JOURNAL OF DEVELOPMENT, EDUCATION & TECHNOLOGY
ISSN 2959-0523 VOL. II ISSUE. 2 (OCTOBER 2025)

Christianity and Health: A Glimpse into the Evolution of Delivery of Modern Health Services in Uganda.

*Gad Ruzaaza Ndaruhutse[1]

Mbarara University of Science & Technology, Faculty of Medicine

ABSTRACT

The Bible emphasizes how Jesus came to preach to teach and to heal, that Christians would attain life in all its fullness (Mattwew 4: 23- 25). This message was internalized by the early Christian Missionaries, since they would preach the word of God, teach initially reading and writing and provide health services. This is likely why among the early missionaries were teachers, doctors, nurses and builders (Ssekamwa, 1997). It is well documented that the earliest schools and health facilities, such as Mbarara Junior School, Nsanji Primary School, Gayaza Girls School, Kings College, Budo, Kigezi high School, Mengo Hospital and Kisiizi Hospital to be built in Uganda were founded by Christian Missionaries, with most of them still thriving today (Ssekamwa, 1997). Both the schools and health facilities have since further expanded their mandate and scope; with some of the schools

Ruzaaza Gad (✉)
ORCID: 0000-0003-1487-1790
Email: gruzaaza@must.ac.ug

G. Ruzaaza, *Christianity and Health: A Glimpse into the Evolution of Delivery of Modern Health Services in Uganda.*
DOI: https://doi.org/10.59472/jodet.v1i3.46

becoming universities, such as the Nomal School in Kabale and Bishop Stuart College and the hospitals further enriching their teaching and training aspect to become centers of excellence and schools of health sciences. Conceived partly from the lived experience, anchored in literature and testimonies of missionaries, this paper aims at tracing the evolution of Uganda's health sector and health professions' education from the foundations. The Christian Missionary Doctors and Nurses, resiliently pursued the establishment of modern healthcare and later health professions' education that became the springboard for Uganda government to establish her health sector on firm ground. At Uganda's independence in 1962, Uganda had one of the best healthcare systems in Africa. The paper proposes the deliberate need for continuing support of church – founded health initiatives for quality health service delivery to Uganda's population.

***Keywords**: Health Services, Evolution, Uganda, Health Sciences*

1.0 INTRODUCTION

Uganda's political history depicts how there was disruption in nation building due to a shaky start and wars, suffering by citizens, absence of appropriate leadership and a general deterioration of health and wellbeing. This has combined to fit Uganda into the group of the underdeveloped countries. It is in this context that the development of the health care system in Uganda can be best understood.

Written from a critical literature synthesis, narrative and the lived experience across time, this paper deliberately sheds light to the understanding of how the advent of Christianity in Uganda, and the growth of the health sector are related. The pioneering work of the Medical Missionaries, the progressive expansion of modern health services through training and delivery, the challenging times of the 1970s during the reign of Iddi Amin, the struggles to renew, restore and rebuild the system and strategies for the future are brought out. Apparently in most aspects religion and health have been kin and kindred within Uganda growing closely together. It is not yet clear,

however, whether the relationship merits them to be called: 'siamese twins'.

2.0 Pioneering Health Services in Uganda

Uganda's medical history into antiquity is not well documented however; evidence exists to indicate that some of the earliest caesarean sections were performed in Uganda in Bunyoro Kingdom (United States National library of medicine, 1997).

Uganda as a nation came into being at independence on 9th October 1962; with a number of national questions. During the colonial times, Buganda was placed at the apex of Uganda's economic pyramid, with the initial scattered health dispensaries (Mutibwa, 1992). The first mobile cinemas, the best sports facilities and the best medical services were placed in Buganda. Nowhere was the disparity in development emphasized more than in education (Mutibwa, 1992). It is surprising though that Uganda was still regarded as fortunate when only about 20 percent of the adult population had four or more years of schooling (King, 1966). Yet, Uganda as a country is much more diverse than Buganda.

The need to start medical services was strongly linked with the political interests of the colonisers. Education shared the same strategy. This general concept is shared elsewhere in Africa (Rodney, 2018). A few doctors were trained basing on experiences of disease in the UK-where they were educated. Only a few privileged Africans, chiefs and Kings initially had access to health and education (Adelola, 1995). There were national variations as well. By 1920, for example, there were 328 elementary schools in Buganda alone and practically none in the north and when the simmering of Makerere Medical School begun in Kampala in 1922 by Dr. Albert Cook and his wife, Sr. Catherine Timpson, all the first students came from Buganda and some of the courses were actually conducted in Luganda (Mutibwa, 1992). Initially, the first Medical School was established at Mengo Hospital.

Makerere College with its medical faculty in Mulago achieved complete autonomous university status in 1970, and although a few more universities have been started in recent years, Makerere carried

the mantle as the most prestigious centre of university education. The medical professionals were regarded to belong to a high social class and attainment of medical qualifications became the most desired goal for most students (Sathymurthy, 1986).

The health care services that existed at the time of independence were, therefore, often bequeathed by colonial governments or imposed carbon copies of those designed and planned in the industrial world (Macdonald, 1993). They often mirrored health services in the industrial countries being selective in their focus and planned at the top of the organisation pyramid (McCormack, 1981). Western medicine was thus introduced in Uganda, without taking note of traditional healing practices and traditional midwifery, which were flourishing well and continue to the present day. Imperial British East African Company (IBEAC) that brought doctors to look after their staff who were constructing the Uganda railway made the first attempt at western medicine in 1819. During those early days of western intrusion, Uganda suffered epidemics of plague, sleeping sickness and smallpox which induced the Christian doctor, Albert cook and his wife, sister Timpson to successfully convince the protectorate government to allow them establish western training programmes for indigenous African people (Government of Uganda, 1987). Therefore, Mengo hospital became the first hospital in Uganda around 1917 by Dr. Albert Cook (Dodge & Wiebe, 1985).

The first training recruits were grateful patients who received food and clothing while they trained. However, this did not work well and Sir Albert had to confess after ten years of effort that he could only point to four thoroughly trust worthy male assistants. He persisted with the idea of training medical assistants in Buganda (Dodge & Wiebe, 1985). Albert started with seventeen students who after a three-year course became African dressers and dispensers. The much larger and more complete school of medical training was initiated at Mulago in 1924. Under the Mulago programme, two years were to be spent at the college in general studies then four in medical studies at the school of medical training the end result being the achievement of a standard in training equivalent to the standard at the Asian sub assistant level. Not until the late 1940's was the standard achieved equivalent to a full

British qualification and the diploma of medicine (diploma of medicine, East Africa) awarded locally (Ibid).

Ultimately, in 1964, the general medical council in the United Kingdom recognised the medical qualification earned at the University of East Africa and the M.B.Ch.B was awarded locally to graduating students (Odonga,1989). Later the university of East Africa was dissolved and Makerere university begun to award the degree to the present day. The first graduates in the masters of medicine programme were in 1970. Medical education then faced challenges of deterioration during the socio-economic and political crisis of the country. While the training of other health care providers continued, though with difficulty, it remained shadowed by the so much needed training of the medical doctors. It needs to be noted that by the time of the late sixties Uganda had one of the best health care systems in Africa (King, 1966).

3.0 The Expansion of Medical Services

There is substantial documentation of the origins of modern Health Service delivery within Uganda; traced within foundations within missionary work and church efforts, with the first Anglican and Catholic Missionaries having chosen Mengo as their initial base. The close relationships were mainly distorted and disrupted by conflicts between the early missionaries and the king of Buganda, Kabaka, Mwanga (Ndaruhutse, 1997; Doyle, 2015; Asasira & Ahimbisibwe, 2018).

European explorers in Africa were soon followed first by missionaries and subsequently by soldiers. Uganda was no exception: the famous explorer Stanley's 'call to evangelism' set off Christians' evangelical efforts in the country now called Uganda. Even in pre-colonial days, Christianity sought the proximity of governing powers. When Anglican missionaries arrived in Uganda in the form of the Church Missionary Society (CMS) in 1877, followed by the Catholic White Fathers in 1879 and the Mill Hill Fathers in 1895, they all chose Mengo, the capital of Buganda, as their domicile. However, from the very beginning the relationship between Christianity and the leadership

of kingdoms was precarious. Rivalry between the different religious factions was rife (Leusenkamp, 2010).

Uganda's National Public Health system was established shortly before independence, but the Christian founded health organizations and institutions maintained their mandate and even in most instances experienced expansion. Although Uganda had acquired top status in her organization and delivery of health services, the challenges that followed disrupted services parallel to the leadership anarchy in Uganda (Dodge & Wiebe, 1985).

Thus, the oldest Hospital is Mengo hospital that opened her gates to the first Ugandan Medical trainees. When the King of Buganda offered land at Makerere / Mulago hills later, this is when the medical school was transferred to Makerere / Mulago, Makerere University. One can thus affirm with confidence that Modern Health Professions' Education and practice have their roots in the Ministry of the Church. I am aware that the developments within the Catholic Church followed the same line with Lubaga and Nsambya hospitals being some of the oldest hospitals in Uganda. Nsambya Hospital manages a Medical School at Post Graduate level offering Masters Programmes in liaison with Uganda Martyrs University, Nkozi, founded by the Catholic Church.

There remains a significant contribution of the church in offering modern health services extending across the whole spectrum of training and care. Some of the prominent examples within Southwestern and Western Uganda include the role played by the church in almost every diocese; since there is a number of church owned health centers in nearly every diocese. Examples are Ruharo Hospital in Ankole Diocese, Kisiizi Hospital in North Kigezi Diocese and Kagando Hospital in Kasese District.

More recently, there is a state of the art Children's Hospital, Holy Innocents Children's Hospital (HICH) that was founded by Mbarara Catholic Archdiocese in Nyamitanga Mbarara that has become a center of excellence offering specialist training and care in partnership with Mbarara Regional Referral and Teaching Hospital. Mbarara Catholic Archdiocese operates a young University, University of St. Joseph.

According to Asasira & Ahimbisibwe (2018), there is an already recognized contribution by Ruharo Hospital in the promotion of health service delivery in Uganda. This has spread much beyond the region, most particularly in aspects of eye care. Furthermore, Ruharo Mission Hospital has ensured reduction in patient waiting time, strengthened Public – Private sector partnership and engagement in health and ensured availability of modern functional medical equipment supply and usage. This has contributed significantly to the quality of care. There is a deliberate reach to the poorest of the poor and some of the patients have received free services, including free hearing aids. The School of Health Sciences at Bishop Stuart University, which was started by Ankole Diocese, collaborates with Ruharo Hospital as a Teaching Hospital.

Kisiizi Hospital begun at the helm of the East African Revival movement, during the 1930s, and has continued to function uninterrupted. It is located in a unique underserved locality. Due to its unique specialized service and training, the hospital attracts patients from different parts of Uganda and hosts global health scholars. Simply put, Kisiizi hospital is a center of excellence in healthcare delivery in the heart of Africa.

Kabarole region provides an excellent case study regarding how the state and faith based organizations can work closely with government with the coordination of the District Health Officer (DHO). Within different areas, including Kabarole, the Church has been active as a force to combat HIV/AIDS, with verifiable success stories. The increasing availability of both prevention-of-mother to child-transmission (PMTCT) services to block HIV infection to newborns, and antiretroviral treatment (ART) for persons living with HIV or AIDS (PLHIV), making management of HIV/AIDS easier (Leusenkamp, 2010).

Leusenkamp (2010), in the article on: Religion, authority and their interplay in the shaping of antiretroviral treatment in western Uganda brings out how after more than three decades, the history of HIV/AIDS can be categorized as a turbulent one. Thus, mitigation of such a notorious challenge can only be through a concerted collaborative effort. Within the field of Antiretroviral Treatment (ART), actors in

Kabarole district offer an interesting and strategic entry point for understanding these relationships. As in the rest of Africa, ART is available in both public and private health institutions in the district, with the latter comprised of missionary hospitals and their satellite clinics (Leusenkamp, 2010).

4.0 The Era of Challenge

The year 1971 saw the capture of power in Uganda by Amin; then followed a period of disrupted service delivery almost to a total collapse. It is probably the 1971-79 period that sunk Uganda into its worst times. Within the overarching frame provided by great dilemmas of Africa and of the third world, the Uganda problem exhibited peculiar 'malignancies' (Wrigley, 1988).

While Amin's capture of power was at first welcomed both locally and internationally (Mutibwa, 1992), the 'honey-Moon' period was short lived. Amin soon started a series of problems for the whole of Uganda. Uganda's false start at independence culminated into a dictatorial regime that led to the expulsion of the Asian citizens, massive massacre of Ugandans and a state of general anarchy. There was a breakdown of services, and a health crisis (Dodge & wiebe, 1985). Across most of the 1970s and 80s, Uganda suffered conflict, political instability and misrule; galloping inflation and rampant unemployment. There must have been a deep "sense of betrayal that most of Africa kept silent while tyrants killed ... Ugandans" (Museveni, 1992: 168).

Although the coexistence of public healthcare and non-state health institutions such as missionary hospitals in East Africa goes back to the 1870s (Iliffe, 2002), the relatively rapid spread of HIV has triggered a range of new, non-governmental actors and new forms of state/non-state relationships (Leusenkamp, 2010).

4.1 Amin's Days

Uganda became isolated from the official international business world (refer World Bank reports 1971-1974). The experienced and skilled

population in the civil service were terrorised by successive regimes and fled the country. Those that remained were deeply demoralised by physical insecurity with resulting collapse of discipline management systems and a decline of the real income.

A once impressive economic and social infrastructure (including communication network, hospitals dispensaries and schools) became devastated by war and lack of maintenance. The war to remove Amin from power was not without effect. Infrastructure was destroyed including health service systems and people's property, though the worst effects were on the peoples' attitude. The wars created a situation where rape, corruption, illegal trade and looting became the order of the day. Innocent killings of Ugandan citizens continued and the pearl of Africa had become "the blood stained pearl of Africa" (see new vision Saturday 25th 1997: 21).

The worsening economic and political situation of land locked Uganda was compounded by oil increases on the world market by organisation of petroleum exporting countries (OPEC) which later led to the present day structural adjustment programmes (SAP). Meanwhile the prices of agricultural produce and cash crops kept on fluctuating as determined by global trends. The breakdown of health services created a crisis of its own (Dodge & Wiebe, 1985). The successive regimes of Iddi Amin and Milton Obote sunk Uganda into international indebtedness though borrowing in the name of development, rehabilitation and reconstruction of a shattered economy. Women because of cuts mainly on health (Wallman, 1996) felt the worst of effects. Amidst the already complex state, Uganda in 1982 noticed the presence of the "new global challenge - HIV/AIDS" (WHO 1996), and has been hard hit.

Bakamanume (1998) in his paper political instability and health services in Uganda, 1972–1997, narratively brought out how the HIV / AIDS pandemic further disrupted the moral fabric and progress of Uganda. It was not easy to rebuild both the systems and the moral fabric of both the population and the Uganda's health workforce. Furthermore, three fundamental questions were brought out meriting the debate towards the restoration of broken systems:

(1) How have health services been influenced by political conditions?

(2) What are the characteristics of a health service system in politically unstable regions?

(3) Could the health crisis in Uganda (for example, high infection rates of AIDS, high incidence of preventable diseases) have been partly a product of the poor health conditions resulting from political instability in the country?

While in 1986 a protracted people's war brought in a new optimism and hope for the majority of Ugandans there was a long way to go (NRM, 1986). Uganda, had become to symbolised Third World disaster in its worst form:

"Famine, tyranny, wide spread infringements of human rights, anarchy at times to genocide, AIDS, malaria, cholera, typhoid and a massive breakdown of government medical services ... Economic collapse …" (Bernt & Twaddle, 1988:1)

These have characterised the period between 1970's to the recent times. Much of this period can be labelled the lost decades of Uganda's development.

"We must understand how our past history continues to influence our present" (Museveni, 1992:169).

4.2 Rebuilding the System

At the outset, the NRM Government put at the forefront enabling the recovering of Uganda's Education System and equitable delivery of health services. The strategies were cross cutting and inclusive (Government of Uganda, 1995). There were multiple priorities and initially Uganda adopted a Minimum Healthcare Package to ensure access to prevention health services by the majority of the population (Kadowa, 2017).

Most of the accomplishments have been collaborative (De Torrente & Mwesigye, 1999; Orem, Mafigiri, Marchal, Ssengooba, Macq & Criel, 2012). The decentralisation of health services and the increased staffing and health facilities relived the majority of the rural population previously without access to services. Deliberate investment

in science, technology, and the opening of more schools colleges and universities have provided expanded opportunities. A successful case study by Mbarara University of Science and Technology has significantly contributed to the health work force within the most underserved locations (Ndaruhutse, 2013).

A major step has been the deliberate engagement and collaboration with Church Based Organizations and Institutions. There are instances where the Church Organizations are more prominent in delivering health services, for instance; currently the sole development-aid donor holding office in Fort Portal is Catholic Relief Services (CRS), which is primarily focused on assisting with the provision of ART and PMTCT services (Leusenkamp, 2010).

5.0 A Fresh Terrain within Uganda's Contemporary Times

Progressively, Community Health Workers (CHWs) have played key roles in strengthening and supporting health systems, through health promotion, disease prevention and promotion of home based care and referral within diverse communities, countries and settings (Doherty & Coetzee, 2005; Liu, Sullivan, Khan, Sachs & Singh, 2011). Within Uganda, although during the 1978, the country was experiencing political strife that almost led to a total collapse of education and health systems (Dodge & Wiebe, 1985), the significant roles CHWs have played over the years have earned them different titles from time to time.

6.0 CONCLUSION

Prof. Paul Farmer and team (Farmer, Kim, Kleinman, & Basilico, 2013) remind us about the scholarly and advocacy work and the required social medicine enterprise that could further uplift health in solidarity. We need to be like an army on the match building and re-building broken systems, and one hopes we will now begin by recognizing and listening to the input by CHWs much more.

In conclusion, there is wider evidence of Missionary Health Services across initially the Anglican Province of the Church of Uganda,

Burundi, Rwanda and Boga Zaire. Such an impact and analysis would merit a book.

Looking ahead, this reflective paper recommends:

- Critically examining how government, faith based organizations and the community could partner in health improvement
- Collaboratively, focusing on Universal Health coverage (Odokonyero, Mwesigye, Adong & Mbowa, 2017).
- Further supporting faith based organizations in the delivery of health services. This may require a think tank. The contribution of faith-based organizations will continue to be important (Dambisya, Manenzhe & Kibwika-Muyinda (2014).

REFERENCES

Adelola, A. (1985) African pioneers of modern medicine, University press limited, Ibadan.

Asasira, J., & Ahimbisibwe, F. (2018). Public-Private Partnership in health care and its impact on health outcomes: evidence from Ruharo Mission Hospital in Uganda. Int'l J. Soc. Sci. Stud., 6, 79.

Bakamanume, B. B. (1998). Political instability and health services in Uganda, 1972–1997. East African Geographical Review, 20(2), 58-71.

Bhangyi, V. B., Kilama, D., Namuwanga, S., Toko, F., & Balyejjusa, S. M. (2024). A Collaborative Agenda for Health and Well-Being in Uganda: Medical Social Workers Working with a Community Church. In The Routledge International Handbook of Social Development, Social Work, and the Sustainable Development Goals (pp. 327-343). Routledge.

De Torrente, N., & Mwesigye, F. (1999). The Evolving Roles of the State, Donors and NGOs Providing Health Services in a Liberal Environment: Some Insights from Uganda. CBR.

Dodge,P.C., & Wiebe,P.D. (1985) Crisis in Uganda : The breakdown of health services, Pergamon press, Oxford.

Dornbos, M. (1987) The Uganda crisis and the national question, Institute of social studies. The Hague, The Netherlands.

Doyle, S. (2015). Missionary medicine and primary health care in Uganda: implications for universal health care in Africa. Health for all: the journey of universal health coverage. Hyderabad: Orient Blackswan, 73-6.

Doyle, S. Meier zu Selhausen, F., & Weisdorf, J. (2020). The Blessings of Medicine? Patient characteristics and health outcomes in a Ugandan Mission Hospital, 1908–1970. Social History of Medicine, 33 (3), 946-980.

Giusti, D. (2005). Pro-poor health services: The Catholic health network in Uganda.

Government of Uganda, (1987) Report and Recommendations of the health policy review commission, Kampala.

Government of Uganda, (1995) Putting people first in PHC, community capacity building process implementation guidelines, Uganda Ministry of Health, Entebbe.

Gusman, A. (2009). HIV/AIDS, Pentecostal churches, and the "Joseph generation" in Uganda. Africa Today, 56 (1), 66-86.

Kadowa, I. (2017). A case study of the Uganda National Minimum Healthcare Package,' EQUINET discussion paper 110.

King, M. (1966) Medical care in developing countries, Oxford University press, London.

Leusenkamp, A. M. (2010). Religion, authority and their interplay in the shaping of antiretroviral treatment in western Uganda. African Journal of AIDS Research, 9(4), 419-427.

Mc Cormack, C. (19870 "Health care and the concept of legitimacy", in Soc.Scie.Med Vol. 29(5) pp.591-597.

Museveni, K. Y. (1992) What is Africa's problem? NRM publications, Kampala; Bogle l'ouverture, London.

Mutibwa, P. (1992) Uganda since independene, a story of unfulfilled hopes, Hurst and company, London.

Mwesigwa, F. S. (2003). Religious pluralism and conflict as issues in religious education in Uganda (Doctoral dissertation, University of Leeds).

National Resistance Movement (NRM), (1986) Ten point programme of NRM, NRM secretariat publications, Kampala.

New vision of Saturday January 25th, 1997 "Extracts from the blood-stained pearl of Africa", New vision publishers, Kampala p.21.

Odonga A.M (1989). Fifty Years of Makerere University Medical School (1924-1974). Kampala: Marianum Press.

Orem, J. N., Mafigiri, D. K., Marchal, B., Ssengooba, F., Macq, J., & Criel, B. (2012). Research, evidence and policymaking: the perspectives of policy actors on improving uptake of evidence in health policy development and implementation in Uganda. BMC Public Health, 12, 1-16.

Orochi, S. O. Art in Uganda Catholic Church Health Facilities: Opportunities and Challenges.

Rodney, W. (2018). How Europe underdeveloped Africa. Verso Books.

Sathymurthy, T.V. (1986) The political development of Uganda 1900 - 1986, Gower publishing company, Hants Vermont.

Ssekamwa, JC (1997). History and Development of Education in Uganda. Fountain Publishers, Kampala

The Gospel according to Matthew 4: 23 – 25

Wallman, S. (1996) Kampala women getting by, wellbeing in the time of AIDS, James currey, London.

WHO, (1996) The World health report 1996, fighting disease, fostering development, WHO, Geneva