COMMENTARY

# The role of a mission organization in building a sustainable government hospital in Southern Ethiopia

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## Abstract

In 1950, the Norwegian Lutheran Mission (NLM) began holistic mission work, including health work in Yirga Alem in Sidama in Southern Ethiopia. The hospital, which had served as a military hospital during the Italian war (1936-41), became a mission hospital. This paper presents some historical developments of a government hospital managed by a mission organization, the story of its medical work, and how the NLM functioned under varying political regimes and societal environments in Southern Ethiopia. At the same time, societal changes occurring in Norway with the weakening of mission organizations and the Norwegian government's policy that influenced external financial support for the hospital are presented and discussed. The key message of the paper is that it is possible under challenging external politics for a mission organization to collaborate with government entities even with difficult regimes. In the area of Yirga Alem Hospital, this was done without compromising the basics of mission, but rather readjusting comparative strategies while ensuring sustainability and local ownership. The uniqueness of this work is that it explores a mission, i.e., the NLM, which developed health work within the context of a nationally owned health service. Moreover, this fruitful collaboration persists until this day and previous missionaries still work to strengthen public health programs that target such major areas as tuberculosis and HIV control, maternal health, childcare, and nutrition.

**Key words**: mission history, mission hospital, sustainability, Ethiopia

## Introduction

This article presents a summary of the 70 year history of the Yirga Alem Hospital in Southern Ethiopia. In 1950, the Norwegian Lutheran Mission (NLM) started health work in the town of Yirga Alem. The NLM's vision, also in line with the Lausanne statement, as written in its constitution, focuses on evangelization to spread the conviction that Jesus Christ died for our sins and forgives the sins of all who repent and believe in Him. The results of evangelism include obedience to Christ, and it comprises social responsibility (for example,

health work) as one of the principal aims of evangelism and the belief that social responsibility can serve as a bridge to evangelism.[1]

The NLM's goal was, and remains, to establish local churches.[2] Its practice is to support institutions, whether church-owned or in cooperation with governments, to develop sustainable work within a national context. Within such a context, the NLM's service has, to a large extent, followed international priority settings with health care that include the setup of basic health services, primary health care (PHC), and sustainable development goals.

This paper presents some historical developments of a government hospital managed by a mission organization, the story of its medical work, and how the NLM functioned under varying political regimes and societal environments in Southern Ethiopia. In broad terms, this is an historical description of the development of Yirga Alem Hospital and some analysis of challenges and success factors.

Developments in Ethiopia during the period of this study include what the Ethiopianist and historian, John Markakis, describes as periods of nation building during the Imperial period (up to 1974), Communist (Derg) regime, (1974 – 1991), and nation building after 1991 that was based on ethnic federalism. This was compounded by multiple conflicts between the central government and peripheral groups.[3] At the same time, societal changes occurring in Norway, which included both the weakening of mission organizations and the Norwegian government's policy that influenced external financial support for the hospital, are presented and discussed. The uniqueness of this work is that it explores a mission, i.e., the NLM, which developed health work within the context of a nationally owned health service.

## Development of the Yirga Alem Hospital

In 1948, the Norwegian Lutheran Mission (NLM) began work in Ethiopia. The organization had been expelled from China, where it had long been running hospitals, and two experienced physicians were consequently transferred from China to Ethiopia. During an audience with the NLM's General Secretary, Tormod Vågen, Emperor Haile Selassie requested that the NLM work in Yirga Alem. His Majesty informed the NLM that he, prior to becoming Emperor, had been the Governor of Sidamo and had resided in Yirga Alem. He told the NLM about a military hospital in the town that had been out of operation for some time. He wanted this to be a civil hospital, and asked the Mission to run the hospital and provide Norwegian doctors and nurses.

The ensuing negotiations between the Ethiopian Ministry of Public Health (MPH) and the NLM resulted in an agreement concerning the management of the Yirga Alem Hospital (YAH) originally constructed by the Italians during the late 1930s. It was clear that new construction was unnecessary, and actual health work could start fairly soon. The NLM took over the hospital in March 1950, and it was staffed with just one missionary doctor and two nurses. According to the agreement between the NLM and the MPH, the doctor at the YAH was also the Medical Officer of Sidamo Province. Consequently, the NLM was responsible for health planning, supervision of government health institutions in the region, and ensuring that the government clinics were supplied with needed drugs.[4]

The facilities at the YAH were very basic at that time. For example, there was no electricity, and water was laboriously brought to the hospital from the nearby Gidabo River on donkeys. Moreover, in the 1950s, the number of hospital beds was 18, and only a few thousand outpatients were treated annually. However, services increased rapidly, and it became necessary to train staff and build additional

housing. After a few years, the number of beds had risen to 60, and, in 1955, formal training of auxiliary nursing staff began.

In 1957, the government terminated the NLM's engagement at the YAH. As a consequence, the institution was without physicians and other qualified personnel for a period of one and a half years.[5] The termination of work in Yirga Alem occurred at a time when substantial tensions existed between the newly started NLM-supported evangelical congregations and the long-established Orthodox Church in Sidamo.[6] These evangelical congregations later became part of the Ethiopian Evangelical Church, Mekane Yesus.

In 1963, the NLM obtained funding from the Norwegian Agency for Development Aid (Norad) for construction of a new hospital in Yirga Alem. King Olav V of Norway honored the hospital by placing its foundation stone in 1966, and it was inaugurated by His Majesty Haile Selassie I on March 14, 1968. The Norwegian Minister of Foreign Affairs handed over the new and fully equipped hospital to the Ministry of Health (MOH) as a gift from the Norwegian people to the Ethiopian people. The name was also changed to the Sidamo Provincial Hospital. The modern hospital had 120 beds. The old hospital, with its equipment, was left to serve as a health centre for Yirga Alem.[4] The NLM was given the responsibility of the management and operation of the new hospital. This was based on an agreement between the MOH and the NLM, and this agreement was renewed every three years up to 2011.

## The Ethiopian Revolution: Change and Conflicts

In 1974, the change of political system in Ethiopia profoundly altered the running of the hospital. During the first years of the Derg communist regime, unrest among hospital workers resulted in adjustments of the cooperation agreement between the MOH and the NLM, and national staff were recognized as government workers and received their salaries directly from the government. They have since worked under the rules and regulations of the national Central Personnel Agency. Labor Proclamation No. 64 of 1975 superseded the Imperial Labor Relations Proclamation and contained provisions of socialist labor legislation. The NLM, thus, had to manage the daily operations of the hospital according to these new requirements. This meant, among several other major impacts, that it became difficult to discharge workers. In this new arrangement, workers not fit to work at the hospital, for example, due to disciplinary issues, had to be transferred to other government institutions. It also changed the way the hospital recruited new workers as they now had to be recruited directly by the MOH.

It is important to note that the NLM came from a country where labor unions were an integral part of society's way of dealing with workers' issues; whereas, this was not the case for other mission-run hospitals in Southern Ethiopia. This led to the expulsion of American-based organizations from Ethiopia, while Scandinavian-supported work remained. Another dimension to this conflict was the hostile environment that existed between the Soviet-associated Derg regime and the U.S. Furthermore, the communists were generally hostile towards evangelical churches, and evangelical Christians were persecuted during the communist period.[7]

One area of value conflict at the Yirga Alem Hospital concerned the role of evangelical work at the hospital.[8] The hospital, through the NLM, had since its inception employed an evangelist to administer the morning devotions to patients and workers. The local government, however, demanded that other denominations, including the Ethiopian Orthodox Church, also be allowed to do the same and that the devotions should not take place during working hours. The NLM did not object to this. Indeed, this work of the evangelist has continued until now, even if the hospital is currently run without a mission or external support.

Another, and more serious, confrontation occurred when the communist regime revised its curriculum for the health assistant (auxiliary nurse) training school, and demanded that a special emphasis on, and education in, Marxism-Leninism should be implemented. Although the NLM staff at the hospital accepted this directive, the NLM board in Norway decided to close the school. However, after two years, the school was reopened and teaching of Marxism-Leninism was included. In addition, the NLM continued devotions, but outside of school hours. The rationale behind the NLM's decision, based upon advice from Ethiopian Evangelical Church leaders and hospital staff, was the belief that although students at the auxiliary nursing school would attend compulsory classes in Marxist-Leninist ideology, they would not follow this teaching due to the great opposition to the communist regime that existed in the country.

During the Derg communist period, work at the hospital expanded to 170 national and expatriate workers, which now included three doctors and 6-9 nurses. The main work at the hospital comprised inpatient and outpatient services, with active operative functions serving a large part of the population in southern Ethiopia.[9] In addition, more primary health facilities were built in the catchment area of the hospital. Consequently, the share of referred patients increased. The hospital had, for years, accepted emergency cases from outside of the defined catchment area, resulting in a high workload for the staff and sometimes overcrowding of the hospital. Furthermore, poor patients were accepted for treatment, and the hospital allocated a substantial part of its budget for such patients.[10]

The agreement between the MOH and the NLM put the hospital in a semi-autonomous position. For example, pharmaceuticals could be imported during periods of severe drug shortages in the country. In this way, patients were guaranteed adequate attention and treatment without undue delay, and much emphasis was placed on securing essential pharmaceuticals.[11] Diagnostic facilities and treatment options also improved gradually. For example, in 1985, a microbiology laboratory, including one that focused on tuberculosis culture, was added, and screening for HIV began in 1987.[12,13] Later, the hospital started its own production of intravenous fluids based on a close collaboration with the St. Luke Foundation in Moshi in Tanzania. In 1981, a blood bank was established and was later expanded through collaboration and funding from the Ethiopian Red Cross Society that has since supported the hospital in its management and to maintenance of a high quality at the blood bank. Ultrasonography examinations started in 1987, and endoscopy examinations by means of flexible endoscopes began in 1992. Indeed, the personnel who started these endoscopy examinations currently teach post-graduate courses in Ethiopia on endoscopic methods.[14,15] With support from the Christoffel Blinden Mission, eye examinations and treatment have been offered since 1976. A facility that makes eyeglasses was also added. Moreover, since 2000, when a new eye unit was constructed, Ethiopian ophthalmologists staffed by the MOH perform over 1200 cataract operations per year. With Norad support and in close collaboration with the Addis Ababa Fistula Hospital (also known as "Hamlin Fistula Hospital") a local unit was built to treat obstetric fistula.

Tuberculosis patients have always been treated free-of-charge at the hospital. However, a review in 1965 revealed that the treatment results were poor, mainly due to non-adherence to treatment.[16] The challenge of a chronic disease that demanded long-term treatment was that it often conflicted with traditional Sidama beliefs concerning disease causation (see also Vecchiato).[17] Starting in 1992, a tuberculosis control program (with the first use of Direct Observed Treatment, Short course [DOTS] in Ethiopia), covering a defined area of Sidama with approximately one million people, was organized through the hospital. Since 1998, this has been integrated with the Zonal Health Office as part of the National Tuberculosis Control Program.[13,18-24]

Research activities that were operational and aimed to improve services and enhance the capacity

of hospital staff, resulted in numerous publications recognized nationally and internationally. Some examples of this research include improved management of uterus rupture,[25] occurrence of resistant strains of helicobacter pylori (the cause of peptic ulcer),[26] identification of major risk factors for deaths among children with diarrheal diseases,[27] effects of poverty on hospital admissions, and description of major cancer types in Southern Ethiopia.[9,28,29]

## Training of staff

Training of staff of all categories, including janitorial staff, laundry workers, and professional staff, was essential in the early years of the hospital since trained and skilled workers were scarce in the post-war years. Already, in 1955, formalized training of auxiliary nurses (in Ethiopia initially called dressers and health assistants) was implemented, as was training of nurses in 1990. With Norad funds, new buildings were also constructed, and it became a well-equipped and efficient teaching institution. Since 2013, the YAH has also served as a medical school. In-service training and teaching were assigned a high priority, and several staff and technical personnel were sent abroad on scholarships and to engage in postgraduate studies. Since 1985, other important changes occurred. Ethiopian nurses, general practitioners, and specialists were assigned to the hospital in increasing numbers. By mid-1997, all positions in the hospital were held by nationals. In July 1998, 17 Ethiopian physicians worked at the hospital. Of these, six had specialist qualifications, and personnel resources in Southern Ethiopia gradually became wholly sufficient to sustain the medical activities of the YAH.

## Administration and management

In the initial years of the NLM/MOH cooperation, the organizational structure was simple and easily managed by an expatriate hospital director (a physician) and an expatriate nurse. The dominant control by expatriates was the natural consequence of the expectation that the NLM should manage the hospital because skilled Ethiopian staff were not available after the disruption resultant from the fascist occupation. However, the significance of the hospital administrator increased when the staff, in the 1970s, were transferred to the MOH payroll and were required to adhere to MOH employment regulations. This also led to the inclusion of a national administrator employed by the MOH. In the 1970s, a hospital board was also established, composed of members of the Provincial Health Office and representatives from the NLM and the Ethiopian Evangelical Church, Mekane Yesus (EECMY).[10] Its mandate was to provide guidance to management, review plans, and approve budgets. In 1997, the board was extended to include representatives from the Zonal Health Bureau, the Zonal Council, and a member elected by the staff. The board was also given the authority to make certain decisions formerly under the purview of the NLM administration.

The necessity for participation in management, as well as nationalization of leading positions, became increasingly evident, as was discussed in an evaluation report in 1984.[10] As a result, handing over leadership to nationals, restructuring of logistics, and strengthening of the board became key priorities. In 1995, the NLM decided to negotiate with MOH on NLM withdrawal from management responsibility as of January 1, 1999. The handing over of full management and financial responsibility to the government was a logical result of rapid development in the area of manpower in Ethiopia, reflected in the fact that the hospital was assigned a number of Ethiopian physicians and specialists.

## Finances

Most of the financial input to the hospitals came from patient fees and NLM sources. However, since 1961, the government granted the hospital a lump sum for the treatment of poor patients. Capital investment funding was provided by Norad. Over the years, a model was developed concerning how to

finance a sustainable hospital. With the government paying salaries to the hospital staff, and with the development of a new financial structure to take care of patient fees, a model was created in which hospital expenses were covered by government salaries, and operational costs were paid with patient fees. This scheme was subsequently evaluated by the Ministry of Health, and today forms the basis of a new healthcare financing law for Ethiopia.[30] Since then, all Ethiopian hospitals and health centers operate under a modified version of this model.

## Basic Health Services, Primary Health Care, Millennium Development Goals, and Sustainable Development Goals

Over the period of the history of the Yirga Alem Hospital (YAH), international policies regarding the place that hospitals should occupy in health systems evolved. Initially, the primary aim was to bring treatment to needy people in southern Ethiopia. In the early 1960s, the concept was to provide basic health services.[31] The YAH was an active participant in such work, and its physicians and nurses regularly visited nearby and remote clinics. In addition, the prison in Yirga Alem was visited regularly, and treatment and preventive measures were carried out, especially during times of recurrent fever outbreaks.[8] From 1961 to 1967, the NLM assigned a physician to cover the position of Provincial Medical Officer of Health for Sidamo Province.[5] The MOH, therefore, made an effort to strengthen the province health offices professionally in order to guide and supervise the new health centers. The NLM also took part in large scale vaccination programs, examples of which included campaigns to treat smallpox and cholera.[5]

This basic health care model continued until the early 1980s, when the World Health Organization (WHO) started to promote primary health care (PHC).[32] With the introduction of PHC, Norad, an important financial contributor to the hospital, began to question the role of the hospital and other NLM-related health work in the overall structure of public health work in southern Ethiopia. The expatriate doctors at the hospital did not fully understand the then-dominant Norad view that hospital care was not a public health priority.[10] Later, and with the change of WHO policies after the end of the Cold War, as well as the findings of several studies on the global burden of diseases, these views gradually changed.[33] Unfortunately, many of the missionary health personnel at the hospital felt that irreparable harm had been done to essential hospital services in the name of PHC.

## Value Conflicts: Traditional Healthcare, Communism, and Nationalism

The NLM's aim was to provide holistic care to the population.[4] This was also in accordance with the EECMY's view that emphasized the inherent value of man, who was deemed to possess both a spiritual and humanistic aspect.[34] The General Secretary of EECMY, Gudina Tumsa, assassinated by the Derg regime in 1980, contributed to the EECMY's holistic paradigm of the undivided human reality. Tumsa's concept of holism was grounded in the African's view of life in its totality and led to influential development work in the 1972 paper, "On the Interrelation between the Proclamation of the Gospel and Human Development."[35]

### Mission, church, and traditional medicine

During the early years of health work, this mission view, also with the vision of converting non-Christians to the Protestant Christian faith, collided both with traditional belief systems, as well as that of the Ethiopian Orthodox Church. Subsequently, during the communist period, conflicts arose with the government's ideology, which favored "scientific socialism."[7] As well described by Donald Donham from Southern Ethiopia, conflicts at the hospital, thus, centered around the following three dimensions: Missionary-associated Protestant Christianity, traditional societal values, and "modernity," as expressed during the communist regime.[7]

In Ethiopia, both good health and sickness possess a religious dimension. Although God may be felt to be at some distance from ordinary people, it is God who is the provider of good health. Health is understood as a balance between the physiological, spiritual, cosmic, ecological, and social forces that surround people.[17] Good health may also be achieved by participating in different forms of rituals. For example, the protective spirits of *wuqabi* (Amhara) and *ayana* (Sidama and Oromo) safeguard the individual and society. The causes of illness are frequently ascribed to events that surround the illness, characteristics of the patient, the elders' beliefs about sickness, and the social status of the healer, which can include such factors as age, gender, religion, and education. Based on such background factors, the illness may be concluded to have a natural or magico-religious origin. Indeed, some characterize Ethiopian ethno-medicine as primarily religious, while others contend that the religious and natural explanations of illness are closely interrelated.[36] When the methods of treatment are religious, the healer may be perceived as an actor between man and the spiritual world. This is manifested by sorcery (*Kilancho* Sidama) and exorcism (*Kallitcha* Sidama). The way that the healers think and act regarding the causes of illnesses and their treatment of them is influenced by his or her religious background. In Ethiopia, many patients use traditional medicine, but this was gradually reduced with the expansion of Protestant Christianity and improved education.[6,17,37]

In Ethiopia, infectious diseases and malnutrition constitute the main health problems. Less than 60% of the population has access to modern medicine and, even today, relatively few utilize it effectively.[38] Because of the above-described established tradition, it has taken a long period of time for people to accept alternative ways of treating diseases. Therefore, when the YAH was started, people did not trust modern medicine, as they did not believe that it provided better cures than their traditional ways of healing. For example, this was observed in the treatment of tuberculosis at YAH. In 1965, as mentioned previously, the treatment results were very poor, mainly attributable to non-adherence to treatment,[16] and the disease had a religious dimension.[17] Sixty years later, however, after the hospital began implementing community-based DOTS, treatment outcomes improved substantially.[22,39]

## Healthcare under the communist regime

Health care during the Haile Selassie period (1916 – 1974) was characterized by extreme poverty and inequality, as well as the slow development of basic health services.[40] Unfortunately, the situation did not improve during the subsequent communist regime. In the 1980s, Ethiopia had a population of approximately 45 million people, comprised a stagnant and agriculture-based economy, and was one of the world's poorest nations. Moreover, 70% of children were mildly-to-severely malnourished, 26% of children born alive died before the age of five, and life expectancy was just 41 years.[41] After the 1974 revolution, the communist government nationalized land and created 20,000 peasant associations and kebeles, units of local government. The government set ambitious goals for development in all sectors, including health. However, famine, periods with severe malnutrition and food shortages, forced resettlement programs, and civil war prevented any meaningful progress.[42-44] The government's approach to health care was based on an emphasis on primary health care and expansion of rural health services, but the government allocated only 3.5% of the national budget to these purposes. Attrition among health workers was also high due to a lack of ministerial support. Indeed, health care was often carried out without proper authorizations, and, in rural areas, one physician served between 200,000 and 300,000 people.[41]

After the overthrow of the communist regime in 1991, Ethiopia embarked on a new structure to govern the country based on ethnic federalism. After about 10 years of instability, large reforms within the health sector started to take form in the early 2000s.

Health care was decentralized and based on a health extension system with paid and trained health workers in each kebele. Thousands of health posts and health centers were constructed, and key indicators of the development sustainable goals, such as under-five mortality, were met, while access to basic health services was increased.[45,46]

After 1991, the hospital again experienced a certain degree of turmoil. The main issue was that the local administrators insisted that all positions of leadership at the hospital be occupied by the local ethnic group (i.e., the Sidama people). The NLM had, for many years, trained Ethiopian staff for positions of leadership in line with the evaluation report of 1984.[10] Such a sudden change in policy made the previous capacity-building efforts superfluous, and the NLM contended that people should be selected due to their merit and not their ethnicity. However, compromises were gradually reached in which professional staff were recruited irrespective of ethnicity, and the top management of the hospital came from the local ethnic group and were acceptable to the political leadership in the area. In ensuing years, however, many missionary health personnel left the hospital, and the mission organization faced increasing difficulties in recruiting experienced personnel.

## The mission hospital in a national and local socio-political context

Working in an area, such as Sidama, means that medical work has to take local, regional, and national developments in social and political dimensions into careful consideration. These were events that occurred outside of the control of a mission organization, but both directly and indirectly influenced how the hospital functioned. While these changes took place in Ethiopia, changes also occurred within the Norwegian Lutheran Mission (NLM) in Norway. The organization faced increasing challenges in recruiting medical staff for such great work. This challenge was worsened by the fact that the leadership of the hospital was Ethiopian, and Norwegian personnel were increasingly reluctant to work under the leadership of the Ministry of Health (MOH).

The present paper has briefly addressed some of the challenges that the NLM encountered in managing the hospital during the Imperial, Communist, and Federal state nation building periods. A common theme during these periods, however, was Sidama nationalism. The Sidama people live in South-Central Ethiopia. In its long history, they lived and developed in frequent conflict and competition with neighboring groups, mainly because of competition for farming land and pasture.[47] They were, to a large extent, independent, but functioned under the influence of the Semitic kings of Central and Northern Ethiopia. It was when Emperor Menelik II conquered Sidama in the 1890s that conflicts between the Sidama people and *Mengist* (a term used to refer to the Central Ethiopian government) first escalated. The right to use land is a key element in Sidama culture, and with the establishment of a nobility-dominated feudal system governing the right to use land, tensions rose markedly, beginning with Menelik II and continuing with Emperor Haile Selassie I. When Italy invaded Ethiopia in 1936, some Sidama groups supported the Italian invasion because their original farming land was given back to the indigenous Sidama people. However, after a few years, the Sidama became active in the opposition movement against the fascist Mussolini regime. When Ethiopia again took control of the area in 1941, some of the resistance groups (*Faano*) refused to accept the return of the privilege of landlords after Italian withdrawal in Sidama and did not support the *Mengist*. The reasons for this were complex, but the right to use land in a nobility-driven feudal system with heavy taxation constituted a key factor in opposition to the central government.[47] Again, when the communist regime (Derg) assumed power in 1974, many in Sidama initially supported Derg. However, after a few years with major developments, such as collectivization and villagization (forced movement of large groups of people to villages) and forced conscription of

young men for military service for the war in Eritrea, the Sidama established a liberation movement in the late 1970s. In the following years, three sub-provinces in the Sidama province became civil-war zones. Although the hospital was not directly affected by the civil war, many civilian and military casualties were treated at the surgical ward, and many patients with malnutrition and tuberculosis were taken care of at the YAH.

The NLM's work in the area led to a rapid increase in the number of Protestant Christians.[34] The national population census in 2007 shows that approximately 50% of the population belonged to a Protestant church, and recent data indicate that this may now be as high as 85%.[48,49] One contributing factor to this rapid rate of conversion was that the evangelical churches were seen as a viable alternative to the old traditional religious system, and also a means of distancing themselves from the Orthodox church that was associated with the nobility and feudal system of the emperors.[6] The NLM, through its evangelistic and development work, mainly in education and health, thus became an ancillary agent of political change with indirect support of a major ethnic movement, in this case, Sidama nationalism.[50]

Since 1991, the Sidama nationalistic struggle has aimed to attain greater autonomy with a fairer representation within a federal state structure in Ethiopia. A consequence of this was that both the national and the local government wanted all positions of leadership at the hospital to be given to people of the dominant ethnic group. Consequently, as the NLM had been one of the indirect supporters of greater dignity for the Sidama, this led to a major crisis in the government and NLM collaboration from 1992-1995. Although the NLM had developed a national leadership at the hospital, that included staff from diverse ethnic backgrounds, these potential leaders were no longer permitted to assume positions of administrative leadership.

## NLM and Changes in Norway

The development of a mission hospital does not occur in a vacuum.[51] It is also heavily dependent on, and is influenced by, the mission organization, in this case the NLM of Norway. Since the mid-1960s, the NLM received Norwegian governmental support for its development program. The first large project to receive such support was the YAH. In 1984, Norwegian government support for the running of NLM's health work in Ethiopia was evaluated, and it was concluded that more emphasis should be placed on strengthening local capacity at the institutions, and even more so at hospitals that were managed in collaboration with the MOH.[10] In the following years, the aim of Norwegian support became to hand over the hospital to the government and reduce the influence of Norwegian expatriate staff. Indeed, from 1995-97, the NLM withdrew most of its staff from the hospital. However, as the handover had not been carried out in a manner that would make the hospital sustainable, a new chapter in the development of the hospital began. This time, the hospital was managed by national staff, and Norwegian professionals and financial support were gradually reduced over a period of 16 years.

### Why did the NLM stop working at the hospital?

The ownership of the hospital belonged to Ethiopia, while the NLM managed the hospital for the government of Ethiopia. Sometimes, these facts created misunderstandings in that missionaries believed that the YAH was a traditional mission-run hospital. When the NLM withdrew from the hospital, it was never the intention of the MOH that the NLM should leave. Instead, they wanted the collaboration to continue under more national leadership. Unfortunately, this model was a challenge to implement and led to a cessation of the recruitment of expatriate personnel. In addition, the NLM did not want to continue financing such work. Instead they wished to work more in other unreached areas, especially in the Muslim world. Although

their intention could have been to continue mission health work, they were not to do it on a large scale as was the case in Yirga Alem.

The withdrawal of NLM also posed a theological dilemma. Specifically, the start of the work occurred with a specific invitation by the government, followed by the Gudina Tumsa and EECMY's strong focus on holistic church service and the NLM's acceptance of the Lausanne declaration of 1982, while the main reason for the withdrawal was purely evangelistic. Indeed, the NLM's focus changed to a drive to reach unreached peoples and less to people in need of health services.

## Post-2012: Current status

Presently, the Yirga Alem Hospital functions well as a hospital for the many people who live in Yirga Alem and its environs. Basic hospital services continue, and the hospital has provided continuous services in the fields of surgery, internal medicine, gynecology, and obstetrics, as well as in pediatric units without any interruption of services. It is the case that some of the more specialized functions, such as endoscopy and microbiology, no longer exist. However, some new functions, such as a neonatal unit, have been established.

This is an example of a successful collaboration between a traditional mission organization and a government. Over many decades, the hospital has helped many hundreds of thousands of patients and established itself as a well-functioning hospital. The main criterion for success has also been achieved in that a government-owned hospital has expanded and continues as a hospital providing essential services to the population in its catchment area. Although an evangelist still works at the hospital, the mission organization that started this work is no longer capable of running such health work primarily due to changes in its home country.

This fruitful collaboration has persisted in other forms. Previous missionaries still work with institutions in Southern Ethiopia, mainly universities, to strengthen public health programs, including those that target tuberculosis and HIV control, maternal health, childcare, and nutrition. The aim of this latter work is to continue strengthen quality-of-care, as well as teaching and research capacity, for improving health policy within the area.

## About myself and use of unpublished sources

I am a Professor in International Health at the University of Bergen in Norway and at Hawassa University in Southern Ethiopia. I still work in the Sidama area, including the YAH.

By training, I am a medical doctor and surgeon with long and extensive experience in hospital work, research, disease control, institutional development, research management, and teaching and work in developing countries. My professional profile includes surgery in developing countries, population studies, health services research, maternal and child health, and control of tuberculosis, HIV and AIDS, malaria, and malnutrition. For almost 40 years I was a missionary doctor with the NLM, and from 1997 – 2015 I led the organization's work at the YAH.

In this paper, I have documented the large political changes that occurred through publicly available references. Some of the information is, however, found in the "grey literature" that I obtained through individual communications both orally and in writing. They are documented in my personal archive. An earlier version of this article has been reviewed by colleagues who worked at the hospital over the last 50 years. I also discussed the article with Ethiopians well knowledgeable about developments in Ethiopia, particularly in Sidama. I am grateful for their comments and corrections.

*Figure 1* The gate to Yirga Alem Hospital


The gate to Yirga Alem Hospital defining the ownership of the YAH: in Sidamu Afoo, Amharic, and in English. The colors on the gate are those of the Sidama national flag. On the left side is the Bible verse that has been on the portal since the start of the hospital: The Lord will keep watch over your coming in, from this time and forever (Psa 121:8).

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