STUDY SESSION
Tanzania’s Episcopal Conference
The Role of the Church in providing Social
Services for the promotion of Justice, Peace
and Reconciliation with special attention to
Health

Summary Report

Kurasini Training and Conference Centre
Dar Es Salaam
June 25th-27th, 2007

In cooperation with medicusmundi
1. **Introduction**

On 25th and 26th June 2007 the Episcopal Conference of Tanzania (TEC), gathered in Plenary with, heads of Religious Superiors’ Associations, heads of Tanzania Catholic Association of Sisters, heads of Catholic laity (including youth, Catholic women’s association and Catholic workers’ association), representatives of Christian Professionals of Tanzania, heads of Major Seminaries and Catholic Institutions (St Augustin University College of Tanzania, WEILL-Bugando University College of Health Sciences and Bugando Medical Centre), heads of TEC Departments, secretaries of TEC Commissions, has considered issues related to the exercise of the Healing Ministry, under the title: **The Role of the Church in providing Social Services – for the promotion of Justice, Peace and Reconciliation with special attention to Health.**

This study session had the purpose of reviving the commitment of the Bishops to the Healing Ministry. The expected outcome was a statement in which the Bishops would identify specific point of action and express them as resolutions, in the critical areas of stewardship to the Ministry (i.e. advocacy for health, empowerment of TEC Health department (TEC HD), governance of Christian Social Services Commission – CSSC). The study day was organised by the Office of the Secretary General of TEC jointly with the TEC HD, and facilitated by the Secretary of the Health Commission of the Episcopal Conference of Uganda. Support was provided by Medicus Mundi /CORDAID. The session spanned over one and half days from Monday 25th (morning) to Tuesday 26th. On Wednesday 27th June, the Bishops, in their business session of the TEC Plenary, formally approved the Statement issued from the study session.

A series of presentations focussing on various aspects of the Ministry – its identity, its sustainability, its ecumenical co-ordination - were delivered on the morning of day 1. The study session continued on day 2 with presentations concerning the co-ordination of the ministry in the Church at global, national and diocesan level, and the collaboration with the Government. These presentation prepared the common discernment through group work. The facilitator provided the necessary guidance through the group work and condensed the results of the work, framing them in the form of a statement to be subjected to approval.
CONTENT

1. Prayer and welcome address

   Rt Rev Jude Thaddeus Ruwa’ichi – TEC President

3. Revisiting the role of the Catholic Church in Tanzania on Health Services
   Rt Rev Aloysius Balina

4. Sustainability of the Healing Ministry and the Catholic Church Health Services
   Rt Rev Severine NiweMugizi

5. The ecumenical venture in Social service – critical issues and challenges
   Dr Adeline Kimambo – CSSC

6. The Universal Church on Social Services: conclusions of the 3rd AISAC meeting
   Bro Dr Daniele Giusti - UCMB

7. Relations with the State: health sector reforms
   Dr Faustine Njau – Ministry of Health

8. Summary of Policy and Critical Issues (Rapoteur and facilitator)

9. Resolution – Bishops
GROUP WORK

Group work was organised around 4 critical issues for consideration. The facilitator, through a brief introductory presentation, recapped the background of the work (the process leading to it), explained the method of work and outlined the topics to be addressed, with a request to discuss matters following the lead questions and other possible questions presented by members of the group on the issue at hand (see Appendix), capture areas requiring attention by TEC and formulate proposals for resolutions.

Ten groups were formed. Rapporteurs were pre-assigned to the work. The groups worked for one and half hours till lunch interval and presented their elaborates in the afternoon Plenary session. The facilitator summarised the reports of the group by identifying recurrent themes and resolutions and organising them in a synoptic presentation for the Bishops after break. Few suggestions were made to enrich the synopsis and the result formed the basis of the formal statement that was submitted to the Bishops the following morning for formal adoption.

Groups’ Assignments

Mission
Group 3: Chair Bishop Nestor TIMANYWA - 11 members
Group 4: Chair Bishop Tarcisius NGALALEKUMTWA – 8 members
Group 7: Chair Bishop Agapitus NDOROBO – 6 members

TEC HD (Health Department)
Group 6: Chair Bishop Beatus KINYAIA – 7 members
Group 9: Chair Bishop Aloysius BALINA – 5 members

DHC (Diocesan Health Commission)
Group 5: Chair Bishop Jacob KODAK – 9 members
Group 8: Chair Bishop Anthony MAYALA – 6 members
Group 10: Chair Bishop Gabriel MMOLE – 7 members

CSSC (Christian Social Services Commission)
Group 1: Chair Bishop Evarist CHANGULA - 8 members
Group 2: Chair Bishop Metodius KILAKINI - 9 members

Cooperation with Government
**GROUP WORK PRESENTATIONS**

Discuss issues related to the **MISSION** (identity, critical and “hard” areas, how to assess Faithfulness to the Mission......) in the light of the presentations given (especially the presentation “Sustainability of the Healing Ministry”) and own experience, to “distill” areas in need of special attention by the TEC and resolve on the most critical actions to be undertaken.

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<tr>
<th>Group 3</th>
<th>Areas in need of special attention</th>
<th>Resolutions</th>
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| Chair Bishop Nestor TIMANYWA | - The identity of our Mission is there (e.g. prayers before working hours, spiritual and physical tender loving care to our patients)  
- There is a mission statement dating ’70 and never revised and it is not known  
- Mission statements of institutions are there but kept in shelves and not known, not inspiring the practice  
- Contract with staff make no mention of the Mission  
- There is no well planned orientation and ongoing formation/education on the healing ministry, its foundations, demands and implications so that those service the ministry can be stewards of the ministry itself  
- Structures of Governance and Management (and tools for it like data) are not very effective | TEC HD to  
- Organise well planned orientation/ongoing formation of the Mission, its foundations, demands and implications, to reach even the grass-root.  
- Provide guidance on formulation of contacts.  
- Establish Church Health Insurance. |
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<tr>
<th>Group 4</th>
<th>Resolutions</th>
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<tbody>
<tr>
<td><strong>Chair Bishop Tarcisius NGALALEKUMTWI</strong>&lt;br&gt;<strong>Rapporteur Msgr Julian KANGALawe</strong>&lt;br&gt;<strong>8 members</strong></td>
<td>TEC form a program to teach health workers skills of how to deal with as “persons”&lt;br&gt;We encourage TEC to produce a document on Health Policy based on the mission of the Church as regards the Healing Ministry&lt;br&gt;TEC to draw a charter spelling out respect of Human Life (Cfr John 10:10) like the old Hippocratic Oath for Medical workers/Paramedical workers&lt;br&gt;More education be provided to make Health workers conscious faithful stewards of the Church’s Healing Ministry by teaching them the foundations, demands and implications&lt;br&gt;Resolutions Organs of dialogue including word of God, Magisterial documents, Health Board, Management team and individuals</td>
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<tr>
<th>Group 7</th>
<th>Areas in need of special attention</th>
<th>Resolutions</th>
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<tr>
<td><strong>Chair Bishop Agapitus NDOROBO</strong>&lt;br&gt;<strong>Rapporteur Ms Agatha DAMAS</strong>&lt;br&gt;<strong>6 members</strong></td>
<td><strong>Sustainability of the Mission is an overarching issues encompassing different aspects of sustainability (personnel, funds, equipment, adherence to mission, medicine, excellence/quality of services)</strong>&lt;br&gt;Adherence to the Mission by staff and managers is a problem&lt;br&gt;There is no adequate documentation of practice of faithfulness to the Mission&lt;br&gt;Consistency with the Mission is not planned for</td>
<td>TEC to Develop clear Mission and Policy for the Healing Ministry&lt;br&gt;TEC to Advocate for Mission and Policy of Healing Ministry&lt;br&gt;TEC to facilitate Dioceses to develop mission statements to be enshrined in Charters plans and programs&lt;br&gt;TEC to ensure institutional capacity building for the Mission (continuous Christian formations through prayers and good actions)&lt;br&gt;TEC to develop mechanisms for monitoring and evaluation of Mission and policy implementation</td>
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Discuss issues related to the **SERVICE OF THE HEALTH OFFICE** of TEC (what should it do, how can it be empowered to do what is necessary, how to interact with CSSC – avoid vacuum of functions or overlap of functions) in the light of the presentations given and own experience, to “distill” areas in need of special attention by the TEC and resolve on the most critical actions to be undertaken.

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<tr>
<th>Group 9</th>
<th>Areas in need of special attention</th>
<th>Resolutions</th>
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<tbody>
<tr>
<td>Chair Bishop Aloysius BALINA</td>
<td>Functions of health dept not well known by everybody TEC HD Strategic Plan exists but not known and not monitored Mission and Policy limited to AIDS TEC HD not enabled to carry out training to inform governance TEC HD has limited capacity to do policy analysis and advocacy</td>
<td>TEC HD to produce Brochure explaining Mission, Policy etc... TEC HD should encourage formation of chaplaincy services TEC HD to monitor DHOs as part of the budget for QA instead of waiting for data to come Regular report on TEC HD Strategic Plan should take place (PC and PA of TEC) A newsletter should be produced to keep Bishops updated on all activities of the secretariat including health office. TEC HD start a program of induction to Governance for managers and staff.</td>
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<tr>
<td>Rapporteur Mr Benedict KISAKA</td>
<td>5 members</td>
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<th>Group 6</th>
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<tr>
<td>Chair Bishop Beatus KINYAIA</td>
<td>Knowledge of the Strategic plan is limited and Monitoring of the implementation of the Strategic Plan does not occur Dissemination of information and participation to meeting is limited</td>
<td>The existing Strategic plan is not sufficiently known and must be better known M&amp;E of the Strategic Plan implementation must be carried out Dissemination of information to stakeholders must be strengthened Participation to meeting must increase Focus of lobbying on protection of unborn Cooperation between CSSC and TEC must be strengthened TEC HD must enable church health services to be permeated by Christian Spirit</td>
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<tr>
<td>Rapporteur Fr Revocatus MAKONGE</td>
<td>7 members</td>
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Discuss issues related to the **SERVICE OF THE DIOCESAN HEALTH OFFICES** (what should they do, how can they be empowered to do what is necessary) in the light of the presentations given and own experience, to “distill” areas in need of special attention by the TEC and individual Bishops and resolve on the most critical actions to be undertaken.

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<th>Group 10</th>
<th>Areas in need of special attention</th>
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<tr>
<td>Chair Bishop Gabriel MMOLE</td>
<td>DHOs exists but quite often with limited time (as a part time job for people with other jobs) There is no formal training for DHOs</td>
<td>In every diocese the should be a diocesan health office (and it must be empowered) There must be regular communication between TEC HD and DHOs (example of Kasada) Religious must be given priority in training for the post of DHO DHOs to form specific groups for service to AIDS programs DHOs should see the possibility of encouraging and exploiting the so called Alternative Therapies to reduce expensive cost-sharing</td>
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<tr>
<td>Rapporteur Fr Michael NSONGANZILA</td>
<td>7 members</td>
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<th>Group 5</th>
<th>Areas in need of special attention</th>
<th>Resolutions</th>
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<tr>
<td>Chair Bishop Jacob KODAK</td>
<td>Offices are in existence but lack appropriate personnel and guidance (policy) They are not sufficiently effective There is not training program for co-ordinators There are no tools for assessment of DHC Co-ordinator have no negotiation skills. Co-operation is good with other Christians but not with Government</td>
<td>TEC HD to develop Mission and Policy (in 2 years) Dioceses to develop own policy in 3 y TEC HD should endeavour to create an awareness program on the Mission TEC HD to build capacity in lobbying and advocacy Continuous formation of owners and managers of health facilities</td>
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<tr>
<td>Rapporteur Fr Lucas LUSIWANDA</td>
<td>9 members</td>
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<th>Group 8</th>
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<tr>
<td>Chair Bishop Anthony MAYALA</td>
<td>- The Diocesan Health Offices are existing but weak in their operations</td>
<td>- To have Health Policy – TEC should have a health policy to clearly spell out the roles of the National and dioceses, structure, links/networks and guide dioceses to formulate their policies</td>
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<tr>
<td>Rapporteur Ms Olive KINABO</td>
<td>- Inadequate financial resources to meet the costs of HR</td>
<td>- Each diocese should have a clear policy to provide guidance on the implementation of the health services in the diocese.</td>
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<td>6 members</td>
<td>- Inadequate capacity to advocate for accessibility of funds and other resources</td>
<td>Policy</td>
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<td>- Inadequate number and capacity of the personnel on administration</td>
<td>- It should spell out norms (emanate from the universal church) of operations to enhance collaboration within the diocese</td>
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<td>- Inadequate collaboration within the dioceses – among the congregations</td>
<td>- It should outline on the resource mobilisation</td>
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<td>- Poor communication between the National Office and Diocesan Health Offices</td>
<td>- It should enhance reporting on time, sharing and feedback</td>
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<td>- Lack of data</td>
<td>- It should enhance transparency and Accountability</td>
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<td>- No regular and systematic assessment of the diocesan health offices</td>
<td>Strategic Plan</td>
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<td>- Develop a participatory Strategic Plan in the dioceses to enhance proper implementation of the health services</td>
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<td>- The Strategic Plan should provide tools for operation among them being Monitoring and Evaluation</td>
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<td>Capacity Building</td>
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<td>- TEC should develop mechanisms to carry out TNA from the Diocesan Health Secretaries</td>
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<td>- Train the Health Secretaries and officers on lobbying advocacy and negotiation skills</td>
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<td>- SAUT to update the course on hospital administration and also prepare tailor made courses according to the needs.</td>
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<td>- Dioceses to employ well trained personnel at least graduates</td>
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<td>Networking and collaboration</td>
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<td>- TEC to strengthen capacity of the dioceses to be able to network – through internet</td>
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<td>- Improve network with other stakeholders</td>
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<td>- Make use of CSSC</td>
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<td>- TEC facilitate the link of the dioceses with other stakeholders</td>
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<td>Information and communication</td>
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<td>- TEC to establish data bank and facilitate the availability and use of such services in the dioceses</td>
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<td>Advocacy</td>
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<td>- TEC and CCT to establish a committee which will advocate to the Government on the health issues in particular about the human and financial resources</td>
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<td>- The Committee should be kept with adequate data from the dioceses</td>
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Discuss issues related to **CSSC** (what should it do, how effective it is in doing it, how effectively its work is monitored and assessed, how focused and pertinent is the participation of TEC in the Governance of CSSC) in the light of the presentations given and own experience, to “distill” areas in need of special attention by the TEC and resolve on the most critical actions to be undertaken.

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<th>Group 2</th>
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<tr>
<td>Chair Bishop Metodius KILAKINI</td>
<td>- Ownership &lt;br&gt;- CSSC seen as donor organ &lt;br&gt;- Inadequate database &lt;br&gt;- Lack of spirit of Christian sacrifice &lt;br&gt;- Partial commitment</td>
<td>- TEC has to be better informed and have full ownership of CSSC through commitment &lt;br&gt;- TEC and CCT have to reformulate policy and direction of CSSC &lt;br&gt;- TEC has to improve the flow of data from grass-root to the national level, to enable advocacy and lobbying &lt;br&gt;- TEC and CCT to infuse the Christian vision among CSSC workers &lt;br&gt;- TEC to appreciate the good that has been done by CSSC.</td>
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<tr>
<td>Rapporteur Sr Florence MHAGAMA</td>
<td>9 members</td>
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<th>Group 1</th>
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<tr>
<td>Chair Bishop Evarist CHANGULA</td>
<td>- CSSC legally owned. &lt;br&gt;- It is sufficiently effective in its pilot areas (education) but excessively donor dependant. Hence freedom to plan own priorities is limited. &lt;br&gt;- It is regularly assessed at least once a year (both at national and zonal level) &lt;br&gt;- It accounts to TEC (PA and PC) &lt;br&gt;- High salary of staff are no guarantee of apostolic services. &lt;br&gt;- CSSC is assessed once a year at national and zonal level by TEC and CCT with reports sent to PC and PA. &lt;br&gt;- Governance of CSSC is fairly good at national level but less so at zonal level.</td>
<td>- CSSC to increase efforts to self reliance &lt;br&gt;- Create and promote use of local capacity through SACCOS and health insurance &lt;br&gt;- TEC to strengthen dissemination about CSSC activities &lt;br&gt;- Co-ordination between national and diocesan offices of CSSC to be strengthened &lt;br&gt;- Qualified personnel should be assigned to CSSC zone by dioceses and followed up (improve capacity of the lead agents).</td>
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<tr>
<td>Rapporteur Fr Vitus SICHWALE</td>
<td>8 members</td>
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Chair Bishop Evarist CHANGULA 
Rapporteur Fr Vitus SICHWALE 
8 members
TEC STUDY SESSION FINAL STATEMENT

Preamble
We, members of the Tanzania Episcopal Conference and the Apostolic Nuncio, are gathered for the 60th Plenary Assembly, co-opting major Religious Superiors, heads of Departments, Commissions, TEC Institutions and leaders of the laity. We have considered issues related to the exercise of the Healing Ministry, under the title: The Role of the Church in providing Social Services – for the promotion of Justice, Peace and Reconciliation with special attention to Health.

A series of presentations focussing on various aspects of the Ministry, its sustainability, its ecumenical co-ordination, its co-ordination in the Church at global, national and diocesan level, and the collaboration with the Government prepared the work of discernment through group work.

To complement the insights provided by the presentations, a reader containing selected documents from the AISAC (International Federation of Catholic Hospitals) congress held in Rome during the month of May and statements from a series of meetings organised over the last years in different Countries on “The Church and her involvement in the Healing Ministry in Africa”,¹ was also provided. (Dr. E. Widmer Medicus Mundi International)

Four key areas of discussion were identified for the group work:

1. The Mission of the Church in the Healing Ministry and its demands
2. The service of co-ordination of the Healing Ministry at National level
3. The service of co-ordination of the Healing Ministry at Diocesan level
4. The service of ecumenical co-ordination at national and zonal level through Christian Social Service Commission (CSSC)

Groups were assigned to each of the four areas of discussion and asked to identify a set of resolutions representing points of action for the Episcopal Conference and its health office and for Bishops and their respective diocesan health co-ordinations. The point thus identified were discussed in plenary assembly and formed the basis for the commitment that Bishops decided to undertake in their collegial gathering, on 27th June 2007. The assembly agreed that the implementation of the points of action identified needed to be monitored and regularly assessed: the Health Office of the Bishops’ Conference was mandated to carry out this task.

Statement
Having considered the challenges facing the exercise of the Healing Ministry at the outset of the XXI Century and taking into account His Holiness Pope Benedict XVI’s invitation to “renewal and deepening of the Ministry – aggiornamento”, we the Catholic Bishops in Tanzania, together with our immediate collaborators, are committed to

¹ Courtesy of MMI Switzerland (Dr. Edgar Widmer), the documents from AISAC meeting (Catholic Hospitals by Card Lozano Barragan; Ecclesiastical Structures in North America by Fr F.G. Morrisey; Ensuring the Sustainability and effectiveness of Catholic Health Care by F. Sullivan – CEO Catholic Health Australia; Conclusions of the AISAC Congress); Excerpts from African Bishops’ Statements on Health (Soesterberg Conference Statement 2000, Kampala Conference Statement 2004, Cotonou Conference Statement 2005, Bangui Conference Statement 2006).
- continue the Ministry in the form we have inherited from our ancestors in Faith, by ensuring that it is better co-ordinated and “informed” by a spirit of stewardship and faithfulness to the Mission at all levels
- being attentive to the signs of the time and need of “aggiornamento” by discerning on new forms of exercise of the same Ministry that the Holy Spirit inspires in the Body of Christ, the Church.

For this we have given special consideration to four areas of concern; for each of them we have identified the most critical issues in need of or special attention. These are:

1. Our Mission and Policy in Healthcare has not been revised for over thirty years and needs revisiting. Furthermore there is a limited knowledge of the “core” of the Catholic Healing Ministry and its foundations in many of the persons working for the Ministry in the Church. It is also infrequent to find health care institutions with a well developed Mission Statement where its demands and practical implications are well spelt out.

We have therefore resolved that we shall mandate our national health office to
• enter into a consultation with us and other actors in Catholic Healthcare to elaborate a new Mission and Policy Statement in the light of the Healing Ministry.
• disseminate it and find the most suitable way to make it known in dioceses and health institutions, particularly by their governing organs (Boards).
• urge these latter to adapt the Mission and Policy Statement to the local context and adopt it.
• elaborate a plan for implementation of the Mission and Policy and monitor its progress.
• regularly inform us of the progress registered.

We ask our Health Department to look at the Ministry with a broad horizon, encompassing both the form of the Ministry well known to us (i.e. institutional health care) and also discern about new forms emerging. Pastoral care of the sick through Chaplaincies needs to be considered and boosted.

2. The functions and objectives of the Health Department of TEC are clear and also detailed in a Strategic plan we have approved, but they are ignored, while the progress of the implementation of this plan is not regularly monitored and assessed. Hence we are not enabled to “own” the process and to account for its development and progress.

We have therefore resolved that our Health Department endeavor to make it self better known through
• increasing its capacity to collect and analyze critical information concerning the Healing Ministry, its challenges, its sustainability and our Faithfulness to its demands.
• provide regular feedback and secure information flow downwards and upwards in view of better advocacy for conditions enabling sustainability of and Faithfulness to the Mission.

3. There is an increasing need of co-ordination of Catholic healthcare at diocesan level, especially considering the decentralisations process that has moved critical allocative powers in Government from the centre to local governments. Likewise, there is need of close links between TEC Health Department and Diocesan Health Co-ordination and networking of Catholic Healthcare.

We have therefore resolved that each Diocesan Health Co-ordination must be effective and that each one of us takes up the responsibility of endeavouring for this objective. In view of the same objective we ask and we shall enable the TEC Health Department to
• identify adequate options for the training of Diocesan Health Co-ordinators in all the skills that are necessary for their effectiveness.
• develop and use tools for assessing the effectiveness of the Diocesan Health Co-ordination, and keep us regularly informed about the outcome of the assessment.

4. TEC's and the Christian Council of Tanzania’s (CCT) “ownership” of the Christian Social Service Commission (CSSC) is limited. On the other hand the effectiveness of CSSC in its advocacy function (especially with Government) is hampered by the scarce compliance of our institutions with the request of information to be used for CSSC's functions.

We have therefore resolved that we shall, together with CCT, re-commit to guidance and governance of CSSC, if necessary by re-defining its mandate. This will occur both at national and zonal level, where we shall ensure that people representing us have the necessary capacity and interest.
We shall also urge our healthcare institutions and services to be timely and thorough in providing the information CSSC asks from them: TEC Health Department will ensure compliance on this aspect and report back to us about non-compliance.

We are quite aware that the challenges presented by the Healing Ministry and its sustainability go well beyond the priority areas we have identified and the resolutions we have formulated. Yet good stewardship of the Ministry, the way we have portrayed, is the right starting point for a work that, we know, is of long term.

We entrust our commitment, our endeavours and those of all people of good will who work in the service of the Healing Ministry to the maternal care of our Mother Mary and the intercession of our ancestors in faith who have endowed our Church with the immense heritage of Catholic Healthcare in Tanzania. We follow in their steps.
## Participant Bishops

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<tr>
<th>Diocese</th>
<th>Address</th>
<th>Contact Details</th>
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<tr>
<td><strong>Apostolic Nuntiature</strong></td>
<td>P.O. Box 480</td>
<td>Tel: 255-22-2666422</td>
</tr>
<tr>
<td>Most Rev. Luigi Pezzuto</td>
<td>DAR ES SALAAM</td>
<td>Fax: 255-22 2668059</td>
</tr>
<tr>
<td><strong>Diocese of Arusha</strong></td>
<td>P.O. Box 3044</td>
<td>Tel. 255-27-2-544362 or 2-508166</td>
</tr>
<tr>
<td>Rt. Rev. Josaphat Lebulo</td>
<td>ARUSHA</td>
<td>Hse 2-548169</td>
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<td></td>
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<td>Fax: 255-27-2-548004</td>
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<tr>
<td><strong>Diocese of Bukoba</strong></td>
<td>P.O. Private Bag</td>
<td>Tel: 2-220189 or 2-220196</td>
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<tr>
<td>Rt. Rev. Nestor Timanywa</td>
<td>BUKOBA</td>
<td>Hse 255-28-2-220746</td>
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<td>Fax: 255-28-2-22113or2-223282 or 2-220006 or 2-220746</td>
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<tr>
<td><strong>Archdiocese of Dar es Salaam</strong></td>
<td>P.O. Box 167</td>
<td>Tel: 255-22-2-113223or2850882</td>
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<tr>
<td>His Eminence Polycarp</td>
<td>DAR ES SALAAM</td>
<td>Fax: 255-22-2-125751</td>
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<td>Cardinal Pengo</td>
<td><a href="mailto:nyumba@cats-net.com">nyumba@cats-net.com</a></td>
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<td>Rt. Rev. Methodius Kilaini</td>
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<tr>
<td>Auxiliary Bishop</td>
<td>P.O. Box 167,</td>
<td>Tel: 255-22-113223or2-602051 or 2-602053</td>
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<td>DAR ES SALAAM</td>
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<tr>
<td></td>
<td><a href="mailto:mkilaini@intafrica.com">mkilaini@intafrica.com</a></td>
<td>Fax: 255-2-12751</td>
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<tr>
<td><strong>Diocese of Dodoma</strong></td>
<td>P.O. Box 922</td>
<td>Tel: 255-2-394462</td>
</tr>
<tr>
<td>Rt. Rev. Matthias Isuja</td>
<td>DODOMA</td>
<td>Fax: 255-2-394513</td>
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<tr>
<td>Joseph</td>
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<td><strong>Diocese of Geita</strong></td>
<td>P.O. Box 120</td>
<td>Tel: 255-28-2-520120</td>
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<tr>
<td>Rt. Rev. Damian Dallu</td>
<td>GEITA</td>
<td>Fax: 255-28-2-520208</td>
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<tr>
<td><strong>Diocese of Iringa</strong></td>
<td>P.O. Box 133</td>
<td>Tel: 255-26-2-702772</td>
</tr>
<tr>
<td>Rt. Rev. Tarcisius Ngalalekumtw a</td>
<td>IRINGA</td>
<td>Fax: 255-26-2-700650</td>
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Diocese of Kahama  P.O. Box 400  KAHAMA
Rt. Rev. Ludovic Minde
Tel: 255-28-2-710950 or 2-710229
Fax: 255-28-2-710229

Diocese of Kigoma  P.O. Box 71  KIGOMA
Rt. Rev. Paul Ruzoka
Tel: 255-28-280-2143 or 280-3129 or 280-3115-6
Fax: 255-28-280-2043

Diocese of Mahenge  P.O. Box 102  P.O. MAHENGE
Rt. Rev. Agapitus Ndorobo
Tel: 255-23-2-620342 or 23-2-620319

Diocese of Lindi  P.O. Box 435  LINDI
Rt. Rev. Bruno Ngonyani
Tel: 255-23-2-220-2550
Hse 255-23-2-220-2177
Fax: 255-23-2510410

Diocese of Mbeya  P.O. Box 179  MBEYA
Rt. Rev. Evaristo Chengula
Tel: 255-25-2-502176 or 252-502250
Hse 255-25-2-2171
Fax: 255-25-2-504170

Diocese of Mbulu  P.O. Box 49  MBULU
Rev. Rt. Thaddeus Ruwa’ichi, O.M.F.
Tel: 255-27-2-533055 or 27-533113
Fax: 255-27-2-533114

Diocese of Mbinga  P.O. Box 94  PERAMIHO
Rt. Rev. Emmanuel Mapunda
Tel: 255-25-2-602868
Fax: 255-25-2-602917

Diocese of Morogoro  P.O. Box 640  MOROGORO
Rt. Rev. Telesphor Mkude
Fax: 255-23-260-3340
Tel: 255-23-260-3341

Diocese of Moshi  P.O. Box 3011  MOSHI
Rt. Rev. Amedeus Msarikie
Tel: 255-27-27-521570 or 27-52089
Fax: 255-27-27-50934
or 27-51982
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<td>Diocese of Mtwara</td>
<td>P.O. Box 526 MTWARA</td>
<td>Tel: 255-23-23-33128or23-33071</td>
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<td>Rt. Rev. Gabriel Mmole</td>
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<td>Diocese of Musoma</td>
<td>P.O. Box 93 MUSOMA</td>
<td>Tel: 255-28-2622017 or 2642472</td>
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<td>Rt. Rev. Justin Samba</td>
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<td>P.O. Box 1421 MWANZA</td>
<td>Tel: 255-28-41609 or 2501029</td>
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<td>Most Rev. Anthony Mayala</td>
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<td>P.O. Box 54 NJOMBE</td>
<td>Tel: 255-26-2-782033</td>
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<td>Rt. Rev. Raymond Mwanyika</td>
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<tr>
<td>Diocese of Rulenge</td>
<td>P.O. Box 50 RULENGE-NGARA</td>
<td>Tel: 255-28-2-223901-3</td>
<td>Fax: 255-28-2-222507</td>
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<td>Rt. Rev. Severin Niwemugiz</td>
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<td>Diocese of Same</td>
<td>P.O. Box 8 SAME</td>
<td>Tel: 255-27-2758028 or 0744-496667</td>
<td>Fax: 255-26-250-2299</td>
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<tr>
<td>Rt. Rev. Jacob Venance Koda</td>
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<tr>
<td>Diocese of Shinyanga</td>
<td>P.O. Box 47 SHINYANGA</td>
<td>Tel: 255-28-2763040</td>
<td>Fax: 255-28-2-802175 or 202380</td>
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<tr>
<td>Rt. Rev. Aloysius Balina,</td>
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<td>Diocese of Singida</td>
<td>P.O. Box 487 SINGIDA</td>
<td>Tel: 255-26-250-2299</td>
<td>Fax: 255-26-250-2773</td>
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<td>Rt. Rev. Desiderius Rwona</td>
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<tr>
<td>Archdiocese of Songea</td>
<td>P.O. Box 152</td>
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<td>Most Rev. Norbert Mtega</td>
<td>SONGEA</td>
<td>Tel: 0635/2007/2330</td>
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<td>E-Mail: <a href="mailto:mtega@cats-net.com">mtega@cats-net.com</a></td>
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<td>Diocese of Sumbawanga</td>
<td>P.O. Box 34</td>
<td>Tel: 255-25-2802178</td>
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<tr>
<td>Rt. Rev. Damian Kyaruzi</td>
<td>SUMBAWANGA</td>
<td>Fax: 255-25-2802175 or 25-202380</td>
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<tr>
<td>Archdiocese of Tabora</td>
<td>P.O. Private Bag</td>
<td>Tel: 255-26-6608</td>
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<tr>
<td>Most Rev. Mario A. Mgulunde</td>
<td>TABORA</td>
<td>Fax: 255-26-2604536</td>
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<tr>
<td>Diocese of Tanga</td>
<td>P.O. Box 1108</td>
<td>Tel: 255-27-2642427 or 255-27-2643548</td>
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<tr>
<td>Rt. Rev. Anthony Banzi</td>
<td>TANGA</td>
<td>Fax: 255-27-2643548</td>
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<td>Diocese of Tundurug/Masasi</td>
<td>P.O. Box 240</td>
<td>Tel: 255-23-2510165</td>
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<td>Rt. Rev. Magnus Mwalunyungu</td>
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<td>Diocese of Zanzibar</td>
<td>P.O. Box 294</td>
<td>Tel: 255-24-2-23061</td>
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<tr>
<td>Rt. Rev. Augustine Shao, C.S.Sp</td>
<td>ZANZIBAR</td>
<td>Fax: 255-24-23061 or 2-233102</td>
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Summaries of papers:

The Universal Church on Social Services: conclusions of the 3rd AISAC meeting

Bro Dr Daniele Giusti - UCMB

The presenter reported about the outcome of a meeting he, Dr Kigadye and Dr. Widmer (MMI) attended in Rome few weeks earlier. The meeting, convened by the Pontifical Council for Health Pastoral Care and organised by AISAC (International Federation of Catholic Health Care Institutions), was participated by about 100 people from 45 Countries worldwide, in responsibility position of Catholic Health Care (CHC) networks. The objective of the meeting was “To ensure that the Church’s Pastoral presence in the ministry of Catholic Health Care (CHC) is effective in the first decades of the 21st Century” while the expected outcome was that “the participants will have learnt from each other about the many challenges to the sustainability of the Ministry and how they are being addressed in different parts of the world.” Dr Giusti briefly reported about the presentations that prepared the extensive group work, in the course of which participants were asked to identify common challenges to the exercise of the healing ministry worldwide and possible ways of addressing them through creation of networks. Dr Giusti remarked that, despite the extreme difference of context, challenges were much the same everywhere, with identity in the rapidly changing context as cross cutting issue and sustainability vis-à-vis lack of consecrated person and shift towards a more pronounced lay presence, dwindling resources, bio-ethical challenges, unfriendly legislation being frequently elusive and a daunting task. The themes for the group work were: 1.Identity, 2.Training (formation) of human resources, 3. Collaboration and co-ordination, 4. Solidarity with the poor vs sustainability, 5. Health as right to be recognised and advocated for. The presenter concluded by reading the final communique’ of the event, stressing the key message conveyed: 1. The Mission of catholic health care must be stated clearly, planned for and the outcomes assessed; 2. People in Catholic healthcare must be integrally formed and trained to be up to the task, as professionals and as Catholic aware of the reasons of the Healing Ministry and its demands; 3. Working together, co-ordination, networking in the Church and with other actors is necessary and must be actively pursued; 4. concerns for sustainability and equity must go hand in hand and poor cannot be excluded from catholic healthcare; advocacy for health as right must be pursued. He finally reported that the meeting concluded with a call to Episcopal Conferences to lead the processes of networking and co-ordination and to the Pontifical Council to provide this service at global level.
Instructions for group work

FIRST THEME
Objective of the group work:
Discuss issues related to the MISSION (identity, critical and “hard” areas, how to assess Faithfulness to the Mission......) in the light of the presentations given (especially the presentation “Sustainability of the Healing Ministry”) and own experience, to “distill” areas in need of special attention by the TEC and resolve on the most critical actions to be undertaken.

INSTRUCTIONS
Groups of about 15 people have been formed in Plenary. A place reserved for discussion has been indicated:
The eldest member of the Group is the Chair. The Rapporteur is indicated.
The Rapporteur has markers and flip charts
You have 1 hr and 15 minutes. Use time in an orderly way:
- 25 minutes for free discussion on the lead questions and other possible questions
- 15 minutes for the identification of areas in need of special attention by TEC and its structures, and their prioritisation
- 35 minutes for the resolutions (maximum 5); In these 35 minutes the rapporteur must write the areas in need of special attention (in order of priority) and the consequent resolutions on a flip chart.

RESULT OF THE GROUP WORK
The result of the exchange and discussion must be an agreement on a maximum of 5 resolutions to be taken up by the TEC and its structures in the next one to three years.

Lead Questions
Lead questions are to facilitate the work. Do not limit yourselves to these questions if you identify other, more burning questions.
1. The Healing Ministry is part and parcel of the Mission of the Church and in Tanzania is exercised through a wealth of healthcare institutions and programs and also through non-biomedical services. Are they equally well catered for?
2. Has the Episcopal Conference produced a document of guidance (Mission and Policy) for all those who want to serve the Healing Ministry in the name of the Church?
3. Do institutions in the Healing Ministry have clearly spelt out Mission Statements, enshrined in Charters, that work out the implications of the Healing Ministry?
4. Is sufficient care paid to the education of those involved in the Healing Ministry of the Church about its foundations, demands, implications, so that they can consciously be stewards of the Ministry?
5. Are there tools that can help to make an objective and iterative assessment of the degree of Faithfulness to the Mission in Health?
SECOND THEME
Objective of the group work:
Discuss issues related to the SERVICE OF THE HEALTH OFFICE of TEC (what should it do, how can it be empowered to do what is necessary, how to interact with CSSC – avoid vacuum of functions or overlap of functions) in the light of the presentations given and own experience, to “distill” areas in need of special attention by the TEC and resolve on the most critical actions to be undertaken.

INSTRUCTIONS
Groups of about 15 people have been formed in Plenary. A place reserved for discussion has been indicated:
The eldest member of the Group is the Chair. The Rapporteur is indicated.
The Rapporteur has markers and flip charts.
You have 1 hr and 15 minutes. Use time in an orderly way:
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RESULT OF THE GROUP WORK
The result of the exchange and discussion must be an agreement on a maximum of 5 resolutions to be taken up by the TEC in the next one to three years.

Lead Questions
Lead questions are to facilitate the work. Do not limit yourselves to these questions if you identify other, more burning questions.

1. Are the functions of the Health Office of TEC clearly spelt out?
2. Does the Health Office have a Plan (strategic and or operational) and - if so - are the objectives of this plan know by the Bishops?
3. Is there anything that the Health Office of TEC should be doing and is not doing? If yes, why?
4. Is the Health Office of TEC enabled to inform the Bishops who exercise Governance of CSSC about what should CSSC be held accountable for?
5. Is the Health Office of TEC perceived as relevant by the health units and program? If yes why, if no why?
6. Is the Health Office of TEC co-operating well with others? (Government, other Christian health services).
INTRODUCTION
The healing ministry
The church and its involvement in health

Excerpts from African Bishop’s Working Conferences

Medicus Mundi International (MMI) is among others engaged in the promotion of "Strategic repositioning of church-based health care facilities". Some concrete achievements during the recent years have been reached, such as:


- Soesterberg-Conference, 2000: Adaptation of the notion of “public-private partnerships” to Church institutions.

- Vatican, 2001 (Conference of the Pontifical Council for Pastoral Health Care), MMI’s reflections on the stewardship role of owners of health care organizations. (Dolentium Hominum, No.49, 2002: „Health and Power in Relation to Hospitals”, E. Widmer)


- Bangui-Conference 2006: Follow-up Conference at national level with the Bishops of the Central African Republic.

Soesterberg: Bishops Commitment to:

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<td>1. Different aspects and forms of the Healing Ministry have to be pursued concomitantly, without omission, in our respective contexts, organisations and programs and we are determined to do so.</td>
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<td>2. We consider it necessary to occupy ourselves with an appropriate and affordable health care; available to those who are most in need.</td>
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<td>3. We commit to playing a prophetic role through an active advocacy with and on</td>
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behalf of the weakest groups in society, for the poor, for women, for marginalised persons and communities, so that their rights are promoted and respected by governments and in society.

4. We commit ourselves to approach health care in a holistic way. We commit to work with the whole of civil society to remove obstacles (political, social, and economic) which oppress people and affect health care.

5. In view of the tragic consequences of the AIDS pandemic and the particular challenges it poses to the exercise of the Church Healing Ministry, we commit to bring the issue of HIV/AIDS in the agenda of our Episcopal Conferences in order to foster an active role by the church in the struggle against the spread of the disease and to mitigate its impact on the life of people, families and communities.

Change

6. We regard it necessary to start and sustain a process of change within our institutions and programmes, and commit ourselves to animate and empower people in our institutions and programs to be pro-active in this direction.

7. We recognise that it is indispensable that we should develop charters, guidelines, mission statements, policy statements, constitutions of health institutions and programmes to ensure that we achieve our common vision and aims in a transparent way.

8. We recognise the need to clarify the relationships between ownership and management of health institutions and programs, according to local circumstance and legal environment, in order to promote stewardship as an added value at all levels.

Professional practice

9. In order to run health institutions and programmes effectively, we see a dire need for professional staff, professional coordinating bodies, professional service units and training institutions. We commit ourselves to promoting professional practice at all levels, with a particular attention for religious who assume managerial roles.

10. Professionals should be allowed to manage Church health services and programs with clear terms of reference and with maximum professional integrity. We commit to creating those conditions which professionalise the management function.

11. We find it necessary that different initiatives and institutions of the church providing training of health managers complement their efforts within the geographical context in which they operate.

Transparency

12. We commit our institutions and programs to a transparent management and accountability in terms of financial and medical performance. We aim at ensuring efficiency, effectiveness and quality in a way that it is harmonious with different understandings of these concepts in different cultures.

Partnership

13. We also need to ensure the participation of communities’ representatives and
other stakeholders in the governing structures of our health institutions and programs. In the understanding that women are key actors in the promotion of health, we shall pay particular attention to a balanced participation of women and men in the governing structures of our health institutions and programs to secure the formulation of gender sensitive policies.

14. We support "contracting out" as a way to enhance and formalise co-operation and integration between the various stakeholders, including (local) government and other providers, and church health institutions in order to offer essential health services of sufficient quality at an affordable cost to a population in well-defined geographical areas.

15. We commit to actively participate in health reforms in order to contribute our understanding and experience to health development.

16. We will engage in contracts with donor agencies which support the capacity of the church to foster health development within a shared framework for mutual co-operation with well-formulated objectives and specified results.

Follow up

As part of this process of change:

17. The representatives of the Episcopal Conferences commit to disseminating the above understanding and commitments by organising appropriate fora of dialogue among stakeholders in the church and other stakeholders in our respective countries. Furthermore we see the need to involve other Episcopal Conferences at regional level and to take initiatives to strengthen the links with the Pontifical Council for the Pastoral Care of Health Workers;

18. The representatives of the donor agencies undertake to provide the technical, financial and moral support for the implementation of the initiatives aforementioned.

As agreed by the participants
Soesterberg/ Rotterdam, The Netherlands, 6th October 2000

The Kampala Statement contains a number of resolutions that have been adopted by the delegates of the participating Episcopal Conferences. To mention but a few:

- To foster stewardship as the most appropriate way to exercise the ownership function the church leaders have inherited;
- To install professional coordinating bodies and equip these with a strong mandate to translate in operational terms and policies the Mission of the Church and the vision of its role in health care and to contribute to renewal of such guiding principles;
- To design strategies aiming at developing institutional capacity with the ambition to guarantee an acceptable quality of health care, accessible to all needing it;
• To engage into partnerships with various stakeholders in the field of health care, and in particular with the Government, using the “contractual approach”, while prudently avoiding compromising the Church’s identity in the process.
• To engage in lobbying and advocacy, addressing the right to health, and to seek participation in debates on health policies at the national and international level.

The Cotonou Conference had multiple objectives, namely:

1- To reaffirm and repeat the importance of the role and responsibility of the Church as an owner of health care institutions and provider of health care services
2- To identify and be aware of current and emerging difficulties which pastoral health care will have to confront
3- To ascertain how the Church authorities can assist and consolidate the health care units it runs
4- To determine how best to benefit from synergies and how missions may be accomplished through better coordination in partnership with the main players in health care provision
5- To foster professional management of institutions run by the Church at all levels (local, national, regional, continental) and of dealings with regulatory and financial organizations
6- To set up a plan for the development of skills required for professional management of these institutions
7- To present and propose the adoption of tools for management and partnership,
8- To clarify the advantages of a contract approach between the private sector and public authorities, in particular Health Ministries
9- To consolidate the network of pastoral health care between countries in order to improve the exchange of experience and expertise
10- To encourage an ecumenical approach.

COTONOU: Introductory Paper (extracts) : (Paper by Edgar Widmer)

«The world has not yet recovered from the shock of the terrorist attack of September 11 2001, and is involved in a battle led by the USA against the aggressors. Nobody knows where this war will lead, nor whether justice will ever be done. All we know is that huge sums of money are being devoted to this cause and no doubt diverted from other urgent causes. Whatever tragedies result from terrorist attacks, war can never be an appropriate response. It simply adds to the tragedies the world is going through. I refer to the world health crisis, which is apocalyptic in scale and which is closely linked to the poverty of millions and millions of people in the world.
Just a short time before the events, the World Bank had changed its policy. The slogan: “Trade, not Aid” no longer applied and, after September 11, its director, Mr Wolfenson, had stated that "the conquest of poverty is a quest for peace”. Since the beginning of the new...
millennium, what is remarkable is that the European Union, the UN agencies and G-8 have been putting forward various international initiatives such as setting up the «Global Fund to fight AIDS, Tuberculosis and Malaria», - or reducing the price of pharmaceuticals to make them more affordable – or the proposal to cancel the debts of the poorest countries – or fairer world trade conditions to improve the economies of the least developed countries. The 3rd United Nations Conference on the Least Developed Countries of May 1, 2001 declared that war on poverty was a crucial element of the UN programme. But since then the number of countries getting poorer has doubled. Besides, it has been stated that good health is the principal condition for increasing productive capacity in order to overcome poverty. Health care has been described as a basic element of the rights of man and as a precondition in the fight against the main infectious diseases. And yet, even if pharmaceuticals are available at very low prices, it is impossible, for example to treat AIDS using anti-retrovirals (ART) if no solid health care structure exists. The universal strategy for the control of tuberculosis [DOTS, Directly Observed Short-Course]…] requires supervisors and, in the same way, the WHO Roll Back Malaria (RBM) Programme also needs the backing of health care services. Although promises to the GFATM referred to a sum of 10 billion dollars, the response to this appeal has been rather poor in comparison with investments being made to guarantee the security of industrialized countries, not to mention expenditure on the current wars. Only about 1.5 billion dollars are available at present. Most important is that the World Fund was to have produced sums additional to the budgets already allocated for development, which has not been the case.

Some words about partnership: We know that the Fund is based on partnership - partnership between the Fund’s administrators and the beneficiary countries and, in the beneficiary countries themselves partnership between governments and health care institutions, including NGOs. This principle makes it possible to make significant changes. It can speed up activities that enhance political commitment and improve administrative capabilities and leadership. When referring to partnership, it is important to remember that it should be based on mutual respect and understanding, complementarity, reciprocity, dialogue and sharing. In this way, once there is consensus, well defined agreements and contracts should follow.

How should national finance of health care services be increased? - As previously mentioned, the Global Fund for the fight against AIDS, TB and Malaria should provide national health care budgets with extra money. – Health budgets urgently need to be increased up to the target of 14 % of the whole national budget, - reduction or cancellation of debt should be considered, - aid from donor countries should reach a target of 0.7 % of their Gross Domestic Product, - health care costs due to pharmaceuticals should be reduced via agreements with the pharmaceutical industry, ...security, stability and political continuity, together with clear definition of multi-sector partnership within national health care policy should prevent investments being wasted, and democratic surveillance should foster good governance.
Last but not least, human resources make up a society’s most important capital and losses therefore need to be avoided. Availability of human resources and the performance of health care professionals is the key to good functioning of health care services. Conditions such as having a guaranteed income above the minimum for survival are an additional prerequisite if health care professionals are to be motivated. But this is insufficient especially in cases where liberal economic reforms have resulted in a loss of community values and the glorification of individualistic behaviour. A multidisciplinary programme giving greater recognition to health care professionals is required, such as participatory management structure and an incentive system rewarding good performance.

Bad working conditions result in absenteeism, corruption or the pilfering of medicines and money. And the ‘brain drain’ causes huge losses for developing countries. Thousands of African doctors and nurses are working in the industrialized countries and many others are being enticed there. Why in these circumstances cannot foreign aid be used to cover the salaries of local personnel local, given that expatriates get salaries ten times higher? There is an urgent need to find solutions for situations like these. Some say it is better to invest in salaries than in training schemes out of all proportion. In any case, the human factor is the main pillar of any health care system.

The commitment of Medicus Mundi International (MMI), an International Organization for Cooperation in Health Care, has been in existence for over 40 years and is active in more than 60 countries. Although non-confessional, our organization has always been involved with Church-run health care institutions. MMI provides partnership and cooperation involving professionals and concerns itself primarily with the promotion and management of human resources in the health care field, the consolidation of health care systems, improvement of information and communications in health care organizations. MMI supports and stands up for private non profit-making initiatives. Strategic commitment to "Health for All" and Primary Health Care, the fight against poverty and commitment to social justice are all part of the main activity of MMI.

United we can do better. The period of history we are living in is one requiring us to adapt to major changes - decentralization and the Sector Wide Approach as well as the fight against major pandemics, all require unrelenting efforts. As a result of globalization and the ever increasing focus on profit and loss, Christian values such as providing for and protecting the sick and fragile are under threat. Non-lucrative private institutions risk falling quality standards or, worse, may go out of business if they fail to adapt their policy to the new circumstances. The first thing they must do is join forces and make exchanges between themselves. They must form associations and find ways of cooperating more closely and they must make clear agreements with the public authorities. In response to this trend, MMI has tried to promote "partnership" at different levels – institutional and political – and the main result has been the adoption by WHO of a resolution dealing with "Improving HFA, at district level, by formalizing Partnership with Non Governmental Institutions with
The role of contract arrangements in improving the setting up of health care systems. Both the Pontifical Council for Pastoral Health Care and the representatives of local Episcopal Conferences are backing this partnership-oriented process. But which strategies are to be followed? The health medical initiatives of the Churches must form a united front and speak with one voice. For this reason, we are convinced that it is essential for them to consolidate their coordination offices in each country. This means that the bishops, as owners of hospitals, will have to provide these offices with clearer mandates and more precise responsibilities, putting the coordinators in a stronger and more equal position during dialogue with governments.

The Bangui Working Conference 2006:

among the Bishops of the Central African Republic (CAR) confirms:

1. the determination of the Bishops to make development of human resources a priority for the Church’s Institutions, with policies to common training concepts and harmonization of working conditions (if possible a collective work agreement)
2. hopes due to experiences in other countries as regards improvement of health care management and public-private partnerships.
3. the need for professional and transparent management of its institutions in order to boost their credibility.
4. the importance of the coordination of health activities at both diocesan and national level with well defined mandates and clear competences.
5. the need for cooperation and solidarity between dioceses.
6. the need to define the profile of diocesan health committees and to establish standard documents.
7. the rationale for partnership (public-private, private-private) that may serve as finance mechanisms for the health care services.
8. an open minded approach to others without loss of Catholic identity.
9. adoption, distribution and implementation of the Cotonou Declaration

The Dar es Salaam: TEC Plenary - Health Study Session on 26.6.2007 is meant as a follow-up of the Soesterberg/Kampala/Cotonou/Bangui-Conferences.

TEC will also be informed about the conference held by the Christian Health Associations from ten Anglophone African countries held in January 2007 in Bagamoyo. Representatives from DR Congo, Ghana, Kenya, Lesotho, Malawi, Nigeria, Sudan, Tanzania, Uganda and Zambia presented alarming data concerning the crisis of the health workforce. Key note speakers analysed the reasons for the lack and mal-distribution of staff and for the phenomenon of brain-drain; HIV/Aids being one of them. Concrete proposals for incentives for retention of staff, for recruitment strategies and for maintaining the morale and cordial relationship among the stakeholders, were shared as well as experiences on how to react politically.

Inspiring will also be a report about the recent Third Congress of the International Federation of Catholic Health Care Institutions, Vatican City, 3.- 5.May 2007. It dealt
with the call by His Holyness Pope Benedict XVI for “Aggiornamento of the Healing-Ministry”. The congress put it under the title “advancing the stewardship” of all involved. The role of bishops for health actions and health pastoral care has been confirmed. It has underlined the importance of their sharing among the leaders of the Church and their responsibility for coordination and dialogue with the health professionals and the community.

The outcome of the Dar es Salaam Conference will be an important step forward for the reinforcement of the Healing Ministry

**Stewardship consists in:**
- Collecting and generating **intelligence**
- building **coalitions and partnerships**
- ensuring **accountability and transparency**
- ensuring **tools for implementing mission statements**
- ensuring a **fit between policy objectives and the organisational structure**
- designing **criteria for setting of priorities**
- promoting **inter-sectorial advocacy**

Dr. Edgar Widmer  
Vice-President MMI  
May 12th 2007

PS Full reports are available in the internet site: [www.medicusmundi.org](http://www.medicusmundi.org)
The Healing Ministry,
A Chronology

Kampala, Working Conference for Anglophone African Bishops, March 2004
by Edgar Widmer,
Medicus Mundi International

800 b. Chr.  Hesiod refers about Aesculap as the healing God

600 b. Chr.  First Aesculapian school in the temple of Epidaurus
Interpretation of disease - magic and rational
Symptomatic treatment: by herbal medicines, hydrotherapy, diets, surgery, advice in lifestyle

400 b. Chr.  Hippocrates (460-377) formulates the doctor’s ethical chart (oath of Hippocrates). His father introduces him into anatomy and sacerdotal medicine. Later he exercises the medical art free from religious contexts rather systematically observing clinical data.

250 b. Chr.  Aesculapian temple on Tiber island in Rome
Christian era  Christ as a healer. St. Luke, Apostle and Doctor,
Faith and charity is one The weak and miserable are looked after by the community.
Solidarity enters into the world

215  Clemens of Alexandria declares that Christ is the healer, Christus Medicus Mundi
Therapy for disease was reduced to reconciliation
Explanation for disease: - punishment for the original sin
- a chance to participate in Christ’s suffering

400  Celsus, a contemporary and friend of Augustinus, published: “De medicamentis”
A proof that Christian doctors also practiced the art of healing.

431  Christian Doctors as Nestorians fled from Syria to Persia and founded medical schools in Nisibis and Gondischapur. Here the antique knowledge of the Greeks was translated into Arabic. Under the rule of Harun al Rashid (786-809) doctors from Gondischapur founded the Bagdad Medical School. One of its scholars, Rhazes, published in 865 Al-hawi, containing the medical knowledge of the age. It had finally been published in the 12th century in Latin with the title: “Liber Continens”, at the time, when in Salerno, the first medical school under western rule started

529  Emperor Justinian closes in Athens the last Aesculapian temple in order to eradicate paganism.
Saint Benedict founded Monte Cassino,
Monks preserve the ancient knowledge of the aesculapian schools copying ancient texts.
For centuries the “pagan” knowledge was only preserved but not further developed,
whereas the School of Bagdad continued to develop medical science. Islamic culture spread all over Northern Africa and reached Cordoba where Christians came in touch with Arab knowledge. Important representatives were: Averroes, Ibn Ruched, (1126-1198) as philosopher and Maimonides Moïse (1135-1204) as physician and doctor. Here Gérard of Cremona translated Albuscaías’ (940) Al Tāsrij, a compendium on surgery, and published it in Toledo in the same period. Albertus Magnus from Cologne, (1193-1280), translated and interpreted the work of Avicenna, (980-1037), who was the most famous doctor and philosopher of Bagdad. By him science was based on exact observation of natural phenomena. Experiments had to prove hypothetical theories. Coming into contact with Arab culture, the later Pope, Gerbert d’Aurillac took over the arithmetic system.

590-604  Pope Gregor the Great renovates the DIACONIAE, institutions for sick and poor pilgrims.
Formerly, in antiquity, compassion was not considered as a virtue. The antique Gods, such as Zeus, may have protected foreigners but never offered help to the poor. Unselfish engagement for the poor and Solidarity was introduced into the antique world as a new challenge, as a Christian virtue. Therefore since Constantin at the Lateran and at S. Peters Diaconiae were installed and new ones were founded by Gregor at S. M. in via Lata, S.M in Cosmedin and S. Giorgio in Velabro Health care became essential part of pastoral care right from the beginning of the Church.

900  Nevertheless, in the* Lorsch’er Arzneibuch”, a Codex of a German Convent from around 900, we still read an excuse for having transmitted pagan texts. It explains that it was only done out of compassion with the sick.
During the crusades the Order of the knights of Malta is founded. It takes care of the sick and wounded. The crusader’s contact with Arab culture leads to the foundation of the First European Medical School in Salerno by Frederic II. Congregations start to serve the sick and marginalised in which Christ is seen. Hospitals are called Hôtel de Dieu, many are dedicated to the Holy Spirit.

French Revolution, Beginning of the period of enlightenment. Secularisation of science.

Industrialisation creates social illness Public Health as a science and Social Insurances start.

Study of tropical diseases goes hand in hand with Colonialism.


Declaration of Human Rights (Art. 25 concerning right for health).

WHO Definition of Health as physical, social and mental well-being.

The first National Co-ordinating Agencies of Church-related Health Services start.

WHO Declaration of Alma Ata concerning PHC. Poverty is recognised as main cause for disease.

36th WHA discussing: “The Spiritual Dimension in Health Care Programmes”.

COR UNUM. Pastoral for Health is defined. A paradigm-shift away from mere Pastoral for the sick towards engagement in favour of health.

By Motu Proprio „DOLENTIUM HOMINUM“ John Paul II creates the Pontifical Council for the Pastoral of Health. Episcopal Conferences are asked to nominate bishops responsible for the portfolio of health. The dioceses are asked to create professional health councils.

The International Vatican Conference, “Church and Health in the World, Expectations and Hopes on the Threshold of the Year 2000” adopts „Health for All- Policy” of WHO.

“Making the Case for Not-For-Profit Healthcare” Joseph Cardinal Bernardin makes the point: Healthcare is one of those goods which by nature, because it is essential to human dignity and part of human rights, can not be a mere commodity.

First International Working Conference among Bishops holding the health portfolio within Bishops Conferences: “SOESTERBERG STATEMENT”.

The World Health Assembly adopts the Resolution on “The role of contractual arrangements in improving health systems’ performance”.

Kampala, Working Conference among Anglophone African Bishops defining the Healing Ministry: and defining the Kampala Declaration.

Working Conference for bishops from Francophone and Lusophone African countries discussing Public private partnership formulating the Cotonou Declaration.

Encyclical of Pope Benedict XVI, “Deus Caritas est”