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Mission, medicine, and power: A Foucauldean perspective

ABSTRACT

For mainline church and theology, the awareness of underlying power structures is of relevance when developing and evaluating theological constructions of health, illness, and healing. This article aims at raising this awareness by way of interdisciplinary research. A Foucauldean frame of reference is applied to the missionary medicine paradigm in order to reveal structures of power as social and religious control hidden in missionary medicine's health constructions and therapeutic practices. The Foucauldean interpretation of the relationship of mission, medicine, and power might very well function as a steppingstone in the development and evaluation of theological articulations of health, illness, and healing in the African context.

1. INTRODUCTION

In the African context, mainstream church and theology are facing the challenge of articulating their conceptualizations of health, illness, and healing clearly. Against the backdrop of the HIV/AIDS pandemic, many believers are struggling to make sense of illness and suffering within the parameters of their own experience, beliefs, ideas, and traditions. The theological discourse is slowly but increasingly responding to these interpretation processes of believers, and a growing number of contextual approaches to health and healing are constructed.

This article is a contribution to the theological discourse on healing in the African context. It is part of a wider (PhD) research on health paradigms in the Southern African context in relation to a Reformed pneumatological perspective on health, illness, and healing. There are basically four main health discourses to be discerned in the Southern African context (the ngoma discourse, the missionary medicine discourse, the HIV/AIDS discourse, and the faith based healing discourse), and each health paradigm has its own impact on how people in Africa develop their understandings of health, illness, and healing. These subjective health constructions have been explored extensively within various social science disciplines (esp. cultural and medical anthropology), and the presumption in this article is that any theological reflection on healing needs to be part of and nurtured by interdisciplinary academic research if it wants to be meaningful, in the sense that it responds to the health seeking behaviour of believers, in the African context.

The focus in this article is the missionary medicine paradigm. The health concepts and practices of medical missionaries in Southern Africa resulted from and were determined by the developments of Western biomedicine. Yet missionary medicine can be regarded as a discourse on its own, based on its extra dimension of Christian belief and ideology in relation to health, illness, and healing. The purpose here is to explore the notion of power within the missionary medicine discourse. Is it possible to say that the notion of power is a crucial constituent of missionary medicine? And if so, what was its function within the missionary medicine paradigm?

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What does this mean for theological reflections on health, illness, and healing within the African context?

The first part of this article is a brief characterization of missionary medicine. Based on how illness was perceived and treated by medical missionaries, missionary medicine can be characterized as a powerful blend of Protestant theological doctrines and European illness etiologies. The description of this *mixtum compositum* provides the foundation for the second part of this article: the exploration of the notion of power within the missionary medicine discourse. A Foucauldean frame of reference is applied in order to get a clearer view on this notion of power (as social and religious control) and on how it functioned within the discourse. The reason for using a Foucauldean lens is that it traces power exactly there where power dissolves in its concrete application. In other words, a Foucauldean-based analysis of the missionary medicine paradigm lays bare those dimensions of health concepts and treatment practices that otherwise remain absent in missiological and church historical treatises of medical missions, or — even more important — in systematic and practical theological debates on church and healing in the African context.

2. CHRISTIAN MEDICINES

Missionary medicine, or Christian medicine (Hardiman 2006:25), refers to European biomedicine that is imbued with Christian notions as a result of the impact of the modern missionary movement in the nineteenth century. One example of the influence of this nineteenth century combination of Christian faith and scientific bio-medicine is the language of biomedicine: "Although there have been persistent attempts to revise and mathemise the language of medicine, the modern discipline still reveals rich traces of its religious inheritance. Neurology is still permeated by Christian notions of order and hierarchy whilst modern pathological concepts of viruses and germs remain rooted in the magical language of agency." (Hayward 2004:58)

2.1 European illness etiologies

One of the elements that make up the distinct nature of Christian medicine is the way illness was perceived by those who reached out in order to bring healing among African peoples. In the missionary discourse, illness etiology was a *mixtum compositum* of Christian beliefs and developing scientific insights. The rigid Enlightenment dichotomy between faith and science had not fully materialized in this field, because basically all medical missionaries (at least up to the second world war) were committed Christians dedicated to practicing their personal faith by offering medical treatment. These medical doctors and nurses stood firmly in the Protestant tradition that was gradually impacted and redefined by political, economic, socio-cultural, and scientific developments in the European context. Simultaneously, the missionary's religious beliefs about health and healing that were configured by Protestant doctrines were supported and even justified by Western feelings of cultural superiority in the era of nationalism and imperialism.

Generally speaking, the attitude of medical missionaries towards disease and illness was precipitated by the Western attitude towards dirt and filth. During the Enlightenment, health and fitness became bourgeois shibboleths in response to the aristocratic obsession with blood and heredity (Foucault 1978; Porter 1985:186; Hardiman 2006:11). The emphasis on health was intricately linked with a disdain for the flesh and its supposed uncleanness. Particularly the female body was the epitome of uncleanness because of its ambivalent physical state that was related to and projected in childbirth and related circumstances (Shorter 1983). In the same vein there was a supposed relationship between uncleanness and sexual activity.

Later on, in Calvinistic circles the emphasis shifted more and more to cleanness as a virtue. John Wesley is often mentioned as one of the initiators of the idea that there is a relation between cleanliness and health: physical well-being could be achieved by moral excellence. However, Wesley's adage of cleanliness as a virtue "next to Godliness" was not the message that was reflected in the thinking and practices of mid-nineteenth century Christians. While John Wesley's theology conveyed the importance of hygiene, purity, and moderate living as a means to become more pious and godly, others would regard the laborious tasks of cleaning, washing, and bathing as a virtue to distinguish one self from the poor and the miserable in society. "Clergy of that time favoured cleanliness to promote not piety but Christian respectability, and eventually, health." (Hoy 1995:3).

In the context of increasing industrialization, urban settings became the scene of sanitation. The awareness grew that hygiene was crucial in the prevention of cholera and other diseases that flourished among crowded and dirty households. City administrators and public health officials began to implement sanitary regulations, and the public effect of eliminating filth as prevention measure was enormous. The importance of health prevention over cure also started to trickle down to other dimensions of life: religious thinking and practices — already embracing the link between body, environment, and cleanliness — now demonstrated a clear preference for and emphasis on order, neatness, and immaculate living. The realization that hygiene promoted a healthy life was supported by the message of the religious revivals: people "began to prepare for the Second Coming of Christ by living more in accordance with the "laws of nature" and by distrusting the pills and drugs prescribed by would-be doctors." (Hoy 1995:6) In striving to live a life that was in perfect harmony with God and that would resist and refrain from sin, one could produce health and healing. Piety and purity were perceived as "a prophylactic against sin and sloth, the mark of the elect" (Porter 1985:186).

2.2 European illness etiologies in Africa

These ideas about physical and moral health in combination with a forceful rejection of dirt were transposed to the African context. The pre-modern African life-styles that the (medical) missionaries encountered, gave rise to the idea that Africa was inherently dangerous, filthy, and full of diseases. Throughout the colonial era, (medical) missionaries reported on the primitivity of Africa and they emphasized that the continent "was inhabited by backward, pagan peoples who suffered from inherent illness and a host of indigenous, pathological evils and defects." (Good 2004:43) The missionaries understood their perspective as justified on biblical grounds: all the diseases and disabilities that are mentioned in the New Testament were abundantly present in the African context (Hardiman 2006:26). And, in the perspective of the missionaries and their supporters, the biblical justification also covered the presence of the (medical) missionaries in Africa: the ignorant inhabitants of dark Africa were in need of civilization and liberation of the evil forces that captivated many people.

The projection of Western illness etiologies on Africa created an antithesis, and this antithesis became a crucial part of missionary medicine. Medical practitioners and other missionaries started to define Christian medicine on the basis of the constructed characteristics of its African competitor. Substantiated with scientific biomedical insights and supported by biblical interpretations, 'African medicine' was portrayed as everything opposed to the medical knowledge, skills, and practices that were part of the missionary frame of mind. Africa stood for everything ranging from primitive, ignorant, pagan, mysterious to dark, cruel, evil, and witchcraft, while the Western world was depicted as modern, sensible, Christian, developed, rational, clean, illuminating, good, and exemplary. The antithesis had developed into a battle that in essence determined the course of missionary medicine.

The discourse of Christian medicine had become a battle against Africa itself, whereby the advocates of missionary medicine regarded the Africans "as the merest adjuncts to the central conflict with the continent." (Hammond & Jablow 1992:169) With such a demeaning and depersonalized perspective of Africa, it was not difficult to accept the idea that the African condition (dark, disease, filth, evil, suffering) was "the sweat of sin in Adam" (Beidelman 1982:110). Basically the whole missionary venture was saturated with this kind of thinking about suffering and sin: there was a close relationship between disease and ungodly living, and the African context was the proof of it. On the other hand, health was the result of inner salvation, and the presence of (medical) missionaries would facilitate this kind of moral redemption (Vaughan 1991:66; Good 2004:43) The connection between physical condition and spiritual state was not new in the Protestant tradition; however, in relation to Africa the fine balance between body and soul had been distorted by the drastic and zealous approach of the missionary movement: the subjection of the body to the soul was the key to missionary success.

3. MISSIONARY MEDICAL POWER

Approximately since the 1990s remarkable studies have been published on missionary (and colonial) medicine with a particular focus on the exercise of power. The practices of medical missions during colonial times have been evaluated with a Foucauldean frame of reference: concepts like power, the body, the gaze, and medical knowledge that were developed by Michel Foucault (mainly in his *Birth of the Clinic*) have been applied to the discourse of missionary medicine. These Foucauldean based analyzes reveal that Western social and cultural attitudes influenced so-called objective biomedical science. That in itself is not novel, but the cultural construction of illness and of "the African individual" through biomedical discourse turned out to be a powerful tool of social control (Vaughan 1991:73).

After a brief clarification of three Foucauldean concepts (body, power, gaze), these concepts will be related to the theory and practices of missionary medicine.

3.1 Foucauldean concepts

3.1.1 The body

The assumption of the Foucauldean paradigm is the contingent state of the body: the body is not something fixed and ready to be read, examined, and treated, but is something that comes into being under influence of the relationship in which the body is. The body of an individual becomes the body of a patient, directing the focus on the disease that needs to be treated, when examined and pressed or cut by the hands of the medical practitioner. So, in Foucauldean terminology, the body is continuously configured and re-created by the power relation of which the body is part. "The individual, with his identity and characteristics, is the product of a relation of power exercised over bodies, multiplicities, desires, forces" (Foucault, in Gordon 1980:74). The difference between conventional approaches of histories of medicine and Foucauldean based approaches, is epitomized in how the body is viewed: according to the Foucauldean paradigm, it is impossible for social and medical science to view the body of the individual as starting point, as the entry of research, since the body is only the result, the invention, and the effect of the actions of the researcher or the medical practitioner. The body is created during the research process and emerges from the treatment instead of being the point of entry from where the research starts (as in conventional approaches implying that the body is a fixed, unchanging entity being the basis of actions and insights of the researcher or medical practitioner). Because of the different perception of the body (namely as the effect of the relation with the researcher or

the doctor), in the Foucauldean approach the body is interpreted as "the very locus of insertion of their knowledge" (Butchart 1998:14). Drawing the attention to the body and the relationship as its framework in which the body exists, leads to the revelation of power that is exercised over the body or the individual. The body is the magnifier or key to discovering the power at work in a personal, national or global relationship.

3.1.2 Power

The concept of power occupies a crucial role in the theories of Foucault. 'Power' should not be understood according to conventional interpretations of it. 'Power' is not a force in a fixed form, or a product resulting from interests, or something that one person does have while others do not have it; "power is not a stricture, or a certain force with which people are endowed; it is a name given to a complex strategic relation in a given society" (Foucault, in Gordon 1980:27). Foucault makes a distinction between sovereign power and disciplinary power – two forms of power that can exist together as well as opposite each other.

Sovereign power is often visible in a relation. This visibility is even necessary for sovereign power since it is a force that is being exercised downwards, from one central point towards the subjects who are supposed to acknowledge and affirm this ruling sovereign power. The power of a king is visualized in his appearance, and visa versa the appearance of the king emphasizes his power; in the same way the mechanism of sovereign power can be explained. In short, sovereign power is being fed by visibility, it exercises control by way of threats and intimidation, and it is centralized in one position ruling over and controlling many subordinates.

The other form of power is disciplinary power. The mechanism of disciplinary power came into existence at a time when the mechanism of sovereign power began to fade under the influence of cultural and scientific developments. These changes in culture and science also impacted the system of ruling within society. Disciplinary power is a general idea capturing every expression or approach aiming at organizing, classifying, controlling, and analyzing every individual in a given society. Foucault exemplified Bentham's 1843 design of an ideal prison (the Panopticum) to explain the concept of disciplinary power. The Panopticum was a circular shaped building designed in such a way that all prisoners were continuously visible in their cells. The guard was able to exercise control over each individual inmate in his cell while being invisible himself. The process of individualization of each prisoner in his cell, and the situation of continuously being exposed to the surveillance of the guard are the crucial elements of the mechanism of the disciplinary power regime. "The Panopticum therefore made the operation of power continuous by inducing in the inmate a state of conscious and permanent visibility that assured the automatic functioning of power" (Foucault 1978:201). The shift to disciplinary power, which should not be understood as replacement of sovereign power since these two forms are always in co-existence, was also made possible by developments in medical science. The study of the anatomy of the human body caused the researcher to focus on the interior of the individual. The body and the individual became the focus point of many methods that were applied in exploring and grasping the human being.

The most important difference between sovereign and disciplinary power is the notion of visibility. Sovereign power is sustained by its visibility while disciplinary power does not depend on its visibility. A relation determined by disciplinary power requires not the power to be visible, but those on whom disciplinary power is exercised. They are the ones who need to be seen, who have to be visible. The very moment of entering the situation of being seen, watched, and inspected, the targets of disciplinary power change into individual objects that are being assessed according to a specific norm established by comparison with others.

3.1.3 The gaze

In a relation of disciplinary power, in the monitoring and manipulating of the individualized body, the body transforms into an object that at the same time is also the effect of disciplinary power, of the surveying eye. In the Foucauldean framework, this process is closely related to the disciplinary gaze. "It refers both to how things have appeared to medicine and to the techniques by which medicine has made things appear, in coming to have particular knowledge of the human body" (Butchart 1998:17). The gaze is the technique applied by the guard or the medical practitioner in observing the prisoner or the patient. This technique is by definition also the boundary of the practices of the guard or the doctor, because the act of seeing and the way of observing is determined by and limited to the zone of social-cultural values and insights.

The gaze, the technique or way of observing, of the medical practitioner is the disciplinary power by which first and foremost the doctor himself is created. Only afterwards does the gaze of the doctor invent the body that is examined. Both the medical practitioner and the body are objects and effects of the disciplinary medical gaze controlling the relation. So the gaze should not be identified as just a specific skill the medical practitioner has to acquire; the gaze is a power regime governing the way people speak, see, and act. In this sense the gaze itself is the creator and inventor of the medical practitioner, and the medical practitioner becomes the object and effect of disciplinary power himself before he exercises with his medical gaze disciplinary power on the body of his patient.

3.2 Medical mission's power regime

When discussing missionary medical power from a Foucauldean perspective, importance is attached to the gaze of the medical missionary that turns the relation between medical missionary and African body into a relation in which the medical missionary is exercising disciplinary power on the African body. The gaze as power regime and the individualized human body as its object and effect, constitute the two main themes in Foucauldean analyzes of missionary medicine.

3.2.1 Regime of sanitation

At the time of missionary practices in Africa, the human body was viewed as "an anatomical container of disease which the hospital medicine produced as its object and effect" (Butchart 1998:74). Based on the anatomical approach in medical science a shift in localizing diseases had taken place: disease was now localized, specified, and classified in relation to the interior of the human body, and the consequence was the drawing of a clear line between everything happening within the human body and whatever was existing outside the human body. As a consequence of this new gap between body interior and body exterior, hygiene became an important issue in medical science and in urban society. "Thus the focus of late nineteenth-century public health became the zone which separated anatomical space from environmental space, and its regime of hygiene developed as the monitoring of matter which crossed between these two great spaces" (Armstrong 1993:396). In this sense, sanitary science enhanced a disciplinary regime since society was now split up in individuals who were governed by physical prohibitions and regulations. Human wastes needed to be controlled and individuals needed to be informed and medically reformed. It was inescapable that medical missionaries, who were objects of the hygiene regime themselves, now generated the disciplinary regime by transporting their scientific insights to Africa. Waste as the new ordering principle in many European and American societies had an enormous impact on society and interpersonal relations in the colonies. The western frame of bodily control was now also imposed on the colonized subjects, often in name of civilization. A characteristic of this focus on the body is that it brought along social and political control of the subordinate, exactly according to the principle of disciplinary power. The waste practices

as method to improve the public health situation in a given society offered at the same time "a potent means of organizing a new, teeming, threatening environment" (Anderson 1995:643).

The focus on hygiene also became the ordering principle of the medical missionaries' practices: their endeavours to liberate Africans from ignorance and superstition in order to civilize them were impacted by the strategy of *moral* sanitation. "Analogous to how sanitary science in Europe individualized the body by delineating the boundaries between it and the environmental space, this new colonial power constellation emerged in the formation of missionary medicine as a device of 'moral sanitation' directed to the boundary between the African body and a surrounding space of customs, rites and superstitions" (Butchart 1998:75). Moral sanitation implied that everything that could distract the African body and soul from becoming cleansed and purified in order to be saved had to be interrupted, put to an end, and if necessary destroyed. The African body and soul had to be aligned towards the light of the Gospel, and moral sanitation was viewed as a necessary means to achieving the healing of the body and cleansing the soul from impurity.

Moral sanitation as a disciplinary power can best be identified by examining the practices of the medical missionaries, since power is difficult to recognize as something defined, explicit or obvious, but it can be traced "at its extremities (…) those points where it becomes capillary" (Foucault, in Gordon 1980:96). According to the Foucauldean approach power should not be detected where it can be logically and easily located (with specific people in specific positions in a given society), but it should be traced exactly there where power dissolves in its concrete application on the ground, "such as the way the doctor's hands palpate the body, or how built space conditions hygienic habits" (Butchart 1998: 32).

3.2.2 Manipulation of the body

One of the most crucial aspects of medical missionaries' practices is the relation between illness and sin, for this link offered the possibility to combine medical practices with evangelism activities. The practices of the medical missionaries aimed at treating and curing the sick body in order to heal its sin. The focus on the individual body was induced by the biomedicine paradigm with its emphasis on distinguishing between the interior of the body and the exterior environment, and its assumption that manipulating and protecting the interior of the body will safeguard it against the evil of the exterior environment. Localizing pain in the body concretized restricting illness to and indicating illness in the body. "Imaging illness meant finding a site for pain" (Landau 1996:272). And precisely in the act of localizing pain in the individual the power of discipline reveals itself: in localizing pain in the body of the individual, the medical missionary "localized the *linkage* between pain and wrongdoing to the individual" (Landau 1996:275. Italics original). Just as the doctor was able to remove the pain from the body, so he was able to uplift the sin of the individual by treating and reconfiguring the African body.

In this sense, the application of minor surgery exhibits the power of discipline that manipulated and re-created the individual African body. One of the most successful therapeutic activities in medical missionaries' practices was minor surgery (see Landau 1996:267; Butchart 1998:82). Striving for winning or creating individuals who would no longer be controlled by evil powers and superstitions, but be cleansed, purified, and civilized, surgical work appeared to be an effective device. "People went to Europeans to be cut" (Landau 1996:267), something which did not happen often in African traditional therapeutic practices because cutting the body on purpose meant not only damaging that specific part of the body but the body as a whole. 'Wholeness' carried a different meaning for Africans compared to western medical missionaries who generally approached the body as a network of separable parts. According to the western paradigm the body was a container of health or disease, so when disease was localized in the

body, it could only be removed from the body itself. Despite the different views on the body of the individual as well as of the community, Africans suffering from illnesses were attracted by the practice of surgery of the western missionaries. Surgical work was quick and obvious: "(t)he removal of huge and disabling tumours remained occasions for the dramatic display of the powers of European surgery" (Vaughan 1991:59). The impressiveness of surgical work and the fast relief of pain served the purpose of convincing local people to become Christians.

Landau (1996:275ff) suggests that this interest in minor missionary surgery also had to do with the interpretation of surgery as rite of passage. Elaborating on the practice of tooth pulling, he shows how the African patient, during the treatment by the medical missionary, undergoes an alteration of the body, which can be seen as one of the most important aspects of a rite of passage. The patient is passing to a new status, and this new status is visualized in a changed appearance, and experienced in the pain that was necessary to reach this new status. "One might even argue that missionaries intended tooth-pulling to be a rite of passage, in that they constantly wished to lead Africans across a threshold into a new, and more perfect, civil order" (Landau 1996:277).

Whether the attraction of surgery is to be explained by the notion of blood and the visibility of this bearer of life on the clothes of the doctor after an operation, contributing to the apparent power over life and death of his patient (see Butchart 1998:82), or whether it has to do with the deconstruction and reconfiguration of the body as part of a rite of passage, a moving away from the norms and beliefs that were captivating the Africans, with the accompanying transition of the soul (see Landau 1996), might be worthwhile to investigate further. Here it suffices to mention that medical mission relied on biomedicine's discursive strategy by manipulating the individual body, while creating a clear distinction between body and soul, in order to make converts.

3.2.3 Invention of the individual

A further aspect of the practices of medical missionaries was the invention of the individual as an object and effect at the same time. Invented individuals themselves, the medical missionaries aimed at promoting the potential status of the individual over against the invisibility and therefore the inaccessibility of the mass or kinship group. The gaze of the medical missionary saw the body of the African as an instrument or a device to reach the soul of the African. For that purpose the space between the body, the individual African with organs and a soul, and its environment had to be addressed. Just as a tumour had to be cut out of the body, in the same way the environment of the individual African had to be eliminated. The environment was occupied by influences of the African tradition, and these beliefs, customs, rites, and regulations of the tribe had to be overpowered by Christian faith, medicine, and practices. The therapeutic practices of the missionaries disturbed the traditional communal ties, and threw them off balance by introducing the concept of the individual. African traditional thinking about health and illness was intrinsically linked with the social network of relations. "Malleable but reliable communal ties were the best insurance of good health" (Landau 1996:266), and from the perspective of the missionaries these communal ties had to be stripped of their influence in order to save the African soul. Substituting the kinship community for the idea of the individual, and locating illness in the individual body in stead of the interpersonal zone of forces, matched very well with the "Protestant's (...) understanding that conversion was a result of inner conflict and turmoil. The evangelical assumptions of late nineteenth- and early twentieth-century missionaries insisted on individual attainment, an elevation of the autonomous Self. Converts had to undergo an internal struggle, leading to a difficult and important resolution." (Landau 1996:274) The manufacturing of the individual, the direct manipulation of the body in order to remove impurities which disclose the threats of the African tradition and community, and the

conversion of the individual which was seen as moral sanitation or internal decontamination point towards disciplinary power and its requirement to make the target over whom power is exercised visible.

3.2.4 Site of healing

Another aspect of the therapeutic activities of the missionaries is the site of healing. The site, the location, where the African body was examined and treated, appeared to be important in the process of making converts. Up to the 1920s the medical practices resembled the therapies of the African priest-healers in the sense that the healing therapy or treatment required to be seen and dramatized: it needed to be witnessed by others who were supposed to be in awe by what they had seen. This theatre or spectacle of healing often happened in the open air, in the vicinity of medical dispensaries where patients would assemble and wait for their turn to be treated. The carrying of the medicine chest, the display of instruments that were going to be used, the examining with the stethoscope, the tooth-pulling or setting of broken bones, the distributing of medicine – all these practices can be viewed as instruments of visibility aiming at manipulating and converting the African body and soul to the kingdom of God and to civilization. The spectacle's features of display witnessed by impressed onlookers resemble the mechanism of the sovereign power regime with its visibility and demonstrated dominance. "The spectacle of sovereignty addressed the onlookers in whose beliefs and deeds were reproduced the forces of darkness that had to be made to bow to 'civilization'. But running alongside, almost incidental to the drama that attracted the African's attention, coursed the whispering currents of disciplinary power: through the doctor, through the catheter and stethoscope" (Butchart 1998:81).

In the 1920s mission hospitals started to emerge, and the hospital as fixed site of treatment and healing shifted the accent in the regime of dual powers: the healing spectacle with its openness and visibility changed into a fixed site where patients were examined and treated in seclusion. The shift from outside to inside, from open to isolation, symbolized the shift in power mechanism: "the dominant power investing in the work of the medical missionary switched from that of conspicuous sovereign to silent surveyor of African suffering and superstitions" (Butchart 1998:83). In fact, the emergence of mission hospitals shifted the attention from successful achievements supported by impression by the onlookers who would spread the good news of the missionaries, to the debilitating circumstances of the Africans. Especially in the hospital, where so many sick people gathered, the diseases and their causes were magnified and over-emphasized. The gaze of the medical missionaries saw African bodies and souls being threatened by traditional beliefs and practices. These sick bodies were held hostage by witchcraft beliefs and therapeutic practices of the African doctor, and the missionaries' pursuit to liberate these bodies and to win them for the Gospel was represented in the mission hospital as healing site, and its threshold was imagined as the absolute separation between superstition and salvation (see Butchart 1998:85). The hospital's power over the heathen African body and soul exemplifies the power regimes, which constituted the missionary practices.

5. CONCLUSIONS

A brief look at illness etiologies and therapeutic practices as basic features of missionary medicine in Africa gives birth to the idea that the notion of power is a central tenet in the missionary medicine discourse. Health constructions as well as illness interpretations by medical missionaries turned out to be important catalysers in the process of reaching out to Africans. The health-illness correlation was often synonym for cleanliness-dirt, European-African, salvation-sin. Consequently, therapeutic practices were framed according to these correlations, and according

to the idea that the body had become the site for spiritual outcomes. Although the exercise of power and control over Africans is not directly obvious and visible, the notion of power certainly lingered under the surface of health ideas and healing practices of medical missions.

A further, critical exploration of the notion of power within the missionary medicine discourse was done with a Foucauldean frame of reference, because such an approach reveals more clearly the mechanisms of disciplinary power in a particular area of society. The main implication of the Foucauldean based analysis is that disciplinary power permeated the whole medical missions discourse, because it nurtured western biomedical faith-based healing constructions and it fuelled those missionary activities that aimed specifically at the conversion of Africans.

The notion of power thus functioned as a firm foundation for the healing-conversion constellation of missionary medicine. Consequently, many currently existing and prominent health concepts (generated by medical missions) in the African context are based on, or at least influenced by, the same relationship of disciplinary power, conversion, and healing.

Even though mainstream churches generally reject a direct link between conversion and healing, between sin and suffering, they do not address the ever present notion of power in this triangle, whilst disciplinary power turns out to be the fuel of the cluster, and therefore at least needs to be acknowledged in theologies of healing produced by mainstream tradition.

The Foucauldean based analysis in this article represents a challenge and an opportunity for mainstream theology in Africa regarding reflections on health, illness, and healing. The exemplification of missionary medicine with its invisible disciplinary power generates the suggestion that equivalent under-the-surface power structures might also be present within the current relationship of church, theology, HIV/AIDS, and healing. The notion of power becomes concrete in its application when one looks, for example, at the dichotomies that continue to exist in the theological discourse on HIV/AIDS: international sources are referred to as knowledgeable informants, whilst African sources rather function as local eyewitnesses; theological health constructions are foremost determined by the general scientific consensus, whilst socio-economic factors, indigenous knowledge systems, or individual experiences play a subordinate role; theological health concepts are constructed by the minority on behalf of the majority that is often portrayed as helpless victims; and the language used to articulate health concepts is infused with dominant negative words like “the needs”, “the deficits”, “destruction”, and “suffering”, which actually reinforces the idea that infected people are automatically disadvantaged and dependent on external sources. I intend to explore these issues in-depth in my broader research project in the field of theology, power, and illness. And one of the proposals will be that the Foucauldean lens can be used as a critical tool in the development and evaluation of theologies of healing in the African context.

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KEY WORDS
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