environment in Tanzania, namely the Arusha Declaration (1967) of Julius Nyerere and his proclaimed Third Way of Socialism. New actors as well as new ideologies, visions and concepts entered the health care arena, and exerted a powerful impact on the future role, function and nature of the three mission hospitals.

In contrast to Agogo and St. Francis Hospital, Elim Hospital introduced comprehensive community-based basic health services to rural areas in the 1970s. This strategy can be seen as a disconnection from national health concepts and delivery. It sheds light on the scope of manoeuvre each of the three mission hospitals had with regard to the development of its own primary health care/public health strategy – and thus deciding whether “the hospital without walls” – an initiative of the (Protestant) Christian Medical Council in Geneva in the early 1970s – would be implemented or the “walls around the hospital” would be just elevated. Particularly Agogo and St. Francis Hospital have chosen to follow a pragmatic kind of double strategy: maintaining the hospital’s high medical standards and at the same time fulfilling its role and function as ordinary district hospital in a wider primary health care network.

The internationalisation of medical cooperation led to secular dynamics of modernity. Hospitals began to attract projects and programmes driven by the research and health development agenda of different donor countries (see below).

Characteristics of mission medicine

In the early years, the Swiss missionaries, doctors and nurses were confronted with British colonial rule and had to find their position within this regime. An uncontested niche was the provision of complementary health care services, mostly in rural areas.

Mission medicine attracted pioneering and often charismatic individuals who wanted to follow the Christian example of “the Good Samaritan and his Christian grace of charity”. But on several occasions, they had to convince the mission leadership at home that mission medicine was a representation of a spiritual vocation.

In fact, Swiss doctors and nurses had to navigate continuously and cautiously between the religious values and norms of the mission at home and the secular concerns of their professional work in Africa. The history of all three Swiss mission hospitals was marked by navigating between these two poles.

Over the years, and especially after Ghana and Tanzania became independent, different trends towards secularisation can be discerned in all three hospitals. 1) At Elim Hospital, the political influence and control of the South African government increased with direct financial involvement and the integration of hospital services into public health structures. 2) Agogo Hospital (like St. Francis Hospital) had already experienced policy interventions in medical matters under the British colonial government; it made a major move by integrating itself into the independent church and, subsequently, into the national health care system of the newly independent state of Ghana. 3) Similar changes occurred in St. Francis Hospital in Tanzania: integration into the Tanzanian Roman Catholic structure and into the national health system of independent Tanzania.

Whether secularisation occurred directly or through the integration into nationalised church structures, former mission hospitals lost at least part of their authority and autonomy, and the Swiss missions some of their power and control. The governments argued that the health needs of the local population now had highest priority and called for a national health policy and a more systematic approach in health care delivery. Hospitals should improve their coverage and efficiency for the sake of the whole society.

In the early years, the funding of the Swiss mission hospitals came exclusively through money transfer from the mission in Switzerland. This policy came to be gradually challenged (particularly for Elim and Agogo Hospital) by new principles of self-sufficiency and self-reliability of all mission activities in Africa and Asia. Over the years, a common agreement divided hospital running costs between the mission, the government and the patients. However, up to now money is a source of hot debates because funding can be (mis-)used as a powerful tool to control the hospital's policy and related decisions. Another recurrent topic is the phasing-out of payments from Swiss missions after their hospitals have been integrated into the national health care system and the introduction of user fees and cost sharing models in mission/church hospitals.

In the past decades, the image of “the Good Samaritan” has been increasingly replaced by the mundane and commercialised image of “Health sells well!” The result can be seen in all three research sites: A transformation from medical mission stations to centres of health development. This process represents not only secularisation but also a modernisation and internationalisation. The rationality of project management has spread around the globe and introduced new values and norms – expressed in phrases like the “burden of illness” or the “allocation of scarce financial and human resources” – and the associated planning, monitoring and evaluation logic. Mission hospitals have become development actors executing health programmes which have to be ‘sold’ on the globalising religious and secular, the private and the public donor market. To capture such dynamics, the research project selected two mission hospitals which were located in focal countries of the Swiss Agency for Development Corporation (namely Tanzania and Ghana). Cooperation, partnership and participation have become the conceptual frameworks which shape these new modes of technical and rational relationships between the African mission hospitals and their foreign donors. Yet all three mission hospitals still remember their origins as institutions of the church and preserve major characteristics going back to the mission foundation. But how far the “Swissness” is still represented in the three mission hospitals is more difficult to grasp and forms part of the on-going data analysis.

Assessment and explanation of success and failure in a historical perspective

The main impact of mission hospitals which the project has been able to identify up to now concerns the education and training of men and women who often came from the local communities. All three hospitals considered the education of medical professionals as a priority, especially the training of nurses. Medical and paramedical education served not only a practical or technical purpose, it helped to build a sense of a corporate identity – ‘I belong to the mission hospital staff and I am proud of it’ – and produced a certain level of professional systematisation and standardisation (e.g. of quality of care).

A dimension to which medical staff and hospital managers seem to have had a rather ambivalent attitude is the so-called Africanisation of medicine, both for obvious reasons related to the political order or professional capacity and underlying symbolic meanings (e.g. gender-race

inequalities). In terms of “contextualising” or nationalising mission institutions, a stronger symbolic force emanates from an African nurse or doctor than from African gardeners and watchmen. They easily become symbols of nation-building and of national development efforts. This may help to explain why the considerable investment in educating and training local staff did not match with the slow handing over of crucial positions in all three mission hospitals. This transformation happened only with external pressure from regional, national or even international authorities.

Summary statement concerning the obtained results

By and large, the results obtained correspond to those expected at the beginning of the research. What were surprised by the often marked differences in the pathways of the three hospitals, but as the understanding deepened, the differences helped to reformulate our questions and to sharpen our thinking.

Information regarding the practical application of results

Although it would be simplistic to expect that historical research can help to avoid mistakes in the present or future, our findings provide a description and explanation of different ways in which African mission hospitals have developed. This deepens our understanding of the complex interplay of changes on the micro-, meso- and macro-levels of health systems over time. Such an approach leads to the identification of recurrent problems as well as of critical situations and events. By highlighting political consequences that specific constellations and processes had on the health care system in the past, the study might at least give hints on how to prevent or to facilitate specific undesirable or desirable outcomes.

Questions that merit further exploration

A more thorough examination of the contemporary social and cultural life worlds of actors working in/making use of the case study institutions by a medical anthropologist would provide highly relevant contextual information which could not be obtained through historical research (and would at best have been conducted simultaneously in close collaboration).

The results of this project – the specific case study results and the comparative conclusions – should be (re-)examined against the background of epidemiological developments. However, this is a difficult task due to the scarcity of long-term epidemiological data for national and particularly for local levels.

Practical and policy recommendations

Since data analysis (especially of the third year) and thesis writing is still going on, the research team cannot make concrete policy recommendations, but (as stated above) the close historical examination of the development of health care systems is an indispensable basis for policy making in the field of health.

Publications

Papers based on concepts and results from the two case studies financed by SNIS were/will be presented at the following workshops and conferences:

Hines Mabika (Elim Hospital South Africa)

- “Francophone sources for writing the history of Swiss mission hospital in Africa” at the *International Conference at the University of South Africa, Pretoria, South Africa, 22-24 June 2009*.
- “At the heart of transnational history and medical knowledge: Elim Hospital in South Africa” at the conference *History of Knowledge and Transnational History: theoretical approaches and empirical perspectives*, in Basel, 10-11 September 2009.
- Presentation of a paper on “Health Actors in Health Systems in Africa” at the *First Advisory Board Meeting of the HHSA Project*, University of Basel, 2-3 October 2009.
- “Africa in Move. Transcontinental Migrations” at *Swiss Society for African Studies Conference* in Neuchâtel, 15-16 October 2009.
- “Entre l’intégration européenne et la décolonisation. Les relations internationales de la Suisse dans les années 1960” at the *Journée des Archives Diplomatiques Suisses* in Bern, 12 November 2009.
- “Swiss mission hospitals in Africa: Elim Hospital as a case study” at the *African History Day* in Basel, 18 December 2009.
- “Georges Liengme: un médecin aux frontières” at the *Swiss History Days Conference on Borders* in Basel, 4-6 February 2010.

Pascal Schmid (Agogo Hospital Ghana)

- „A Swiss Hospital in a Colonial Health System – The Early Years of Agogo Hospital (ca. 1925-35)“ at the conference *Hospital History in Africa: A Conference Spanning the Continent*, Groote Schuur Hospital, Cape Town, 24-26 November 2008.
- “A rural Hospital as a transnational hub for medical knowledge: The Agogo Hospital in Ghana” at the conference *History of Knowledge and Transnational History: theoretical approaches and empirical perspectives*, University of Basel, History Department, 10-11 September 2009.
- “Nursing und Krankenpflege in Ghana (ca. 1930 – 1975)” at the workshop *Transfers – empirische und theoretische Perspektiven*, Graduate School of History Basel, 7-8 October 2010.

Marcel Dreier presented the Tanzanian case study in the same and additional conferences. Further presentations and a panel (organised by Hines Mabika and Marcel Dreier) on “Hospitals, Health and Development in Independent Africa” will be held at the 4th European Conference on African Studies (ECAS), 15-18 June, 2011 in Uppsala, Sweden.

The presentations of the case studies have been revised based on the discussions at these events and will be prepared for publication in the form of two monographs, chapters in readers and articles in scientific journals. Pascal Schmid plans to submit articles for publication to the following journals: *Ghana Studies* (The Journal of the Ghana Studies Council); *Social Sciences and Missions/Le Fait Missionnaire*; *Gesnerus* (Swiss Journal of the History of Medicine and Sciences); *Social History of Medicine*. He will submit a chapter for the planned publication on the “History of Knowledge and Transnational History: Theoretical Approaches and Empirical Perspectives“ by Prof. Martin Lengwiler and Prof. Patrick Harries. Further, Pascal Schmid will contribute to the edited collection of the papers of the HHSA conference in September 2011. His PhD thesis is planned to be submitted by early 2012 and to be published as a monograph in 2013. He further intends to produce a ‘popular’ booklet with photographs on the history of Agogo Hospital in 2013. Copies of his books and possibly other publications will be made available to

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interested institutions in Ghana: Department of Sociology, Department of History, College of Health Sciences at University of Ghana, Legon; Presbyterian Church of Ghana, Accra; Agogo Presbyterian Hospital; Public Records and Archives Administration Department (PRAAD), Accra; Akrofi-Christaller Memorial Centre, Akropong). A similar dissemination strategy will be followed for the case studies in South Africa and Tanzania.

Hines Mabika has completed to long chapters of a five-chapter study. These cover the history of Elim hospital to the nationalisation of the institution in the mid-1970s. He has secured further funding that will allow him to complete the three remaining chapters in the months May to September 2011.

To give visibility to the project both in Swiss society and in national and international networks of (medical) historians, anthropologists, and public health specialists, the websites of the Centre of African Studies at the University of Basel (<http://zasb.unibas.ch/research/research-projects/hhsa/>) and SNIS was used.

Through additional fund raising initiatives, a graduate course (for doctoral students) and an international conference will be held at the University of Basel in September 2011. A selection of papers from this conference will be published in an edited volume.