Preparing

a

**Working Conference**

for

Anglophone African Bishops

in

Kampala

March 2004

on the

**Healing Ministry**

and on the

**Strengthening of the Co-ordination**

of the Churches Health Activities

Part I

**Introductory Texts**

a compilation presented by

Edgar Widmer
Proposed overall objectives

At the MEMISA 75 Years Jubilee Working Conference in the year 2000 Bishops responsible for health matters within the Episcopal Conferences of eleven developing countries met to discuss the healing ministry.

The aim of the Kampala Conference is a follow-up on the statement given by these bishops, in order to enhance at African regional level capacity of church leaders and faith based organisations for health care in administration and management of their institutions. By improving sustainability and increasing their viability (in technical, in financial and in organisational terms) they should become less donor-dependant and reach maximum recognition by the Public Administration in merit of their contribution to public service without loosing any of the typical elements, which are key to their faith based character and to the inspiration of their staff.

Outcomes envisaged and to be achieved by the combined investments in documentary inputs, in selected case presentations and selected resource persons and facilitators:

- Participating bishops will have had a thorough and convincing exposure to aspects of viability and sustainability in the administration of organisations for public service provision with particular emphasis on administration and management of health institutions and – programmes.

- Participants will have acquired clear understanding of the impact of current contextual changes on the faith based institutions and programmes and of their organisational and institutional needs in order to cope with expectations and growing demands on the part of the community served, of the Public Administration and of their donors.

- Participants will have a clear understanding of the possible gains and the way in which to attain those aims through capacity building and administrative reform and they will be aware of the high expectations and opportunity laying ahead

- Participants will also be aware of potential risks and pitfalls to be expected from ill-guided changes just as much as from NOT adjusting at all.

- Participants have discussed and understood in operational terms the difference in exercising the ownership role versus a stewardship role in relation to the faith-based institutions and programmes and are ready to reconsider and eventually adjust the own role as well in line with the conclusions reached in this respect during the conference

- Participants will have expressed themselves clearly as to the need for institutional/ organisational reform and the way in which they intend to go about it in their home country and within their own institutions soon after the conference and in the near future.

Medicus Mundi International / Cordaid, June 30th, 2003
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1. “Health Care for All” Round about the Antwerp Meeting
25-26 October 2001
(cf. MMI Newsletter Nr. 68, 2002)

The world, still under the shock of the terrorist’s attacks of September 11th, is fighting under the lead of the USA a battle against the aggressors and no one knows where war is leading nor whether justice can be reached.

We only know that enormous amounts of money are invested and eventually diverted from other urgent needs in order to revenge the 3000 killed persons of New York and Washington. Upon this a few dozens of Antrax cases kept the whole world in alert and became part of our daily news.

Despite the terrible tragedies the conference organised by the Belgian government and the Antwerp Institute of Tropical Medicine as part of the EU-presidency came up with a call for “Health Care for All” as a response to the much greater tragedy the world community is living in. The health crisis of today is of an apocalyptic dimension and has straight links to the poverty of billions of people.

Only since a few years the World-bank has changed its policy. The slogan: “No Aid, but Trade” has changed, its director Wolfenson after the 11th of September has declared: “The conquest of poverty is the quest for peace”. As a matter of fact since the beginning of the new millennium, the European Union, UN-agencies and the G-8 currently are disputing several international initiatives, such as - establishing the Global Fund for AIDS, Tb and Malaria.- to improve drug accessibility by price reductions,- to offer dept-release for the Least Developed Countries, - to improve trade conditions and so on.

The third United Nations Conference on the Least Developed Countries on May 16th 2001 declared the fight against poverty as a crucial element of UN-programmes, since the number of impoverished countries within the last ten years has nearly doubled up.

It has been declared that health is the main condition for enhancing productive capacities in order to overcome poverty.

In Antwerp health care has been declared as a basic human right and as the prerequisite for the fight against the main infectious diseases. Even with free drugs, antiretroviral treatment (ART) for AIDS is not possible without solid medical structures. The universal strategy for tuberculosis control, the so called “Directly Observed Treatment Short-Course” (DOTS) needs “observers”. WHO’s Roll Back Malaria (RBM) programme calls first of all for strengthening the health care service.
We were informed that the newly created Global Fund should have reached 10 Billion Dollars. The response to this appeal was rather poor compared to the money the security efforts after September 11th will cost; not to speak of the ongoing war expenses. About 1,5 Billion Dollars only are available. (while in the Swiss spend three times more for the revival of a national air company) Most important is that the Global Fund should gender additional money to current Government budgets. Principally, the fund is based on partnership between the governing board of the fund and the receiver-countries and within the receiving countries on partnership between Government and its Health Institutions including NGOs. It is hoped that the Fund becomes operative on January 2002 and that it will be able to accelerate activities such as political commitment, strategies for change, administrative preparedness and leadership.

Speaking of partnership it was mentionned that it has to be based on mutual respect, comprehension, complementarity, reciprocity, dialogue and sharing. Once reached a consensus, agreements and well defined contracts may follow. Equity is a main target but notwithstanding decentralised money allocation may create inequities when each province or region uses different criteria for training, curing and prevention or concentrates on some issues while leaving others aside. Partnership with the private sector needs criteria for accreditation, being aware that health services for the scope of profit can be another reason for inequities

**How to increase national health budgets?**

- The Global-Fund for AIDS, TB and Malaria, as mentioned, provides additional money to the national health budget.
- There is the tendency and an urgent need to increase the national health budget up to the target of 14 % of the whole national budget (Why not reduce the defence budget?).
- The debt release should be another factor of income.
- The aid of donor countries should reach the target of 0,7 % of their gross–domestic-product
- Reduction of health costs may be reached by price-agreements with the pharmaceutical industry
- Security, stability, continuity and a clearly defined intersectional national health policy avoids misuse of money and waist.
- Democratic control promotes good governance
- The memory on cultural values and the traditional capacity of the individual to survive is part of a nation’s capital
- Last but not least the human resources are the most important capital of a society.

**The importance of human resources.**

The health worker performance is the key for proper functioning of the health services. Conditions such as a proper living wage are an obvious prerequisite for health workers’ morale and motivation. But these are insufficient, especially where liberalising economic reforms result in a decline of community values and a rise in self-interested behaviour. A multidimensional programme of public health worker rehabilitation is needed including some components like: provision of decent living and working conditions, including adequate supplies of operating inputs, especially drugs; quality improvement programmes, regular support from trained supervisors, participatory management systems and an incentive structure offering professional and financial rewards for good performance.

Individual contracts between the employer and the health worker should regulate the above mentioned circumstances under the condition of a satisfactory adherence to a given job description and working hours; no informal charges; no misappropriation of drugs, materials or money can be allowed nor poaching of patients to private practice.

The selection of staff should follow a merit based and transparent selection process providing equal job opportunities. Internal ongoing training should lead from a basically programmatic training to management training and finally to the transmission of a corporate culture allowing identification with the institution’s philosophy.

Lack of money is the key reason why the human resources are badly off in most developing countries. While in most countries enough staff is trained, many Governments can not afford the employment of those they have trained. From Uganda I heard that every year about one hundred of the newly trained doctors remain without any possibility to find a job and they never get the necessary practice for what they have learned. The situation for nurses is similar or worse, an enormous waste of investment. And those who have work, too often are frustrated. Absenteeism, corruption or misappropriation of drugs and money can be the consequence. Finally brain-drain causes enormous losses for so many developing countries. Thousands of African doctors work in industrialised countries.
Why in such a situation external aid never covers salaries of local staff, while expatriates get ten and much more times higher salaries?

Many speakers of the conference have urged to find solutions for the impossible situation of the health workers. Rather invest in salaries than in over-proportional training, someone said. Quite desperate was the proposal of a Congolese representative: “Why not create a doctors’-market as already happens for footballers?”

In any case the **human factor is the pillar number one** in the health system and certainly needs more attention.

An important opportunity to secure funding to help respond to health workforce and other health system needs is about to begin. Round 10 of the Global Fund to Fight AIDS, Tuberculosis and Malaria will launch on May 20, 2010, opening up a three-month window for countries to develop a proposal (due August 20) that can address not only the Fund’s three priority diseases, but also the health systems strengthening (HSS) needed to address these diseases.

Activities to strengthen the health workforce have been among the main health system areas for which countries have used the Global Fund. Countries have received funds for interventions including to:

- expand capacity of health training institutions;
- provide health workers retention packages aligned with national policies;
- provide hardship allowances;
- rehabilitate and expand rural housing;
- strengthen workplace safety;
- improve health workforce management; and
- conduct health workforce studies and planning activities.

The representative of Ruanda said that there have been unrests in his country as a revolt to lacking health facilities. There is a risk that unrest can change into aggressive revolts or into terrorist acts. The first speaker of the conference, Dr. Kyonga, former minister of health of Uganda, and now director of the Global Fund for the fight against AIDS, TB and Malaria, was right when he said that **the dramatic health situation in the world is a global threat**

**One speaker said:** “The world needs a socially managed globalisation”.

**MMI on its CD meeting of September 13th 2002 had already decided to review the argument and commissioned Dr. Bruno Marchal and Guy Kegels of the Department of Public Health at the Institute of Tropical Medicine, Antwerp, to initiate a study,**
reviewing the literature, the concepts and strategies of Human Resources Development (HRD) and to propose eventual action plans

2. Development, Capacity Building and Promotion of Stewardship
An Extract of Bruno Marchal’s and Guy Kegel’s Text: “What Role for Medicus Mundi by E. Widmer (25.10. 03)

Goals of a health system:
- Improving health
- Be responsive to expectations
- Fairness

Responsiveness
- Respecting - dignity, - confidentiality and - autonomy
- Offering - prompt attention, - access to social support network, - quality, - choice of provider

There is consensus on the state's authority in the health sector
It implies - Good Governance
- Policy, serving public interest
It implies – Stewardship infusing values into technical and process-oriented institutions
- Stewardship providing an organising principle for power
It implies - Capacities
- A strong and well functioning state structure

The market theory has proved not to be robust enough to embrace both, governance and guarding public interest

Governance
Means: – transparency, - accountability, -- participation
Matters for development outcomes
It is - the process by which governments are selected, monitored and replaced
- the capacity of formulating and implementing sound policies
- respect for the institutions that govern economic and social interactions

Stewardship
Key aspects:
- Setting, implementing and monitoring the rules for the health system
- Assuring a structured platform among all stakeholders
- Defining strategic directions for the health system as a whole

Stewardship is the assumption of responsibilities by human beings, individually and politically for the welfare of the world.

The allocation of responsibility may vary: - executive versus legislative - national versus local, - public versus private

Stewardship differs from Governance more in its style or approach:

- it needs to internalise and reflect the cultural and political context and broader societal norms
- it fosters a culture of self-determination and self-direction - Conducting a Consensus-building process among individuals and organisations within an overall framework of agreed norms and values.

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 intersectorial advocacy

Capacity-building

We distinguish between - institution development
  - community development
  - human resources development

The input in development means not only a quantitative gain, it means more. By internalising an experience of a partner, the staff and the organisations can identify with it and then the development becomes a permanent one and will be sustainable.

However, development interventions have to avoid to be - top-down fashioned, - donor-driven, - interfering in national priority setting, - short-term oriented, -predominantly quantity-minded.

Keywords for good development are - partnership,
  - local ownership, and
  - empowerment

Capacity building means:

1. to create healthy and productive organisations
2. allowing development and sustainability
3. building up an identity to an institution or program
4. enabling performance and achieving objectives
5. performing functions effectively and efficiently
6. improving the ability of a person or entity to carry out stated objectives
7. developing knowledge, competence and well-functioning institutions.
8. equipping developing countries with basic public sector institutions
9. or supporting existing institutions
10. creating possibility to adapt to change, to generate new knowledge

Competence

For medical professions competence means:
Judicious use of -communication, - knowledge, - technical skills, -clinical reasoning,
- emotions, values.
It also means being able to ponder in the daily practice between the benefit of the individual and community being served, to deal with uncertainty and to take decisions with limited information.

**Competence is more than just problem solving capacity**

**Competence is also a matter of attitude**

MMI had published the full report on January 2003, under the title: *Which role for Medicus Mundi International in Human Resources Development; current critical issues in HRD for health in developing countries*

### 3. Decisions taken in the Executive Board of MMI

**Friday 10th of January 2003**

*from the protocol*

**Venue:** Medicus Mundi International
Rue des Deux Eglises, 64
1210 Bruxelles

**Participants:**
Mr. M. A. Argal, President
Mr. G. Eskens, Cordaid, Netherlands
Ms. S. Fluethe, Action Medeor, Germany
Mr. B. Pastors, Action Medeor, Germany
Dr. T. Puls, Cordaid, Netherlands
Dr. S. Rypkema, Medicus Mundi International
Prof. H. Van Balen, Medicus Mundi Belgium
Dr. E. Widmer, Medicus Mundi Switzerland
Ms. F. Wijckmans, Medicus Mundi International

**Ad discussion point 4. Human Resources Development**

Dr. Bruno Marchal presented the final draft of the Research on Human Resources.

The EB decided to start a second phase concerning HRD:

The MMI ‘triumvirate’ (Mr. M. A. Argal, Dr. T. Puls, Dr. E. Widmer) and the Tropical Institute Antwerp (Dr. G. Kegels and Dr. B. Marchal) will meet for a brain storm in order to select MMI relevant topics within the panoply of HRD subjects.

MM Switzerland, MM Spain and Cordaid Netherlands have a very positive and open attitude to co-finance this second phase and to continue the cooperation with the Department of Public Health in Antwerp.

The secretariat will address a letter to all the branches with the final report, asking the branches and associate members of MMI in which field they could foresee or imagine a joint action in HRD together with MMI. In such a case the branches or associate members could take over the operational part, whereas MMI could become active with:

- methodological support,
- Lobbying,
- advocacy,
- search for possible international funding,
- documentation
- sharing of information and
- co-ordination

The secretariat asks the branches and associate members to give a reply within the end of the coming month of February 2003.
Bruno Marchal would then work out an action plan on HRD of a reduced size, which by the
financial help of its members (Guus Eskens of MEMISA/CORDAID in this EC meeting
promised to reserve in their budget 2003 about 50,000.- Euros for such a purpose) can
immediately be realized. A second type of action plan in HRD of a larger scale would then be
elaborated. **A follow up of the Soesterberg Working Conference for Bishops holding a
portfolio for health within their Bishops Conferences might be a first step**

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**Therefore MMI initiated the following correspondence with the Pont. Council for Health
Pastoral Care:**

Dr.med. Edgar Widmer
Alte Landstr 92
CH 8800 Thalwil

Mgr Jean-Marie Mpendawatu
Officiale
Pontificio Consiglio per la
Pastorale della Salute

Reverendo Mons. Mpendawatu

Pochi giorni fa il Comitato Esecutivo della Medicus Mundi Internazionale (CE/MMI) ha deciso in una sua riunione di
concretizzare delle azioni per la **promozione di risorse umane in campo sanitario**, cioè di persone capaci della leadership. Gli
Anglosassoni definiscono questa leadership con:

1. Capacity to generate relevant intelligence
2. Capacity to formulate strategic policy direction
3. Capacity to build coalitions and partnerships
4. Capacity to ensure tools available to implement pro-poor policies
5. Capacity to ensure a fit between policy objectives and organisational structures
6. Capacity to ensure accountability

A questa riunione del CE/MMI ho accennato a un pro memoria di un colloquio con Lei e il Professor Quattrocchi del giugno
2002. I miei colleghi confermano che qualsiasi riforma a sostegno e per il miglior funzionamento degli ospedali della Chiesa,
soprattutto in Africa, dipende dai loro “padroni” cioè dai vescovi. Senza una loro convinzione sul ruolo del servizio della Chiesa
per la salute e senza rendersi conto del loro potere sarà difficile dare delle risposte valide ai problemi drammatici attuali.

Come mi ha accennato il novembre scorso, Lei sta pianificando un incontro di lavoro tra vescovi e responsabili degli uffici di
coordinamento delle opere mediche della chiesa, in base alle esperienze fatte in Uganda

Lei già conosce il documento: “The Church and its involvement with health”, risultato di una simile impresa organizzata da parte
della MEMISA / Medicus Mundi 2000. La Medicus Mundi Internazionale col’aiuto della MEMISA sarebbe disposta a dare un suo contributo per un incontro di lavoro
come da Lei pianificato per l’Africa dell’Est. Se il Suo progetto si dovesse realizzare entro quest’anno, sarebbe necessario
informare la MEMISA /MMI entro la fine di febbraio, perché nel mese di marzo si prendono le decisioni budgetari per l’anno in
corso.

La prego di farmi sapere se sarebbe utile un incontro tra i responsabili del Pontificio Consiglio per la Pastorale della Salute e il
direttore della MEMISA. A questo scopo il Dr. Guus Eskens sarebbe disposto di venire a Roma.

Dato che il tempo corre, mi permetto di farLe avere questa lettera direttamente a Ginevra, dove Lei attende le riunioni dell’OMS.

In attesa di una Sua prossima risposta Le invio i miei saluti cordiali

Thalwil, 22. 01. 2003

PS: Copy to MEMISA/CORDAID

Dr. Edgar Widmer

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e-mail del 6. febbraio 2003 da: mpendawatu@virgilio.it

Caro Edgar,

Mi dispiace che mia lettera l’ho persa. Tuttavia cerco di riassumere velocemente le idee. dopo un interessante colloquio al
riguardo con S.E.Mons. Redrado, sono in grado di darle indicazioni che puoi valutare:
1. È meglio collaborare esternamente con il Pontificio Consiglio per la Pastorale della Salute per evitare che qualcuno si mescoli in questo senso alle opere sanitarie cattoliche in Africa. Il P. Guillet, direttore dell'OCIC, può invitare alcune persone interessate all'incontro.

2. C'è necessità di rafforzare le capacità degli Uffici Nazionali per la Salute delle Conferenze Episcopali, per permettere a questi Uffici di fronteggiare le sfide sanitarie nei paesi in sviluppo.

3. In questo caso, si suggerisce a Medicus Mundi, insieme a l'Ufficio dell'Ufficiale Nazionale delle Conferenze Episcopali dell'Uganda per la Salute di prendere in mano l'iniziativa, di collocare la sede del Simposio a Kampala e di coinvolgere l'Ufficio per la Salute del Benin (au Togo?) dove un buon lavoro è stato fatto con l'aiuto di Medicus Mundi. Sul piano operativo ed organizzativo, l'Uganda, il Benin, Madagascar, Mozambico. In tutto sarebbero 20 persone. A questi occorre aggiungere alcuni cardinali: Etsou (Kinshasa), Wamala (Kampala), Tumi (Douala), Agre (Abidjan); alcuni arcivescovi: Khartoum, Luanda, Kisangani e il vescovo incaricato per la pastorale della salute del Ghana, l'unico membro africano del Pontificio Consiglio per la pastorale della salute.

4. Il Simposio ha luogo all'inizio di Novembre 3,4,5 novembre, ciò potrebbe essere una data buona. Si potrebbe invitare direttamente me (Mgr. Jean-Marie Mpendawatu) dal Dicastero perché parti della sua esperienza presso l' OMS e delle sfide che si presentano in questo senso alle opere sanitarie cattoliche in Africa. Il P. Guillet, direttore dell'OCIC, può essere invitato per l'opportunità aperta agli ospedali nostri per l'uso della telemedicina a costi bassissimi; a nome del Vaticano, il Padre ha firmato un interessantissimo accordo con un gigante delle telecomunicazioni. Si potrebbe chiedere un messaggio del Presidente del Dicastero ai partecipanti.

5. Le Conferenze Episcopali da invitare a livello dei vescovi incaricati per la pastorale della salute e i responsabili (direttori) degli uffici nazionali per la salute sono: R.D. Congo, R.Congo, Ruanda, Burundi, Gabon, Centrafrica, Tanzania, Angola, Sudafrica, Madagascar, Mozambico. In tutto sarebbero 20 persone. A questi occorre aggiungere alcuni cardinali; Etsou (Kinshasa), Wamala (Kampala), Tumi (Douala), Agre (Abidjan); alcuni arcivescovi: Khartoum, Luanda, Kisangani e il vescovo incaricato per la pastorale della salute del Ghana, l'unico membro africano del Pontificio Consiglio per la pastorale della salute.

6. Dall'Uganda, oltre al Dott. Giusti, sarebbero coinvolti il vescovo incaricato per la pastorale della salute. Dal Benin, verrebbe il Direttore dell'Ufficio Nazionale per la salute. Suggerisco che un medico di nome Jean Paul Mundama, conoiese che ha studiato a Louvain e a Anvers e che lavora bene come medico responsabile si zona di Butembo (R.D. Congo) venga per esperienza, competenza ad aiutare per il dopo simposio.

7. Si tratta di una trentina di persone (35) delle quali molte sono in Africa e vicino a Kampala. Ciò ridurrebbe in parte le spese.

8. Tra le questioni concrete che premono al Dicastero, oltre al programma centrale sulle possibilità di rafforzamento delle capacità degli uffici nazionali per la salute della conferenza episcopale all'esempio dell'Uganda e del Benin, ci sono:

- Il Fondo Globale per la lotta contro aids, malaria e tubercolosi. Come accedere al fondo?
- Il condono del debito del paese da parte del donatore e le opportunità per accedere ai fondi che il paese si impegna a stanziare nell'ambito dell'accordo con il paese donatore e che in parte vengono investiti nell'ambitosanitario.
- La possibilità di organizzare una rete informatica di collegamento tra gli uffici nazionali per la salute del continente.
- La scelta della giornata mondiale del malato come giorno di mobilitazione della Chiesa africana riguardo alle patologie emergenti, alla bioetica e alla pastorale della salute.
- La creazione di un ufficio a Kampala, con il Dott. Giusti, un medico di Medicus Mundi e Dr. Jean-Paul Mundema per aiutare gli uffici nazionali delle Conferenze Episcopali a portare a termine le risoluzioni. L'ufficio avrà una legame stretto con il Simposio delle Conferenze Episcopali Africa e Madagascar.
- Alcune decisioni e orientamenti o linee-guida possono essere presi in vista della conferenza, per aiutare gli uffici nazionali della Chiesa e per la crescente consapevolezza della Chiesa riguardo alle patologie emergenti.


10. Il Pontificio Consiglio sarebbe presente, parteciperebbe senza essere l'organizzatore.

Caro Edgar, è un'iniziativa importantissima. Una volta che c'è già qualche cosa di avviato nella preparazione, si potrebbe rendere visita ai superiori del dicastero, illustrare il disegno (progetto).

Colgo l'occasione per salutarti cordialmente

Mons. Jean-Marie

Pontificio Consiglio della Pastorale della Salute

Dr. Edgar Widmer
Alte Landstr 92
CH-8800 Thalwil

Mgr Jean-Marie Mpendawatu
Officiale
Pontificio Consiglio per la Pastorale della Salute

Concerne UGANDA: Conferenza di lavoro a livello dei vescovi incaricati per la pastorale della salute con l'intento di rinforzare gli uffici nazionali di coordinamento delle istituzioni sanitarie delle chiese.

Reverendo Mons. Mpendawatu,

Appena tornato da Bruxelles vorrei informarLa sull'esito delle nostre deliberazioni in relazione alle Sue proposte inviate il 6 febbraio 2003, in vista della conferenza suddetta.

Il direttore della Memisa/Cordaid, Guus Eskens, il suo collaboratore Tom Puls, Daniele Giusti e i suoi collaboratori dell'Uganda Catholic Medical Bureau e il direttore della Medicus Mundi Internazionale sono con Lei convinti, che l'iniziativa: “UGANDA” sia importantissima, desiderabile, opportuna e necessaria.

Si tratta di un’investizione per uno sviluppo istituzionale per meglio affrontare le sfide urgenti in vista del “Contracting” e della crisi delle risorse umane in campo sanitario.

Proprio in questi giorni si sono terminati i lavori per le nostre pubblicazioni: “L’Approche Contractuelle” e “Current critical issues in Human Resources for Health in developing countries”, pubblicazioni, che permetteranno ai partecipanti del seminario previsto, una lettura preparatoria.
Il Dottor Daniele Giusti ci ha confermato che il suo ufficio e lui stesso non solo sono interessati a partecipare ma che cercherà di fare ogni sforzo per organizzare l'avvenimento. Senz’altro sarà necessario offrirgli dei mezzi di sostegno e ci scrive: “the how and under which terms are open for discussion/thinking.” L’unica obiezione è la proposta della data del Novembre 2003. Lui propone come data ideale l’inizio dell’anno 2004. Perciò, a nome del direttorio della Medicus Mundi vorrei chiedervi se la fine del mese di Gennaio per Lei potrebbe essere una data possibile.

Rimarranno aperte altre domande, come per esempio l’opportunità di raggruppare insieme gli anglofoni con i francofoni. Abbiamo fatto l’esperienza che per una migliore comprensione è bene non solo partire dalla stessa lingua, ma anche da situazioni ben paragonabili. Ma questi dettagli dovranno essere discussi in un altro momento.

Rimango in attesa di una Sua risposta riguardo alla data e per oggi Le invio cordiali saluti

20. 02. 2003
Dott. Edgar Widmer

Città del Vaticano, 5 marzo 2003
Caro Edgar Widmer,

Dall’Uganda mi hanno chiamato per dirmi che forse sarebbe più facile organizzare un incontro per gli anglofobi a Kampala e i francofoni per esempio in Benin. Non so cosa ne pensa. È il Nunzio Apostolico Mons. Pierre Christophe che aveva parlato con il Dott. Giusti che me l’ha riferito.

Le due riunioni potrebbero essere convocate ufficialmente dalle conferenze internazionali di conferenze episcopali:

1. Per la riunione di Kampala
   - A.E.C.A.W.A (Association of the Episcopal Conferences of Anglophone West Africa) 5 membri
   - I.M.B.I.S.A (Inter-Regional Meeting of Bishops of Southern Africa) 7 membri.
   - A.M.E.C.E.A (Association of member Episcopal Conferences in Eastern Africa) 8 membri

   N.B. 20 Conferenze Episcopali = 40 persone (Vescovo incaricato e il Responsabile del Bureau), più una decina di persone tra Medicus Mundi, Dicastero per la Pastorale della Salute, S.E. Mons. Mosengwo Pasinga, arcivescovo di Kisangani e Presidente del S.C.E.A.M, Simposio delle Conferenze Episcopali d’Africa e di Madagascar, nonché qualche osservatore e qualche cardinale della regione.

2. La riunione del Benin
   - A.C.E.R.A.C (Associazione delle Conferenze Episcopali della Regione dell’Africa Centrale) 6 membri
   - C.E.R.A.O (Conferenze Episcopali dell’Africa dell’Ovest francofona) 9 membri
   - A.C.E.A.C (Associazione delle conferenze dell’Africa Centrale) 3 membri

   N.B. 18 Conferenze Episcopali: 18 x 2 = 36 persone (Vescovo incaricato e il Direttore del Bureau nazionale della Conferenza Episcopale). Per il resto, esattamente come la N.B. precedente.

Per le date, oltre a quella di Kampala per cui c’era già un orientamento di massima, occorre vedere il periodo buono per il Benin. Sembra che nel 2005 (12 febbraio) si celebrerà la giornata Mondiale del malato in Africa. Quindi occasione per fare di nuovo il punto. Tanti saluti

Mons Jean-Marie Mpendawat

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4. E-mail discussion forum on: Cordaid's policy concerning Health and Care and Technical Assistance:
A comment by Guus Eskens, Cordaid's Project Director,
February 2003
(an excerpt)

Dear all

Cordaid opened the policy discussion on health care and technical assistance with stakeholders in the Netherlands and Africa, expecting that it would provide insight in how
development co-operation in the field of health can be more effective. The discussion yielded positive results: valuable points were brought to people’s attention and interesting suggestions came up. But moreover, the involvement of stakeholders in important discussions that move us was inspiring. I want to thank all participants, those who have contributed to the discussions and those who have followed the discussions, for the interest that they have shown in accompanying Cordaid in its policy-making process. It certainly was a valuable input.

Cordaid's policy on health and care is undergoing changes, as needs differ and insights grow and change over time. Therefore, rather than a fixed set of policy decisions, it should be considered a framework that needs to be filled in and adapted according to local circumstances, evaluations, lessons learned and changing contexts. A framework that at times will need to be readjusted. Cordaid needs to keep an open ear and eye to arguments and lessons learned in practice. That is why we are not closing the discussion and why we much appreciate your contributions.

At this moment we want to highlight issues that came out as a result of the email discussion and indicate how Cordaid will process the contributions and incorporate them in its Health and Care policy.

Quotes from participants are put in quotation marks.

Ad discussion point 3. COOPERATION

Cordaid agrees with the statement that church health institutions should participate actively in the district health system. This means increased co-operation of church-based health institutions with the public sector and other NGOs – especially at the district level – while maintaining their own identity. This increased co-operation needs to be based on clear contracts, which specify the rights and duties of both parties.

**Cordaid does support the church health sector’s participation in the District Health Management Teams by facilitating organisational strengthening of Diocesan Health Departments. The importance of the contractual approach has been discussed under the discussion theme "Dependency".**

**Cordaid supports national co-ordinating bodies and umbrella organisations, enabling them to accomplish their tasks of supporting dioceses in participating in District Health Management Teams (DHTs) and of negotiating with the MOH on behalf of the church-based health sector.**
Other mechanisms related to the support of church-based institutions in their collaboration with the public health sector that came out of the discussion that are:

- Inter-country consultations on issues such as contracting, monitoring and evaluation.
- Regional, inter-country meetings for bishops who are responsible for church health institutions to exchange experiences.
- Support PHC programmes at the district level, where church-based health institutions are fully participating – rather than supporting the national level SWAp approaches.

Cordaid is willing to invest more in alternative mechanisms and to use Technical Assistance as an instrument. In order not to overload organisations with consultative meetings, Cordaid strongly invites organisations to come up with proposals that are in line with their own priorities and needs.

Regarding individual health-care institutions, it was mentioned that (quote): "Support for strengthening local management skills is important, as well as improving the quality of services by continuing support for the upgrading of health workers’ competence and capacities. Reducing the number of expatriates where local expertise is available and transferring responsibilities to capable local or regional organisations requires support for maintaining the level of knowledge and skills within the health system. Cordaid should support refresher courses, upgrading of training sessions, bringing the accumulated experience and expertise together."

At present Cordaid follows a two-way strategy:

1) stimulating organisations to integrate the activities related to the strengthening of staff skills (management and health workers) within their strategic plans, and
2) identifying and supporting training and education institutions in the field of health-care management and development of human resources in health service provision.

Several participants stressed that Cordaid should also aim to get involved with other than church-related partners. Various considerations play a role in our current practice. Given Cordaid's mandate to work with the non-governmental sector and church-related organisations, it might as well remain loyal to the (networks of) church-related health-care providers. These church-related organisations have a tradition in care provision in which they achieve a huge coverage. In many developing countries still very few other civil society structures achieve what church-related institutions involved in health-care provision do.
In view of the increase in formalised public-private partnerships, there is no reason to discontinue our long-standing co-operation with them to foster their participation within national (district) health-care plans and allow them to contribute their share to the achievement of the Health for All (HFA) objective.

Cordaid’s commitment with church-related organisations does not imply permanent or exclusive relationships. Every relevant and interesting new initiative that is presented to Cordaid will be considered for support in a balanced and serious way. Cordaid will go on with the identification of initiatives taken with "full participation of the people served", which implies promotion of a degree of decentralisation in state-run systems and a degree of public-private partnership in the NGO-run ones. This tends to exclude a far more rapidly growing group of local NGOs, established by professionals as co-operative societies. It rightly also constrains co-operation with some church-related institutions that fail to achieve more direct, tangible popular participation.

5. Institutional Development and Promotion of Human Resources for better Health Care

A Brain Storm, Antwerp, 30.04.2002

A brain-storm between Peter Kok, Cordaid; Bart Criel and Harrie van Balen, MM Belgium; Guy Kegels, Institute of Tropical Medicine of Antwerp; Sake Rypkema and Edgar Widmer, Medicus Mundi Int.

A paper written by Puls, Rypkema and Van Balen on 19th February 2002 explains why MMI considers Human Resources Development the most urgent topic for the coming action plan of MMI. As a matter of fact, the International Antwerp Meeting on November 2001 stressed the importance of human resources (cf. MMI Newsletter 68 p. 38/39) be it for the battle against Tb, Malaria and HIV/Aids, as well as for the overall improvement of health care. And so did the WHO-Consultation of Addis Abeba, on November 2001 on: "Lessons from Health Sector Experiences on Contracting in Africa" (as described in my paper on: "Promotion of Contracting, a framework for activities of MMI" (MMI Newsletter 69).

MMI restricts its actions mainly to the African areas South of the Sahel and concentrates its activities on NGO’s working at district level as not for profit institutions having to fulfil a public purpose. It considers the co-ordination of their work as a main challenge, in order to reach an institutional exchange and partnership with Government.

Those who join in a co-ordinating office must be given clear mandates and competences.
Those in charge of these co-ordinating offices need specific training for partnership-dialogue, policy-dialogue and communication. They need to be trained as stewards for health economy, for contract design and good governance. The co-ordinating office should become the starting point for intelligence gathering, for creating alliances and for formulating policies.

Those who are responsible for private health institutions, i.e. the owners, mostly church leaders, should be aware of these necessities. The seminaries should offer modules, teaching the Church’s role in the health field. The bishop’s conferences should clearly define the healing ministry of the church and be aware of the ongoing paradigm changes in the field of health. Every diocese would need professional health councillors. Its health workers need continuous promotion of their competence and motivation and they should be employed in the best possible way.

Such councillors - should be able to work in a team (Health Committee), - they should be able to develop a vision and strategy to reach the vision. - They need relational training in order to be able to create consensus on an overall policy among all the stakeholders.

Donors should be aware of the needs for human resources development within their own organisation. They should maintain and promote their own capacity for professional dialogue with their partners. Partnership without dialogue is no longer partnership. As Peter Kok said, it leads at its best to “proper administration of the wrong project”.

Specific research in human resources development will be necessary. Comparative studies on positive or negative issues should be shared. Whenever a foreign institution or an international organisation is launching some investigation, the “local human resources” should be involved and in this way have a chance to develop their own capacities in research work.

6. The Pilot Role of the Uganda Catholic Medical Bureau (UCMB)
Insights into the work of a national Co-ordinating body

6 /I. Letter to the Board of MMI
Concerning the Strengthening of national Co-ordinating Offices of NGO Health Care Institutions
04. 04. 2002
The UCMB Bulletin, the Newsletter of the Uganda Catholic Medical Bureau (Vol. 4, No. 2, December 2001) has just reached me. It is worth-while reading and I suggest, that MMI should help to disseminate this bulletin to those English speaking NGO-Co-ordinating Offices we are in touch with.

Once more I have the impression, that the Uganda Bureau is a pioneer in its work, especially in developing professional capacities for all kind of tasks.

MMI, trying to promote human resources development, should share their experiences and make them known to the sister organisations in neighbouring African countries.

The UCMB Bulletin informs us about the creation of three new staff departments:

- 1. Advisor for Information, Communication and Data Management, providing all Hospitals and Diocesan Health Offices with information and communication technology.
- 2. Advisor for Human Resource Development, dealing with questions of authority, problems of relationship between managing organisations and boards, the effectiveness of boards and committees, the terms and conditions of service, salaries and accountability.
- 3. Advisor for Organisational Development

Further the Bulletin informs about a Draft Policy for Partnership and Policy Implementation Guidelines for partnership between private-not-for-profit facility based health providers and government.

UCMB is also engaged in the formulation of the National Poverty Eradication Plan. The question is whether the country is equipped to absorb more resources. The Bulletin launches an appeal to rethink what kind of investment has to be done in order to be ready to offer the additional services needed for proper AIDS treatment.

These are just a few items the UCMB Bulletin is dealing with.

So I come back to my proposal: **MMI should sponsor the distribution of the UCMB Bulletin to the English speaking Co-ordinating Offices of Church Related Health Services of Africa.**

With my best regards

E. Wid.

6 /II. "Strengthening Diocesan Health Co-ordination"

Newsletter of the Uganda Catholic Medical Bureau, June 2002
(cf. MMI Newsletter Nr. 69, 2000)

"Last year the UCMB commissioned a study on the effectiveness of the diocesan health Co-ordination to the Department of Health Services Management of Uganda Martyrs' University. When the results of this study were presented some co-ordinators took it to be a criticism of
their performance. It is instead necessary to place the study in its right context and to consider the note of caution the team of researches has expressed:

"We would like to make it perfectly clear that our criticisms are not meant to hit the individual Coordinators. In most cases, given their working conditions, they could hardly do better. Without the necessary requirements, without means of work, without the necessary continuous support, the level of performance is not surprising. It is the overall system that comes under scrutiny and criticisms, not the single individuals. We would request the readers of the Report to keep this important point in mind."

The gist of the study's findings is the following:
Only few Dioceses have a health co-ordinator that is up to the needs. In Dioceses where the co-ordination is effective the key factors identified are:

1. Personal characteristics of the co-ordinator: strongly proactive attitude, very good communication skills, strong commitment, ability to learn, deep motivation, knowledge and competence.
2. Strong and visible support by the bishop
3. Significant level of external financial support: one should underline that the characteristics listed under point 1 are the basis to get external support.
4. Clear understanding of the role and the objectives of their work
5. Academic qualifications

Although the creation of Provincial co-ordinating bodies may be aimed at, the study indicated that first and foremost the main road to follow is that of continuing the slow work of strengthening the existing co-ordination. For this the study adopted the suggestions concerning the profile of the Co-ordinators, namely people with:

- At least five years practical experience in public health services management
- A diploma in public health or health services management
- A detailed knowledge of the Uganda Health System and its most recent policy developments.
- A good knowledge of the current global trends in Health Sector Reforms.
- Very good oral and written communication skills
- Computer literacy and having the following attitudes:
- Share the values expressed in the "Mission Statement and Policy of the Catholic Health Services of Uganda"
- Have a high degree of maturity in dealing with others
- Be able and willing to work as a member of a team
- Be ready and willing to work long hours
- Be able and ready to assist, help and guide the Health Units personnel
- Have a strongly proactive attitude towards self development, personal growth and the enrichment of their own professional activity.

The study also requested the Executive secretary of UCMB to present the following recommendations to the Bishops Conference:

- take notice of the job-description and profile of the Diocesan Health Co-ordinator-
- study the Study-report
- check the status of appointment of current co-ordinators and check their qualifications- if not adequate consider substitution or further training.
- consider request of kick start funds once the right person has been identified.
- solicit/commit other funds

6 /III. Further News from the Uganda Catholic Medical Bureau,

Excerpts of the UCMB-Bulletin, Volume 6, No. 2 by E. Widmer, 07.04.2003

The UCMB co-ordinates the work of RCC (Roman Catholic Church) Health Institutions. Statistics show how important their contribution to the Uganda health system is. In the year 2001 the RCC-hospital sector had 3600 staff. In terms of bed size, the sector had 4972 beds in 27 district- hospitals and 2656 beds in lower units (207 registered units). As a fraction of the PNFP (Private Not For Profit) health sector, the RC Church runs 54 % of all the PNFP health units and is responsible for 11 of the 19 PNFP-Nurse-Training Schools. Financially, 3.35 Billion shillings have been received from government, 7,4 Billions have been generated from user fees and 6,8 Billion shillings came from other sources.

The UCMB Bulletin gives a detailed insight into a workshop organised at diocesan level in Fort Portal by the Bishop and the Health Co-ordinator. The targets were the Parish Priests, the members of the DHAB, the Superiors of the four Congregations working in health in Fort Portal Diocese and the in-charges of the health units. The aim was to sensitise them among others on topics such as:
- Mission Statement and Policy of the Catholic Health Services of Uganda
- Public/Private Partnership in Health
- Training needs
- User fees
With the end of the year 2002 a line was drawn for the RC Church health Units to solicit accreditation with UCMB. The Health Commission had decided that units could be accredited if:

- they had a valid licence for 2002
- they had paid their contribution to UCMB for 2002
- they submitted the report for year 2001/2 within the set deadline.

Additional criteria:

- they had a charter (submitted to UCMB)
- they had a Health Management Committee (to be certified by the DHC (District Health Committee)

Sixteen out of the nineteen Dioceses of the Uganda Bishop’s Conference reached a 100% accreditation for their health institutions.

The Diocesan Health Co-ordinators at the end of 2002 had been involved in a national workshop and they were encouraged to take an active part in an important change in the Essential Drugs Management Program. The major change regards the shift from receiving a pre-defined supply of drugs to receiving a demand driven supply of drugs.

At the beginning of 2003 another national workshop was organised for hospital managers dealing with a strategy for accelerated reduction of user fees. Hospitals which in a former survey showed to have higher user fees compared to others, had been able to reduce their fees and hence be more accessible without endangering the viability of their services.

The UCMB-Draft-Policy concerning Public/Private Partnership has been explained and discussed at different levels initiating a process of consensus-building. Eight regional workshops have been organised from November to December 2002. They were well attended, attracting the District Chairmen, the Chief administrative Officers, the Heads of district PNFP desk officers and the proprietors (Bishops) and managers of the PNFP institutions.

A wide consensus was reached and the stakeholders appreciated the intention of Government to share with them the drafts and not just to enforce policies. This sharing makes ownership broader, which is indeed a precursor for successful implementation at the latter stages. The presentations made were on the following topics:

- Contribution of the Private Health Providers to the Uganda Health System
- Public/Private/Partnership and its effect on the performance on the Health Sector
- Introduction to the policy implementation guidelines
- Draft National Policy on Public/Private Partnership in Health
UCMB refers also about twice yearly organised joint review meetings for the health sector where the Uganda Government meets with Development Partners. Among the eight working groups, one deals with Public/Private Partnership in Health and another one with Human Resources. In the optic of the Sector Wide Approach these meetings review progress in the sector of health against agreed work plans and budgets, identifies sector priorities for the next six months and discuss programmes for the further future.

Key issues of concern in the last meeting of 2002 were:
- lack of progress in increasing deliveries facility based
- lack of essential drugs and supplies
- rapid population growth
- the question of whether global funds would really be additional

Progress in the Poverty Eradication Plan could be reached
- by the reduction of user fees and increased allocation of resources to districts and Health sub-districts. This led to an increase in Out Patient Departments utilisation.
- There is a downward trend in HIV prevalence
- approved posts by qualified health workers could be filled and continues to rise.

Further a plan for an integrated national drug procurement system has been approved including the need for a policy on Anti Retro Virals against HIV/AIDS-

Discussed was the process of finalising the policy on Public/Private Partnership for Health and gathering further evidence on the value of publich subsidy to nthe PNFP sub-sector.

Final remarks:
Networking within the members of the UCMB is now possible by e-mail among all their 27 hospitals as well as among the 17 Diocesan Health Co-ordination Offices. The above mentioned Bulletin gives all the addresses on page 12/13

The UCMB Bulletin is a rich source of information not only for those working in Uganda. It is worth reading for all those who are responsible for private health institutions and for those who try to improve the efficiency of national Co-ordinating bureaux of Non Governmental Health Facilities.

Actually Medicus Mundi International is planning an International Workshop among owners of PNFP-Health Institutions in order to discuss strengthening of national Co-ordinating offices. In the beginning of the year 2004 it is foreseen to organise such a meeting in Kampala together with UCMB, and Anglophone African Church Leaders.
A. Vision

The vision of the RCC health services, as defined by the Uganda Catholic Medical Bureau, is a healthy and reconciled life for all individuals, their families and their communities.

It is a world where:
- the individual, the families and the communities pursue a holistically healthy life style
- the families and the communities are empowered to accompany those who suffer
- those who suffer find support, care and treatment in a spirit of Christian solidarity.

The RCC health care services are based on this Vision and the concept of Primary Health Care and the ensuing strategy of Health for All and seek to realise that:

- health units offer basic curative, preventive and promotional health care services that are available, accessible and affordable for all in the defined catchment area;
- services are sustainable in the local socio-economic system;
- health care providers work together with communities and related sectors to promote a better health care status for all based on community involvement and responsiveness to local needs;
- services are integrated with- complementary to other services in the public health system in the context of the district health care system;
- services are provided in harmony with other sectors of development.

(RCC = Roman Catholic Church)

B. Mission Statement and Policy

of the Catholic Health Services in Uganda

Text as Approved by the Bishop's Conference in Uganda
June 1999
The Draft of the Mission Statement was examined by the Health Commission, circulated to all Diocesan Health Co-ordinators and to all Catholic Hospitals and presented at the Annual General Assembly of the Catholic Health Units in April 1999. Suggestions and comments were kept into account and incorporated in the text.

The final draft was eventually presented to the Episcopal Conference during the Plenary Meeting of June 1999 and received approval after few amendments.

The Document is composed of 4 sections:

- Section A is the Mission Statement proper. It states the mandate for and commitment of the Catholic Church to the exercise of the healing ministry of Jesus Christ.
- Section B presents the principles guiding the exercise of the healing ministry.
- Section C presents the policy priorities. It is deemed necessary to revise this section every 5 years or with different periodicity, if need arise.
- Section D presents the policy specific objectives for the next 5 years. Each objective to be pursued is stated in detail. Each Diocese is requested to use this section and section C as reference for the preparation of Diocesan health Policy and Plans. It is understood that the proposed objectives can be pursued at a different pace in each diocese. It is anyway expected that within 5 years all objectives will be achieved.

Sections A and B are expected to remain unchanged along time. Section C and D present instead the way the healing ministry is going to be exercised in the present time, and therefore these sections are contextual and may change along time.

Kampala 24. 06. 1999, Solemnity of the Nativity of John Baptist

Section A

Mission Statement

1. The mission of the Catholic health services in Uganda is derived from the mission of the Church which has a mandate, based on the imitation of Christ and His deeds, to promote life to the full and to heal. These services are committed to a holistic approach in healing by treating and preventing diseases, with a preferential option for the less privileged.

2. Since the person is at the centre of all activities of the catholic health services, a basic attitude of respect for the human dignity will be the guideline for all. Therefore the principle of subsidiarity will be applied with equity in all relationships within the catholic health service network.
3. Justice, universally and equally will mark the work of all catholic health units in Uganda. Their work will be done in a professional way and in a spirit of total dedication and transparency. Human life being sacred, the basic attitude of all personnel in catholic health services will be the healing of the person with total respect for life.

Section B

Policy Statement

All catholic health services shall adhere to in their constitutions, statutes, policies and work to the guiding principles of the mission statement and of the policy statements here below.

Co-ordination of services

1. Between all health units there should be a spirit of open and frank collaboration where the principle of subsidiarity is the rule and is respected. The common good of people and of the nation will be the concern guiding all initiatives of collaboration.
1. To facilitate collaboration between them and with other bodies, all Catholic health units should seek accreditation and register with the Uganda Catholic Medical Bureau.

2. For the purpose of effective co-operation, each diocese will have a health Co-ordinator who will work together with the Executive Secretary of the Uganda Catholic Medical Bureau and with the persons in charge of units. The Co-ordinator will be guided and assisted in his work by a team of advisors to form the diocesan health advisory board.

4. Each advisory board and Co-ordinator will adapt the church common health policy to local situations and will be responsible for its implementation.

5. The establishment of intermediate levels of co-ordination between dioceses and Medical Bureau will be considered as an option to be pursued once the Ecclesiastical Provinces will be timely established.

**Consolidation of services**

6. The existing units and services set-up will be consolidated during the next period of five years. Clear objectives aiming at consolidation of the existing units will be set in each diocesan policy, pursued and regularly assessed. National guidelines about the establishment of new units will also be respected.

7. The opening of new units in a diocese will be decided upon the ground of thorough previous evaluations of need, feasibility, viability and sustainability. It is of great importance that an equal distribution of services is attained in co-operation with government and other health service providers and keeping into account government policies.

**Professionalism, quality of care and training**

8. The personnel of units and services will be professional in their work. High quality and professional standards will be the rule and to maintain these, there is a need for constant and continuous education and training. Professional posts will be filled with personnel with adequate qualifications.

The existing training institutions will consider diversifying the type of training offered. This option is preferred to the setting up of new schools. Training plans will be co-ordinated with Government and other organisations like Uganda Protestant Medical Bureau. In all aspects of training it should be remembered that any school is a place for life-long learning. When talking of professionalism, specialised areas of the profession have to be strengthened, thus
giving to all a possibility of access to the best possible services. In doing so, quality care should remain at the heart of all health services.

9. In the training of health personnel, be it on-going or pre-service, ethics will have to have central place, thus introducing into the profession the basic attitudes needed in the exercise of the health profession.
10. The Uganda Catholic Medical Bureau will endeavour to assist units and services in the training of health personnel and may call upon specialised institutions, to assist in this task. A formal co-operation will be established for this purpose with the Uganda Martyrs University, particularly with regard to the training of health services’ managers.

**Equitable sustainability**

12. Services have to be sustainable in a reasonable way. This purpose of health care is not to create money-making business but to develop services in such a way that all may have access to it. Hence all catholic health services will pursue a “NOT FOR PROFIT” rationale of operation.

13. A certain contribution towards the health services received shall be asked from patients and users, but it should be of such a nature that the “caring” aspect of health care be safeguarded. It is of paramount importance that the question of fee structures will have to be studied in the light of the mission of all Catholic Health Units in Uganda.

14. As there is a preferential option for the less privileged in our health services, the poor have to be enabled to obtain services in an equal way as others and obtain the best care possible.

15. The achievement of a sustainable service will require high managerial skills where accountability and transparency are the rule. Without these, no sustainable service will be achieved. Units and services will take particular care in developing managerial skills of their personnel.

**Integration and co-operation**

16 Catholic health units do not work in isolation and must always remember that there are other providers in the Country which need to be recognised and respected. The Catholic health units will operate as part of a national health system. Therefore, a sound working relationship within the church services, with Government institutions and with other health care providers is of paramount importance and will be pursued.
17. There will be co-operation in all possible fields, from training to health care delivery. Each one has to be recognised for its own work although no Catholic health unit should compromise on its identity and the principles it stands for. Advocacy for the RCC health services will be pursued at all levels.

18. A system of referral and counter-referral will facilitate the movement of the patient and user through various levels of service delivery system and to specialised institutions of whatever kind and affiliation.

Section C

C Policy Priorities

1. The consolidation of the existing services is the main goal to be achieved in the next five years

2. Within this time frame, each Diocese will set the pace of the policy implementation by adapting this policy and drawing up/implementing Diocesan/Hospital plans.

The monitoring of the implementation of such plans will be responsibility of the Boards (Diocesan Health Boards and Hospital Boards) with the facilitation of the Diocesan Health Co-ordinators and the Catholic Medical Bureau and will be carried out with the use and objective means of verification

5 /V. Further Documents of the UCMB

cf. UCMB Bulletin Volume 6, No 1, June 2003
A summary by E. Widmer

- - The standard Charter of Catholic Hospitals
- - The Manual of Employment for Hospitals
  - The Manual of Employment for Lower level units
- - The Constitution of Diocesan Health Departments
- - The “Modus Operandi” of the relationships between Dioceses and
  - Religious Congregations in healthcare

All documents, although developed in different times, respond to a coherent vision of Catholic healthcare. They facilitate the implementation of the formerly described UCMB-Mission- and Policy Statements of 1999.

Of course all these documents need to be understood, owned and formally adopted.
The UCMB can provide guidance but cannot impose. On the other hand, some kind of *harmony, consistency and procedural discipline* is required in order to **increase the unity within UCMB**. These documents are meant as point of reference and in order to keep them alive, with the help of the members of UCMB, they will have to be adapted to the ongoing changes of the respective context.

*The Manual for employment* for instance is not only an attempt to ensure correct and fair handling of all employees, it also attempts to make terms of employment similar but not identical. **Harmonisation** is the key word here.

- The Manual describes the conditions for **job security in exchange for performance**. As long as the public is well served, the employment is protected and good performance is rewarded.

- The Manual mentions that the **terms of employment** should become more flexible. It may be wise to foresee that a work relationship may have a time limit, allowing to better respond to the needs of the employer as well as the employee. Especially for female workers, which also have to cater for the needs of a family, the possibility to opt for part time employment has to be taken into account. Part time employment may also respond to the needs of the organisation to meet peak of demand of service in specific hours or period.

- The Manual also deals with some interesting **financial aspects**. Whatever the mix of activities of an employee are, curative, teaching, research or other, there should be only one employer and one remuneration, avoiding cumulating of two or more packages of income; allowing in this way better transparency and equity and avoiding absenteeism for a second or third job.

- According to the Manual, no Catholic Institution can employ without subscribing its employees to, the national **social security** fund, the NSSF. Nevertheless pension schemes are still insufficient. Access to financial institutions, which are strong enough to guarantee the returns of the investment made, is still lacking. It is apparently not only a problem for RCC health workers, but even for Civil Servants, who may be entitled to a pension. But in the absence of a Pension Fund for Civil Servants, money to pay pensions depends from each years Budget. If the Fiscal flow does not yield as expected, one is left waiting for his title to be realised.

*The Charters and Constitutions* give a clear definition of the **role and organisation of a hospital as well as of the Diocesan Health Department**

Many things go wrong because, even if the reason for existence is clear, nobody clearly knows who is responsible for what and to whom.
- On this, the new documents make a step ahead, by providing clear Terms of Reference right down to Job Descriptions, at least for those in key positions.

- One point of the document is particularly important: the distinction between 1. Ownership, 2. Governance, 3. Management and Implementation.

It is too important for everybody to know who is who and what function is proper, either for the individual or as member of a committee.

- The documents also insist on the importance of the creation of larger advisory forums, in order to create a more concise dialogue with the local community, the politicians and the users.

- The documents go further in providing a proposal for harmonious organisational structures, not only describing the functions of each involved, but clarifying the style, value set and practices to be adopted by different bodies and people and enshrines them in a Code of Conduct. It expresses the concern of the Church for all her sons and daughters, who, while serving, also exercise power, and are thus exposed to various forms of temptation and corruption. Its value does not lie in external coercion, but on the fact that those concerned feel bound by what they themselves freely decide to adhere to and undertake, once their conscience has been dutifully and rightly informed.

- The documents also deal with the Ownership and Governance.

The Owner of an institution is the person or group of persons that embodies the physical continuity of the assets. in the context of Church healthcare it is always a juridical entity. Strangely enough one always mentions the Bishop, but it is not actually the Bishop who owns, but the local Church: the Bishop is the most fundamental person for a local Church to exist. As such he is the supreme Custodian of the Mission of the Organisation. He relies on a Board which has the duty to transform the Mission in clear policies, regulations and controls.

The Owner delegates his power vis-à-vis this level of responsibility to the board, The Charter enters into a detailed specification of what this practically means. The appointment of Chief Executives pertains to the Board and the Owner in consultation on the basis of professional-, managerial skills, personal authority and loyalty to the mission.

The board assigns on his side the day to day business of the Organisation and the implementation of policies to the Management Team, which has to insure the channels of communication between the different levels, information, accountability and consultation on strategic choices, being the main elements for an optimal performance.

The described documents can play a very important role for Human Resources Development. Working under well defined conditions with a clear and shared vision of the common aims and tasks will improve the personal motivation and strengthen the spirit of team work..
7. Dialogue with Bishops involved in Health

7/I. “Soesterberg Statement”
Statement by the participants of Memisa’s 75-Years Jubilee Working Conference
October 2000
Cenakel, Soesterberg, The Netherlands
“The church and its involvement with health:
The healing ministry”

From Monday 2nd to Wednesday 4th October ten Bishops responsible for health matters within the Episcopal Conferences of eleven developing countries from three continents, their health secretaries, representatives from Cordaid/ Memisa, Medicus Mundi International, Misereor, CAFOD, Porticus Stichting and various experts, attended a working conference, in the framework of the jubilee celebrations of the 75th years of Memisa.

The conference was held at the Cenacel in Soesterberg, the Netherlands. It was opened by His Eminence Adriaan J. Cardinal Simonis. The conference was entitled: "The church and its involvement with health care: the healing ministry".

The purpose of the conference was the need for the church to adapt its approach to health care in response to the ever changing circumstances in which the healing ministry has to be exercised.

The objectives of the conference were the following:

- To increase the general understanding among representatives of Episcopal Conferences and donor agencies of the threats and opportunities related to the contribution by the church towards health promotion and health care provision for disadvantaged persons, groups and communities in developing countries so that they can make well balanced choices for future direction of health policy.
- To increase the understanding among representatives of Episcopal Conferences of optional roles the church may play at policy and implementation level, complementary to other stakeholders and/or health care providers, with a distinguished identity, competence and ability to reach the less-advantaged in society.
- To increase the understanding among representatives of Episcopal Conferences and donor agencies of the requirements of owning and managing of health care institutions and programmes, which includes matters related to planning, financing, staffing, transparency and accountability, etc.
- To improve the co-operation between Episcopal Conferences and donor agencies in general, and between the donor agencies and church health institutions, programmes and co-ordinating bodies, for mutual support and fruitful co-operation in achieving the overall objective of improving the health situation of the less advantaged in the world.

Three themes were examined in depth through presentations, experiences, group work and plenary discussions about:
1. the healing ministry of the church;
2. current policies and practice of church health promotion and health care development in developing countries, and the perceived need for change;
3. strategic options available to the church in promoting health and/or in implementing health care.

At the end of the conference, the participants decided to issue a statement on their position in relation to health care.

Statement

I. The healing ministry of the church is part and parcel of the church's mission to healing and wholeness in accordance with Christ's mandate: The spirit of the Lord has been given to me, for He has anointed me. He has sent me to bring the good news to the poor, to proclaim liberty to captives, and to the blind new sight, to set the downtrodden free to proclaim the Lord's year of favour This text is being fulfilled today even as you listen. (Luke 4:18,22)

II. The church is a complex reality made up of persons, organisations and institutions, both hierarchical and social, with different and complementary functions. It expresses this ministry in different ways and forms, ranging from direct provision of health care in institutions (hospitals, health centres, health programmes), to animation and mobilisation of communities for their empowerment to achieve health for themselves. In this sense it subscribes to the philosophy of primary health care of all.

III. The action of the church as a whole aims at the liberation of the human person from the slavery of poverty, sickness, ignorance and evil, at the promotion of the dignity of the human person in a holistic perspective and therefore in all dimensions: physical, psychological, spiritual and social. Paul VI 's encyclical, “The Development of People,” (1967) describes development as: “the growth of each person and the whole person.”

IV. In her fight against poverty and sickness, the church has developed and continues developing organised forms of action in different fields, which includes health institutions and programmes. This is one of the ways the Church shows her solidarity with the poor and the suffering.

V. Health care is affected by poverty, sometimes by traditional cultural values and practices, by ignoring the human rights of women, by the neglect of children and orphans, by ignoring the problem of international debt.

VI. Direct provision of health care, though an important aspect of her healing ministry, is not the only way through which this healing ministry is exercised. Advocacy with and on behalf of the weakest groups in society, for the poor, for women, for marginalised persons and communities and active lobbying for the defence of their rights are complementary options for the exercise of the healing ministry.

VII. In different geographical, social, environmental contexts, within the same understanding of the healing ministry, the same mission and vision, the church's approach to health is diverse.

VIII. Aware that the she is the largest actor in health besides governments, the church knows that this is not the time to sit back contemplating past achievements. More than a billion people are still struggling in abject poverty. Although health care is a basic human right, health services are scarce, often not available, nor appropriate or affordable. When looking at basic statistics of life expectancy, child mortality, maternal mortality, the need for great efforts to further improve health is patent. Investing in health care as well as in social economic advancement have to proceed
together. Moreover, the HIV/AIDS epidemic exacerbates the situation and threatens past achievements. Evidently, there is still a lot of work to do and the church is determined to continue to be active.

IX. The church is still at the forefront of health care development, but not without major difficulties. Over the years many developments in the configuration of health care have occurred, changing the environment in which church health services are implemented.

X. Church health care is evidently an intrinsic part and parcel of society, and she is rapidly losing its former, comparatively independent position. New paradigms on health care development, lead to new conditions as far as the work of church in health is concerned.

XI. Sometimes, the church finds it hard to adapt to these new circumstances. Interaction with governments is often strained. Health institutions endure financial and personnel hardships. A clear, well worked out and distinguished path for further development of the church health activities is often lacking. Among other issues this implies that the capacity and professional profile of personnel needs to be adequate to the demands posed by the new circumstances.

XII. As a member of civil society, the church advocates for a correct understanding and application of the principle of subsidiarity in the relationships between different levels of organisation of the state and of civil society itself. Convinced that in the increasingly complex environment, all actors in civil society have their contribution to give and a right place to occupy, the church knows that it is no longer time to pursue initiatives in splendid isolation but to join hands in a bond of partnership: partnership between the church and the communities, between donors and churches, between different health care providers, between health care providers and communities, between church and state.

XIII. The church believes that co-operation and partnership should not merely consist of the transfer of goods from the developed world to developing countries. It should rather be a real solidarity among peoples. It should be a relationship that seeks the good of the other through a sharing in a humane way and in a dialogue among peoples, of personnel and funding.

XIV. The special partnership existing between church in developing countries and church donor organisations in the north requires a well structured dialogue. Church donor organisations are accountable to the public for the use of the funds provided to target the poor. On the other hand, church organisations in health in the south own the programmes and institutions implementing interventions that contribute to the reduction of poverty. This shared vision needs a new form of co-operation that is tangible and well defined with shared objectives, leading to documented results.

XV. No fruitful relationship among partners is possible without transparency and reciprocal accountability. Transparency is needed in any declaration of intent, in the process of decision making, in financial management, in the management of human resources and in the documentation of quality and results. What is needed to make any partnerships effective and valuable is that it should be based on general understanding of on what partnership is all about. Constitutions, mission statements, charters, contracts are essential elements in this, as means to make each partner’s role and function explicit.

On the ground of the common understanding reached, the participants wish to express also the commitments they are ready to jointly undertake.
Commitments

To:

Healing Ministry
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.

2. We consider it necessary to occupy ourselves with an appropriate and affordable health care, available to those who are most in need.

3. We commit to playing a prophetic role through an active advocacy with and on 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 place with the whole of civil society to remove obstacles (political, social, 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 programmes, 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 co-ordinating 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 professionalize 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 in.
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 a key actor 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.

(Text as agreed by the participants, Rotterdam, the Netherlands, October 6th 2000.)

7 /II. The Healing Ministry

A paper given by E. Widmer at the MEMISA Jubilee Working Conference with Members of Episcopal Conferences holding the health care portfolio. October 2/4 2000

Since antiquity religion and health, priesthood and the healing ministry were combined. In the 6th century B.C. Hesiod refers us how the Greek God Aesculap was brought up by the Kentaur Chiros. He was taught how to prepare medicines, how to use the knife and the word in order to heal, and how to use word and knife at the right moment and everything in a holistic way. The temple of Epidaurus since the year 600 B.C. became the most important model of an antique
health centre and from there religion, combined with health activities, spread to Corinth, Kos and finally in the year 290 B.C. to the Tiber island in Rome. The Emperor Justinian closed in Athens the last one of these pagan temple-schools in the year 529, in the time when Saint Benedict started building up the convent of Monte Cassino. The schools of Aesculapian doctors changed from a magical and mystical understanding of disease to a rational approach and in this way medicine became a self-contained discipline. Nevertheless it remained tied up with the temple and later with the church, first in the convents and then with bishops who had founded hospitals next to their cathedrals. The monks were the real saviours of the antique knowledge. Without them the texts of the Greek and Roman doctors would have been lost. The application of this pagan knowledge was admitted by the Church only out of mercy with the sick. The 1100 year old “Lorscher Arzneibuch”, a medical codex of a German convent, in its introduction gives us prove for that. By the way many of these hospitals were dedicated to the Holy Spirit. He was considered to be the Unificator between body and soul, the single and the community. This was a holistic approach. It was Christianity which introduced solidarity into the world, because true Christian faith is closely linked with charity (In Fide et Caritate). Many congregations specialised in hospital-work. I just mention the 400 years old Hospitaller Order of St. John of God, with 200 hospitals in 40 countries, an associate member of Medicus Mundi International. The Church looked upon disease on one hand as a consequence of the original sin, on the other hand disease was considered to be a chance to participate in Christ’s suffering. Furthermore healing was bound to reconciliation.

After the French Revolution the sciences became secularized. Modern medicine concentrated for a long period on the body only until the discussion began on how to define health. In the 33rd WHA in 1980, Dr. Abdul Rahman Al Awadi, health-minister from Kuwait, claimed that physical, social and psychical wellbeing were not the only criteria for health. Spiritual wellbeing had to be added to the definition.

In 1983 the Vatican convened a consultation on the question on how to define the Health Pastoral. The meeting was organised by Cor Unum. Its conclusions were the starter for the Motu Proprio: “Dolentium Hominum”, by which two years later the Pontifical Council for Health Pastoral was founded. The above mentioned consultation responded to the paradigm-shift from the pastoral for the sick to a pastoral promoting health, corresponding to St. Matthew’s last Judgement speech, projecting a clear image of a dynamic Church-community at the service of all, contributing to the “good life” of all. In 1985 the Tanzania Churches Consultation on PHC said: “Reflecting the comprehensive call of the Gospel, the Churches impel a concern for all people, especially the poorest members of society, to enable and empower them to play a direct role in the promotion and preservation of their own health and affirm that a people oriented concern by the Churches closely coincides with the objectives and approach of PHC (as declared by WHO in Alma Ata, 1978).
A seminar organised by Medicus Mundi International (MMI) and the Christian Medical Commission (CMC) of the World Council of Churches hosted by the Hospitaller Order of Saint John of God (Fatebenefratelli) in Rome, 1984 on „Strengthening Coordination of Health Activities by Local NGOs towards Health for All“ assembled Coordinating Agencies of Church Related Health Services from many African countries. This seminar confirmed the consensus on the desirability of coordination between NGOs and Governments and suggested that one should move from simple collaboration and exchange of information to true agreements on common action at all levels, national, regional and local and that implementation of PHC needed urgently such an approach.

At that time the „District Health Concept“ was not yet born. It was in 1987 that WHO organised the Harare Conference redefining the role of the peripheral hospitals in their district. Many Church-bound hospitals fulfil the role as health care providers with public purpose and have a clearly defined ethical attitude of not for profit. But when the World Bank spoke of a „Better Health for Africa „ (1992) and when the World Bank together with WHO invited „development partners“ to a meeting in Dakar in 1998 discussing „The Contractual Approach as a Tool for the Implementation of National Health Policies in African Countries“ the large not for profit NGO community was not included in the discussions. Their important role as development partners was not considered and not officially recognised, although they play a dominant role in many national health-service networks. If contracting is being considered as a means of assuring better coverage of essential health care needs of the entire population, then the least it would be logical to consider the potential benefits of contracting those private organisations which have shown to have capacity, a commitment and a sustainability of their own and which endorse the same PHC objectives as proposed by the national health policy.

Therefore MMI in 1999 has decided to propose a statement to the World Health Assembly with the proposal to better integrate NGO hospitals into the District Health Concept by well defined contracts and agreements. Such a statement could promote the issue of a resolution by the WHO. Of course such a resolution is only possible when Member-States endorse the subject. Therefore MMI hopes to get the support of those European Governments who have already links with its European branches as well as from those Governments of countries in which MMI cooperates with local partners. The Holy See has demonstrated an eminent interest in sustaining this statement. In order to strengthen the many Church bound hospitals it has encouraged the Bishops Conferences to give its support.

We remember that the Holy Father himself urged International Catholic Health Organisations to join WHO in its effort for Health for All when he spoke to the Vatican Conference in 1997 on „Church and Health in the World, Expectations and Hopes on the Threshold of the Year 2000“. Dr Nakajima, then Secretary General of WHO on this same occasion explained how much the
Church related health work is appreciated and that the world needs its holistic approach. “Unirsi per fare meglio”, is the slogan.

On May 26-28th 2000 the International Association of Catholic Health Care Institutions AISAC (Associazione Internazionale Istituti Sanitari Cattolici) had an important meeting in Rome.

The meeting was presided by Archbishop Javier Lozano Barragan and Bishop José Redrado.

The Continental Delegates were Rev. Michael Place, Catholic Health Association of the United States, Mr. Francis Sullivan, Australian Catholic Health Care Association, Rev. P. José Anadon Martinez from Colombia President SELARE of CELAM for South America, Rev. P.L. Gregortsch from Vienna together with Dr. Salvador Rofes, Spain, Delegates for Europe, Dr. Douglas Ross from South Africa together with Rev. F. Edward Phillips from Nairobi as Delegates from Africa and Rev. James Culas from India representing Asia. This meeting was organised by the Pontifical Council for Health Pastoral Care as a follow up of a consultation held one year ago. The intention was to reactivate the international cohesion between the many world wide existing Catholic Health Care Institutions: 5200 hospitals,12,200 hospices,17,200 health centres. AISAC has to contribute to the policy of the global network of health-care-NGOs and to be actively present where international policy decisions are made. The above mentioned continental delegates were all elected as AISAC Board Members. Bro Pierluigi Marchesi, former Prior General of the Fatebenefratelli, was confirmed as its Director. Rev. Mons. Osvaldo Neves de Almeida took part in the name of the Secretary of State among some other councillors. Medicus Mundi was the only non-church-bound observer at this meeting, due to its engagement for HFA (Health for all), as the letter of invitation specified.

The Aims of AISAC had been drawn up in a paper given by Bro Marchesi. Summarising it says the following:

By the fact of growing interdependence and the increasing speed of changes due to the paradigm-shift after Alma Ata and due to consequences in the field of health care by the Globalisation, there is a felt need within the Catholic World to share responses to these new challenges. Health promotion and engagement for sustainable development are important issues as well as codes of conduct, based on human rights and ethical values.

While recognising Governments’ responsibility for formulating health policies and organising health services the civil society with the increasing move towards democracy, plays an ever important role in its realisation.

NGO’s, and among them Church-bound Institutions, will continue to contribute inputs in kind of services. More important still will be their engagement for solidarity and ethical standards. In the Encyclical „Sollecitudo socialis“, Pope John Paul II defined solidarity not as a mere feeling of
compassion, but as a firm determination to commit oneself to the common good of each and all, because we are responsible for all.

AISAC encourages Catholic Health Care Institutions to identify their juridical identity and by such guarantee their future accreditation within the national system.

In co-operation with Governments the mixed public/private and non-profit health care system should be clarified. Especially for Developing Countries the Pontifical Council and AISAC support the proposal of Medicus Mundi concerning „Contracting“.

I literally quote: “The proposal of Medicus Mundi Internationale consists in improving health care through contracts with non-profit NGOs that accomplish mission of public service and which are recognised as constitutive in the health care sector.

The proposal presented at the WHA is officially supported by the Holy See through the Pontifical Council for Health Pastoral Care and contains the following recommendations (synthetically)

- to classify the health care institutions according to their capacity and not to their belongings;
- to base the operational definition of services offered on the possibility of access to the entire population of a given zone without discrimination of sex, race, religion and social status;
- to define precisely the terms of collaboration between the local national health authorities and NGOs of public utility;
- to include in the contract between the partners an agreement on the criteria for the proper evaluation concerning quality and efficiency of the care given (end of the quotation).

The delegates of Africa giving their report to the meeting could not give an overview of the church health care institutions of their continent. I therefore distributed the list of addresses of the African Co-ordinating Agencies of Church-related Health Services as collected by MMI with the plea to co-operate with these bodies although, or just because, they work in an ecumenical spirit.

I also explained that hospitals at peripheral level should no longer work within their walls only, but be part of the so called District Health System and that „Contracting“ is an important tool for reaching this goal.

As an appendix I might mention here at the occasion of the 75 year jubilee of MEMISA, that it was the Encyclical “Maximum illud” of Benedict XV which gave in 1921 the initial start for medical-mission-work of the Catholic Church. Besides MEMISA other institutions were founded in the same years such as: the German Medical Mission Institute in Würzburg, the Catholic Medical Mission Board in New York, the Congregation of the Medical Mission Sisters, the
Foundation Ad Lucem in France/ Cameroon, and the Swiss Medical Mission Doctors Society now called Solidarmed. All these Institutions have been involved with Medicus Mundi in one way or the other. Today’s challenge is the co-ordination within the Church in order to take part on national and international level for decisions concerning health and life such as sense of life, ethics, human dignity and equity, accessibility, sustainability and quality of given services.

7 /III. Church leaders and Health, a letter from Rome

Dear Dr. Widmer

e-mail 20. 03. 2003

It was good to hear from you, and thank you in a special way for thinking of us on the Feast of St. John of God. I just arrived back in Rome after an absence of two months. I was in Africa and went straight to Asia. We had some difficulties with one of our hospitals in Ghana, which has been resolved, but they have urgent need of doctors and other professional staff. In this regard I believe that Br. Stephen has been in touch with you and MMI. It is always difficult to find professionally trained people, as soon as they are trained or train overseas, they don’t want to work in their own country. The salaries that are in offer in Africa compared to what can be had overseas, one can understand their position. A way has to be found to reverse this situation otherwise there is no future for the health services in Africa.

Thank you for the copy of the “Dossier – Working Conference for Bishops, Uganda, 2004” which I read with interest. You asked for my opinion/advise. In terms of Africa, and especially Uganda, I would be reluctant to respond, because of the superficial contacts I have with the continent. When one hasn’t lived and worked in a country or continent, it is not easy to really understand the complexities of the various situations. However, I will give a couple of general comments and a share a few thoughts from my ‘African experience’ superficial and limited as it may be.

As a general comment, the Church, many bishops, have not a good biblical and theological understanding of the very important, central, place that the ‘Healing Ministry of Jesus’ should have in the life of the Church. This healing ministry is being carried on today by his followers, lay and religious, and is of huge importance in the work of the Church’s Mission of Evangelisation. If somebody who knew nothing of the Church or religion, was given a copy of the New Testament to read, and then he was to visit any parish in the world, the Vatican, Bishops’ Palaces, speak with those who are in ‘charge’ etc, would he come to the conclusion that this is truly the ‘Church of Jesus of Nazareth? Would he see the values which
Jesus upheld and promoted by word and deed, central to the life of ‘His Church,’ especially 
with regards to the importance that is given to the ‘healing ministry?’ I think not. Sure there is 
plenty written, and nice words are spoken at openings of services for the elderly or hospitals 
wards etc.

However, are centres and services for people with variety of health needs; places for 
training, education and caring for people with physical or mental disability; the caring for the 
elderly, immigrants etc. etc. are these as central to the Church’s Ministry, as they were in 
Jesus Ministry? I think not. The reality seems to me, especially in the developing countries, 
they are only too often seen unfortunately, especially with regard to hospitals, as a financial 
resource for the diocese. This is why I have difficulty with hospitals been ‘under the bishop,’ 
except in terms of a general pastoral concern. Certainly not administration, for the reasons 
mentioned above. In Europe Catholic hospitals are generally not considered to be ‘under’ the 
Bishop, except perhaps where these are administered by a Congregation of Sisters who are 
directly subject to the Bishop. In Africa every Bishop assumes that all the Catholic Hospitals 
in the diocese ‘belong’ to him, and they behave accordingly. I agree with Tom in his letter of 
26.02.2003, where he states “We need to have informed bishops having a conviction of the 
need and a sense of direction and purpose” before we can insert concrete proposals e.g. to 
“embrace the role of the steward rather than to keep insisting on the prerogatives of 
the owner” (my indentation, and I would add ‘money’).

Not all bishops are like that I’m sure, but I have met several who are, and I have met a few 
who are not. Unfortunately from what I have read and heard, the number of the former 
outweighs the number of the latter, which makes ‘partnership’ on an equal basis, which what 
partnership means, is difficult. You see Doctor Widmer, the Church is seen purely in parish 
and diocesan terms, everybody has to fit into that narrow view, subject to a pyramidal view of 
the Church with absolute authority invested solely in the hands of a few - the Bishops and 
priests. Rather than the Vatican 11 model of Church, which is, Christ at the Centre and all of 
‘Gods people’ working together in a circle ‘by Him, with Him and in Him’ to bring about HIS 
KINGDOM on earth. In this concept or model of Church each individual is considered of 
equal importance, each one is cherished and valued for who they are, their specific vocation 
is respected, their gifts are valued and they are encouraged to contribute these gifts for the 
good of the Church’s over all mission of evangelisation.

I have gone on more than I had intended and I do not wish to appear too critical, but it is 
done out of love for a Church which is over due of renewal, radical change. As a Brazilian 
Bishop has written some years ago, “…we do not need a new Church, we need a new way, a
new model of Church." I believe the struggle that you and so many others like you among the 'people of God' are having, what you say and what you write gives me great hope for the future. As this is the work of the Spirit it will eventually lead to change, but slowly. He is at work in all of this and in all of us, so in the end His/Her will ‘will be done on earth as it is in Heaven.’

Don’t lose heart and keep up the struggle with conviction, patience and in the sure knowledge that the Divine Physician Himself is working in and through you, and those like you who work for the good of the Church, helping it be true to itself and faithful to its mission of evangelisation, especially in the area of caring for all who are sick or troubled in any way, in the way Jesus, THE Good Samaritan, has shown us.

God bless you Doctor Widmer and thank you. D. F..

7 /IV. Bishops Conferences and Health
an inquiry made by Rome

Excerpt from a survey related to the Catholic health care world
Published in Dolentium Hominum No 52, 2003 by Fiorenza Deriu

In the year 2001 a questionnaire was sent to bishops responsible for pastoral care in health in their respective countries. Out of one hundred and twenty only 76 bishops were able to answer the questionnaire and 71% duly filled it in in the right way. They came from the bishops-conferences of:

Ecuador, Bolivia, Argentina, Colombia, Uruguay, Venezuela, Peru, Haiti, Guatemala, Cuba, Canada
Italy, Germany, Spain, Belgium (2), The Netherlands, Ireland, France,
Georgia, Slovakia, Romania, Poland, Slovenia, Albania, the Czech Republic,
Benin (2), Chad, Tanzania, Mozambique, Equatorial Guinea, Zambia (2), Sierra Leone,
Sudan, Togo, Madagascar, Nigeria, Uganda, the Central African Republic, Guinea, South Africa, Ghana, Lesotho,
China, Thailand/Singapore, Korea, Indonesia,
Papua New Guinea, Australia.
The Lebanon,

1. The bishops conferences seem to acknowledge the existence of the lay working in the health field, be it Catholic NGOs, Catholic health associations and Catholic people’s (civil) groups. The report mentions a surprisingly high involvement of civil society.

However the relations between the bishops for pastoral care and these bodies do not seem to be very deeply rooted. considering that 70% of those answering the questionnaire said
that at the most they met such representatives twice a year. The tradition of networking among them seems to function best in Europe and South America. Networking is however a must wherever needs are to be identified and met with.

2. What provokes worry is that despite the situation of many Churches working in countries that are especially afflicted by grave economic, political and health emergencies, the need for contact and co-operation within a network is not fully realised. Instead the bishops considered –lack of funds, - lack of human resources – lack of response to local health care emergencies as more important.

The local Churches could play a more important role in becoming meeting points for the above mentioned needed resources. National Co-ordination of the work of the Catholic Health Care Sector is absolutely urgent.

3. Another question was whether the Catholic health institutions are officially recognised or accredited as of public interest. In most countries Church institutions generally have a private legal status. This may lead to confusions as nowadays by the effects of globalisation and new economic developments private is very often synonymous to "private for profit".

Church health institutions should try to be legally recognised as Private Not for Profit and with a Public Function

4. Analysing the investment in training activities it is shown that Management and administration is at the top followed by health care information, pharmacological up-dating ethics and finally health care education. At the same time courses on ethics are addressed mainly to medical staff, nurses, technicians and pastoral workers and only marginally to administrative directors.

These data provide interesting information on the direction that the health care systems are in general taking: that of becoming mainly an organisational and bureaucratic machine with the serious risk to lose contact with the individual human being and its suffering and pain. The holistic approach should remain an important challenge.

5. The survey's most alarming result was that 52 % of the bishops declared that less than a half of the Churches health institutions could be kept on working for the near future unless new human and economic resources can be mobilised.

In view of the grave local health emergencies, especially in Africa and Asia, the inquiry concludes with an urgent appeal to the sister Churches

- to achieve fairness in relation to resources and means,
- to promote the creation of local and international catholic networks and
- to strengthen co-ordination in the local and national area, around shared objectives.
- to encourage greater contacts between the different bishops conferences and their offices for pastoral care in health.(actually only 50% of those who answered the
Considering the above summary of the paper given by Dr. Fiorenza Deriu at the International Conference in the Vatican on November 2002 dealing with “The Identity of Catholic Health Care Institutions” we of Medicus Mundi come to the conclusion that the approval of the WHO Resolution on “Contracting” as well as the planned Working Conference for Anglophone African Bishops in the year 2004 will be important milestones for the sustainability of Catholic Health Institutions, especially in Africa.

Edgar Widmer, July 2003

7 /V. Health and Power

Practical Actions to be promoted in Relation to Hospitals and other Health Centres

A paper given at the XVI International Conference, Pontifical Council for Health Pastoral Care.-November 2001, Vatican City, by E. Widmer
(cf. DOLENTIUM HOMINUM, Church and Health in the World, No. 49, 2002)

Speaking of Health, Power and Actions to be promoted in Relation to Hospitals and other Health Centres we will consider the first referral level, Institutions within the so called District Health System (DHS) The DHS is a functional and coherent decentralised health care organisation aiming to implement Primary Health Care for a defined population, with participation of the communities and ensuring responsiveness to the local needs. It consists at least of the community, first line health and first referral Hospital. Primary Health Care is defined as the basic curative, preventive and promotional health care services available, accessible, affordable and acceptable for all.(1.) The DHS is the nucleus of a National Health System, as the family is the cell of society. Actually the ongoing health policy reforms foster decentralisation, concentrating the main responsibilities to the district health authorities. At this level we find most Church Health Institutions. The challenge is to better integrate them into the DHS by intensifying partnership between Government and Church-bound Services. Considering that about 40 percent of the health services in Sub Saharan Africa belong to the Churches, we realise the enormous potential integration of these NG-Institutions into the DHS have for an optimal overall efficiency of health services. The responsibility for integration lies in the hands of those in power. Since more than 30 years we of Medicus Mundi co-operate with more than 250 Church Hospitals. Sharing with you this experience, we witness important changes concerning “Health and Power at District Level”.
1. What do we mean by power?

We read in the introductory text for this conference that Power means *force joined to intelligence*. May I propose to add to this definition that *Power should be the capacity to generate consensus*. Consensus gives legitimacy to power.

2. Who has power?

According to law power is in the hand of the owner of an institution. Power is bound to responsibility and vice versa.

But, what is the LEGAL ENTITY of the institution? Who is the owner? Is it the Bishop, the Diocese, the Parish, a Congregation, a Church-bound Foundation or an Association? Does it belong to the legal entity of the Diocese or has it a SEPARATE LEGAL STATUS?

Most Church-bound hospitals lack a separate legal status. This may hamper transparency and be a cause for a difficult relationship with Governments as well as with Donor Institutions. A Church Hospital should have its own governing body, accountable to the owner but not subject to his arbitrary interference. There is a need for greater autonomy and self governance within the different structures and entities of a diocese. It is necessary to clearly define what kind of responsibilities and competences are delegated to them.

An intelligent owner knows that despite having power and responsibility, he is not the only one to determine affairs. He will have to rely on all those who perform the services. Those in charge must be competent in their field, be it the doctors, the different health workers or the administrator. They all have authority and decision making power, always within the limits of the overall interests of the institution as defined in Mission- and Policy Statements. An owner will also know that those who procure the money, be it the Government, the users or donors, that they give money usually under specific conditions.

3. What norms and factors determine power?

1. The VISION OF THE CHURCH FOR ITS ENGAGEMENT FOR HEALTH:

At global level the vision of the healing ministry (2.) is given by Christ himself as described in the Gospel, by the Churches’ tradition throughout the centuries and by its Magisterium. We all know the merit of this Pontificate for having for the first time in history created a specific Dicasterium by the Motu Proprio: “Dolentium Hominum”. This Dicasterium for Health Pastoral Care, among others, co-ordinates the work of International Catholic Health Associations, such as the International Federation of Catholic Health Care Institutions. This Federation, last year, has given new directives for the future work. It strongly recommends to stand up against the new tendencies of mercantilism in the world of health, to defend the Not for Profit policy for the benefit of all parts of society, to reinforce the position of Church-bound
Institutions by optimal co-ordination among themselves and to support initiatives for a better partnership with Governments.

The Vatican has given full support to an initiative launched by Medicus Mundi International promoting in the World Health Assembly a resolution in favour of: “Contracting NGO’s for Health” or in other words: “Strengthening Health Service Delivery by Improving Partnership between Public and Private Health Care Providers”. (3.)

At local level some Episcopal Conferences together with Catholic Lay Health Professionals have elaborated MISSION STATEMENTS as well as POLICY STATEMENTS. Excellent examples are the statements recently approved in Uganda. (4.) All the bishops of the country, the Catholic Medical Bureau in Kampala, the Nuncio and many experts have worked on it. The different power structures are described, such as the authority and competence of the owner, the role of the board of governors, the administration and the medical staff. These statements are aligned to the specific country realities, they consider the ongoing health-sector-reforms and they are aware of the consequences the paradigm-shift Alma Ata brought into the world of health. In 1978 the Alma Ata Declaration on PHC and in 1987 the Harare Conference defining the District Health System have changed the Churches’ traditional engagement for the sick. This engagement is now widened towards health promotion, towards the defence of life and the protection of human dignity. Strategies such as PHC and Prevention have become essential. The slogan: “Health for All and Health for the Whole Man” has become a new vision which corresponds widely to the strategies of the World Health Organisation, as confirmed in the Rome-meeting in 1997 when discussions were held on: “Church and Health in the World, Expectations and Hopes on the Threshold of the Year 2000”. (5.)

According to the mentioned global and national vision of the Churches role for health, a bishop should be encouraged to formulate a DIOCESAN HEALTH CONCEPT and procure a Diocesan Health Committee out of which he can delegate representatives to the Government Health Committees at district level. Government representatives on the other hand should be invited into the boards of the Church Services, institutionalising a well structured partnership.

II. The POLICY OF THE NATIONAL CO-ORDINATING AGENCIES OF CHURCH-RELATED HEALTH SERVICES.

At national level the Church should have one voice. The power of the different hospital owners should be channelled through these national bodies and the Church Health Services should be co-ordinated with clear mandates in those already existing CATHOLIC OR CHRISTIAN MEDICAL BUREAUS
These Co-ordinating Agencies should foster ecumenical and inter-religious co-operation to increase negotiating power in dealing with Government. A strong position may even help in giving a contribution to formulating national health policy.

Health Institutions should only be recognised as CHURCH BOUND on the base of their faithfulness to the Mission- and Policy-Statements and not on the mere grounds of legal ownership by the church. (6.)

III. The Institution needs a CONCEPT FOR A HEALTH PASTORAL which is aware of the paradigm-shift from the former pastoral for the sick towards the broader one for health, for health promotion, a pastoral also for the health workers, a pastoral actively educating the single and the community, promoting their responsibility for health and fighting mere consumism. (7.)

IV. Church bound Institutions have to be inspired by a specific CHRISTIAN CHARISM. Every man should be called by his name in the way Christ is calling us by our name. Charisma is not a matter of stereotype friendliness, it is above all love, compassion and respect, love combined with hope and faith being the most important healing factor. The dignity of every man has to be at the centre of our interest, humanism has to dominate technology and science. (8.) Those in power set standards by their own attitudes

V. The Institution is bound to ETHICAL STANDARDS. It should have its own Ethical Committee for matters such as the option for the poor, non-discrimination, equity, accessibility, keeping up solidarity, mercy and empathy with the needy.

VI. The Institution is bound to HUMAN RIGHTS
The Declaration of the Universal Human Rights have been formulated in the year 1948. The declaration of Alma Ata, 30 years later, indicates the PHC-concept as an important strategy to reach the right for health. Nevertheless in the declaration of human rights some conflicts are inborn: - demands and needs can be controversial, - scientifically sound principals may socially not be acceptable, - individual interests and community necessities can be antagonists. The rights of society may precede individual rights. There is a hierarchy of values. Even knowing that every human being has the right for security, for respect of its dignity and the right for health, we have to acknowledge that each one of these elements depends on human solidarity and therefore economical, cultural and political interests of society have to be protected. (9)
Every country is faced with the problem of money allocation, with the problem on how much to spend for health and how much at what level.

An Institution may be confronted with the troubling question: “Who has to die when the means do not allow the survival of all and no one wants to die”? “How can one decide upon priorities within a particular health care system”? “Does the right for health and the intention to heal allow to neglect our obligation towards God’s creation”? Progress in medical research provokes many bio-ethical questions. Human rights are deeply bound to ethical values and faith. is confronted with daily reality. Even trying to take decisions by interdisciplinary discussions, setting ethical standards does not mean to procure acceptance for every feasible new trend. Very delicate discussions are going on and limits, especially in the field of reproductive health, have to be pronounced.(10.)

VII. Most Private Not For Profit Health Institutions have a public function and should be integrative part of the NATIONAL HEALTH POLICY. They have to adapt their policy according to Governments legislation, its standard-setting and its basic criteria for employment of personnel. Criteria for equipment, teaching aims, service delivery, transports, supervision, monitoring and money allocation have to be defined.

Transparency and accountability are the main prerogatives for mutual trust. An institutionalised dialogue between Government and the Privates is necessary. The improvement of Partnership between the two requires a process where step by step one comes to common agreements and memoranda of understanding and finally to legal contracts. Once the World Health Assembly has agreed upon the above mentioned Resolution on: “Strengthening Health Service Delivery by Partnership with NGO-health Care Providers” or: “Contracting NGO’s for Health”, this process will be accelerated for the benefit of a better integration of NGO Health Services into the District Health System.(3.)

VIII. The Institution has to observe MEDICAL PROFESSIONAL DIRECTIVES, such as decisions concerning priority-setting or defining the type of health care. Discussions about optimising care, quality-assurance and rationalisation of services are professional matters. Clerical interference should be avoided. A Jesuit once spoke about the danger of consecrated incompetence.

IX. The institution is bound to SOCIAL OBLIGATIONS towards all those working in a hospital. Besides economic aspects, the health workers expect career-planning, professional ethics and the satisfaction gained by doing a good job. This helps to avoid brain drain, corruption and demotivation. (11)
X. FINANCIAL CONSTRAINTS:

First of all, the concept of « Not for Profit » has to be defined. It means that although a Non Governmental Health Care Institution aims at a balanced budget, no alien gain is sought. Contributors to a balanced budget are on the one side Government, Users and Donors, on the other hand strict control over spending is just as important, optimal management and administration is required. (12.)

The Institution needs money for investments, maintenance and the running costs including the costs for ongoing training and for capacity building for reforms. Governments' contribution may vary from country to country. The fact is that Government has the responsibility to guarantee the delivery of health services. Due to structural reforms imposed by the World Bank and by the International Monetary Fund many subsidies have been dramatically reduced. For the sake of fairness criteria for money-allocation have to be re-discussed for those private institutions recognised and accredited as Not for Profit and of Public Interest.

The users contribute by their fees. These are fixed either by the political authorities or by agreements between the Institutions and the population. Sometimes fees are established by Institutions only.

Balancing budgets by increasing fees often causes a reduction of the utilisation of the services and can lead to the critical point of collapse.

Therefore, before fees are increased one has to define the average basic package of health care to be given and then to analyse the real cost-factors. Without evidence based information it is impossible to fix realistic fees. In many places one knows at the end of a year the overall cost of care. That, however, is of limited use. In a study made in Zimbabwe Medicus Mundi Belgium together with the Ministry of Health and Child Welfare and the Institute of Tropical Medicine, Antwerp, (13.) showed how to provide further data: What are the cost data per facility level? What percent of the total health cost goes to the District Hospital and how much to the Dispensaries? How much is spent in the different departments of a hospital? How much is spent for the different compartments of a hospital? How much is spent for the different components of disease specific groups? (malaria - or HIV-patients) Are the consumables used at their best? Who is employed and what is the average salary per hour of work? One can also measure and compare how much time staff members need to deliver one unit of service. Is the staff efficiently deployed and sufficiently motivated? Is the institution, compared with similar private health services or with public services competitive? For this purpose MMI published together with WHO Guidelines for Hospital Reports (14.), an instrument which allows to compare the efficiency between different institutions and which helps to analyse the hospitals impact on the improvement of the health status of a given population. These are just some practical examples on how in a
differentiated way one can calculate the proper costs and accordingly fix fees or correct eventual mismanagement.

Proper bookkeeping, transparent financial reports, clear plans for managerial operation are needed as well as the advice by health economists.

More money not always gives better results. A few years ago studies have demonstrated that poor institutions may even have better performances than richer ones. (15) Kerala, with a very low income per capita, shows an infant mortality of only 31 per thousand life birth. This is forty percent lower than in Punjab which has twice the income of Kerala.

**Balancing budgets** by creating departments for private patients is another possibility. There are examples where fees for special hotel-like services allow some gain and the mix of “Private for Profit” with “Private Not for Profit” may compensate deficits.

**Balancing budgets** by collective solidarity introducing insurance systems, as has happened in more advanced countries, may help to reduce individual hardship. Insurance systems can be started by civil initiatives on a small local scale, or on a large scale by Government. (16)

XI. Institutions should ensure the PARTICIPATION OF COMMUNITIES’ REPRESENTATIVES in the governing structures and programs. In the understanding that women are a key actor in the promotion of health, particular attention to a balanced participation of women and men in the governing structures of Church health institutions should be offered to secure the formulation of gender sensitive policies.

XII. Up to now many DONOR GOVERNMENTS invested their aid directly through NGO’s. Many DONOR AGENCIES and INTERNATIONAL ORGANISATIONS, apart their own money-raising-campaigns, depend on money they administer on behalf of their Governments. We are witnessing a change of policy. The so called Sector-Wide Approach diverts foreign Governments Aid directly into an overall basket administered by the Central Government, unless the Private Institution and the local Government have come to clear contracts. Institutions must know that such contracts may be the condition for further direct payment by Donor Countries through NGO’s.

The help of DONOR AGENCIES and INTERNATIONAL ORGANISATIONS will greatly depend on whether administrative efficiency and reliability exist. In many cases sustainability may better be reached by offering help in terms of administrative assistance, instead of offering money. The International Federation of Catholic Health Care Institutions (AISAC), in its working-program 2000, therefore has decided to offer training facilities for administrators and health economists in order to strengthen capacities. Health Economists should be placed within National Co-ordinating Agencies and serve as experts to the single
NGO-Hospital. DONOR AGENCIES and INTERNATIONAL ORGANISATIONS not only offer partnership and advocacy. Due to their development work and partnership with other private Institutions, be it within the same country or in different geographical regions, they can share experiences and offer advice so as to avoid mistakes or indicate successful strategies.

4. Instruments of power.
Command, force, fight, punishment and sanctions have often been connected with power. We have to consider that forcing the truth by authority the stronger ones, not the intelligent ones are favoured. Using power by command and force is disruptive and destructive. Another approach may be the dispute, a dispute where convincing each other is the prerogative. It’s what Jürgen Habermas describes as: “Herrschaftsfreier Diskurs”, a dispute free of command. It is a dispute where Information has to flow two ways. Free Dialogue has to replace blind obedience. Decisions have to be taken bottom up and top down and need consensus. Team dynamics ensure creativity. Participatory methods optimise motivation and improve efficiency. Every training should include the teaching on how to reach consensus.

Clear job-descriptions and attribution of responsibilities stimulate initiatives. Well defined targets facilitate the introduction of a monitoring system which allows corrections and improvement of the performance. Incentives for good accomplishments will keep engagement alive.

It has to be avoided that the institution becomes an autonomous workshop for one or the other stakeholder. I may cite a Medical Mission Sister who 25 year ago in a COR UNUM workshop said: “If we want the Health Institution become devoted to the health of many, the first and essential thing is a change in mental attitude on the part of:

1. the doctors who see the hospital as “their” workshop.
2. the nurses who want to use their training only for personal gain.
3. the sick and their relatives who demand the doctors personal attention for all kind of minor illnesses.
4. the hierarchy and religious, who insist on the “most modern and best” in services regardless the cost, instead of being content with giving good simple service.
5. the administration of the hospital who wants to keep up with the neighbours in the scramble for the latest in equipment and drugs.

Attitudinal change may still be necessary nowadays.
Assuming responsibility and using power by respecting the above mentioned norms is quite an effort. Only in such a way an owner will become a real servant for the well being of individuals and society. The proper understanding of power, the sharing and
intelligent channelling of power are part of a modern process which includes also
democratic control (by the church community, diocesan health boards or district authority)
over the use of power. There is great hope that in such a way optimal health care
services and efficient District Health Systems can be reached.

The world community has never before been aware of such an apocalyptic dimension of
health crisis as we are today. Therefore since the beginning of the new millennium, the
European Union, UN-agencies and the G-8 currently are disputing a dozen international
initiatives, such as the UN fight against poverty, the WHO fight against AIDS, TBC and
Malaria and the right for cheaper drugs. But the first and foremost obligation is to
ensure access to adequate health care as a basic human right and as a crucial
element in the fight against poverty and underdevelopment. Free drugs alone, without
solid medical structures, will not be sufficient for antiretroviral treatment (ART) of
AIDS The universal strategy for tuberculosis control, the so called “Directly Observed
Treatment Short-Course” (DOTS) needs “observers”. WHO’s Roll Back Malaria (RBM)
programme calls first of all for strengthening the health care services. (17)

Once more therefore we have to confirm, that the Church using its power properly,
and strengthening its service for the improvement of the District Health System
Church Health Institutions can play a crucial role for the improvement of health, and
that is what I wanted to share with you.

7 VI. Profit versus not for profit.
Highlights of the celebration of 275 years of Catholic social services,
Chicago

August 1-6, 2002
(cf. MMI Newsletter Nr 69, 2002)

Catholic Charities and the Catholic Health Association of the US had joined for the first time
in a meeting discussing: “Accessible and affordable care for all in a just health care system”
and “Development of value-based principles for transforming the delivery of health care to
best meet the needs and changing demographics of persons and communities”. The two
great organisations established plans for common actions where social engagement and
health promotion should be strengthened.
In the opening address Dorret Lyttle Bird, the Executive Director for Overseas Operations of
the Catholic Relief Services claimed that “the war on terror should include a war on poverty”,
because terrorism is a result of impoverished and disenfranchised cultures. Compassion
should reach not only the afflicted of terrorist attacks, but also the hungry, the sick and uneducated multitudes all over the globe.

Fr. Michael Place, the president of the Catholic Health Association, and Chairman of the International Federation of Catholic Health Institutions, drafted a short history of the specific engagement of the Church. Concomitant with the American commitment to individual responsibility, the Church insists that some situations call for collective responsibility in addition to individual responsibility. At times that responsibility which might be called solidarity, was best exercised by private/charitable entities. History shows that their performance was optimised when partnership with government could be reached. The late Cardinal Joseph Bernardin in 1995 had to intervene, when business corporations increasingly, under the flag of globalisation, considered health services as a commodity, by which shareholders should reach maximum profit. In an address to the Harvard Business School Club of Chicago he spoke under the title “Making the Case for Not-For-Profit Healthcare”. He argued that the provision of health care is a “social good” and most appropriately provided in the voluntary sector. According to him, healthcare – like the family, education, and social services- is special. It is fundamentally different from most other goods, because it is essential to human dignity and the character of the communities. It is one of those goods which by their nature are not and can not be mere commodities.

Given this special status, the primary end or essential purpose of medical care delivery should be a cured patient, a comforted patient, and a healthier community, not to earn a profit or a return on capital for shareholders. Bernardin considered not only the commercialisation of health care as a danger for accessibility and affordability. The unlimited demand, no matter how effective or how expensive a treatment or drug may be, should be put under control by discussions on what can reasonably be expected to be covered by insurances without excluding part of the population due to uncovered budgets. Bernardin said:" It is proper for society to establish limits on what it can reasonably provide in one area of the commonweal so that it can address other legitimate responsibilities to the community. But in establishing such limits, the inalienable life and dignity of every person, in particular the vulnerable, must be protected."

The Chicago-congress confirmed the belief that as a social good, the promise of health care, is fundamental to human dignity. And as not-for-profits they understand this as part of their role in improving the human condition. The convening organisations formulated the following action plan:

1. Taking a leadership role in the communities.
2. Responding to the needs of the poor and vulnerable and urging others to do so as well.
3. Identifying unmet needs and working with others to meet these needs.
4. Advocating, both locally and globally, just and equitable health care policies that will lead to improved health for all.
5. Attending to the future of health care by preparing human resources and leading health delivery research

Excerpt from the congress-communications by E. Wid.

7 /VII. Advocating versus administering health services,

a correspondence

To His Eminence
Mons. Wilfried Cardinal Nappier
c/o Fastenopfer der Schweizer Katholiken, Luzern

His Eminence

Yesterday I listened with great interest to your statements given at the Swiss Television and I wish to express my admiration for what You and the Churches have reached in the defence of Human Rights and Peace not only for South Africa but for the whole continent of Africa...You spoke about the Church’s engagement in advocating the right for health. You mentioned that the Government has the task to offer equal health services for all and that the former engagement of the Church in building up its own health institutions is now more or less replaced by advocacy. That’s how I understood your statement. Are Your really proposing a shift in the Church’s health policy? And if, is this only meant for South Africa?

I know that the financial situation of some Church health institutions might be critical and that their future existence might be in danger. That is the reason why Medicus Mundi has launched an initiative to propagate “Contracting” in order to give the Church the chance to continue with its healing ministry

Medicus Mundi (MM) is an international organisation for cooperation in health care. Since exactly forty years it has been engaged in partnerships with Ministries of Health and with Church-bound institutions in more than 60 Developing Countries.

A main focus are the countries South of the Sahel and it concentrates its activities on NGO’s working at district level as not for profit institutions and having to fulfil a public purpose. It considers the co-ordination of their work as a main challenge, in order to reach an institutional exchange and partnership with Government. We are convinced that
“Contracting” will be a process by which Church bound hospitals can survive and remain an important factor in the healing ministry of the Church.

Those who are responsible for private health institutions, i.e. the owners, mostly church leaders, should be prepared for their task. The seminaries should offer modules on the teaching of health pastoral care, the bishop’s conferences should clearly define the healing ministry of the church and be aware of the ongoing paradigm changes in the field of health. Every diocese would need professional councillors, in order to better promote motivation and competence of its health workers and employ them in the best possible way.

Such councillors should be able to work in a team (Health Committee), they should be able to develop a vision and strategy to reach the vision. They need relational training in order to be able to create consensus on an overall policy among all the stakeholders.

Important is the strengthening of national co-ordinating offices of church related health institutions. They must be given clear mandates and competences.

Those in charge need specific training for partnership-dialogue, policy-dialogue and communication. They need to be trained as stewards for health economy, for contract design and good governance. The co-ordinating office should become the starting point for intelligence gathering, for creating alliances and for formulating policies. The better those in charge are trained, the better their voice will be heard in defence of the Church’s vision of its healing mission. Advocacy alone, without continuing responsibility for health services, giving the proof of good governance and real Christian service, risks not to be credible.

That is the reason why I ask Your attention for our initiative concerning “Contracting” as alternative to ones only engaging in advocating.

Those who work for Development very seldom get the floor at television. I fear that the engagement of many of my colleagues might be discouraged in hearing that the running of private hospitals is no longer part of Church policy. May be You find the time to clarify Your position in this matter.

May I add two documents which give further information on what “Contracting” means.

With my best wishes and respectful greetings

Thalwil , March 24th 2003                      Yours

Dr. Edgar Widmer

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Dear Dr. Widmer

May 14th 2003
I have only just found the time to review the file on my recent visit to Switzerland at the invitation of Fastenopfer der Schweizer. So I take the opportunity to explain the context and the deeper meaning of my statement about the Church’s actual and potential role in the provision of healthcare in our country.

First of all, I was so much stating a policy as an historical fact. The Church has for a number of reasons been compelled to surrender hospitals and clinics that were once pioneering ventures in the deep rural areas, among them the following:

a) Lack of personnel. Many Sister’s Congregations have lost members and have not been able to replace them in the numbers required.

b) A hostile state that saw the Church’s role in healthcare and education as a threat and so by various means including reduction of subsidies, has forced the Church to give up control of one hospital after the other;

c) Lack of finances. With the dwindling number of Sisters’, hospitals and clinics have been forced to employ more and more laypersons. This has resulted in an astronomical rise in costs, way beyond the reach of the local Church.

d) Lastly, and in this there is an element of policy. Since we now have a democratically elected government, which is also committed to taking care of the needs of all its people but especially the poor and vulnerable, the Church has recognised the need for lobbying and advocacy to ensure that the people receive what they are entitled to by right and in justice.

It is in this light that the Church is lobbying much more vigorously for people, who have an need and right to good healthcare, to receive their just deserts from the state hospitals and clinics, from state welfare offices, and from state schools.

The number of private healthcare institutions in the hands of the Church in South Africa is so insignificant, even if the service they give by far surpasses that of state institutions, that advocacy and lobbying are a much more effective tool for getting better healthcare to a larger number of people.

This past weekend of 9-12th May, I had the opportunity of speaking to the Medical Superintendent of the only Catholic Hospital still in the hands of the Church in KwaZulu Natal, namely St. Mary’s Marianhill. I told him about your concern and especially about your statement that organisations such as “Medicus Mundi” were founded and remained committed to making financial resources available to places like St. Mary’s that are struggling to survive even with limited state assistance.
Dr. Ross was greatly interested in this information. I gave him your contact details, so that he can enter into communication with you about the needs of St. Mary’s.

On this last point, it is precisely because St. Mary’s is so well managed that we have a strong case for advocating that state institutions be equally well run. Even if that were not the case, the Church has an unenviable record with government for running and managing its projects with efficiency, transparency and honesty. So I do not think government would have grounds to question our credibility when we lobby for better services.

Trusting that this will help you to understand the situation in South Africa in general and KwaZulu Natal in particular

Sincerely yours in Christ

+ Wilfried Cardinal Napier OFM
ARCHBISHOP OF DURBAN

8. Promotion of „Contracting“
A framework for activities of MMI and its member-organisations
( Cf. MMI Newsletter Nr. 69, 2002)

The scope in drawing up contractual relations is broad. It serves to make the best use of the available resources in view of - the ongoing health sector reforms including privatisation
- the sector wide approach (SWAp)
- the implementation of the national health policy, especially the district health concept

I. A potentially large diversity of contractual arrangements can be identified. Prerequisite for contracting is the clear definition of the policy of each partner involved. In a participative process among equals, the common policy of the partners has to be developed. Once this is reached it becomes governments’ policy. Once the contract between partners is reached it becomes the tool to implement this policy.

- There are contracts between employer and employees within a specific health structure. Kenya f.i. is making first experiments in contracting liberal specialists for work in governmental hospitals and on the other side allowing dual employment, which means governmental employees are allowed part time private practice.
- **One off contracts** exist for construction of health facilities, for their equipment or for the procurement of drugs. These are not durable contracts.

- **Contracting ancillary services**, such as outsourcing laundry, cleaning and catering, is experienced in some big towns.

- **Contracts between Governments and International Donor Agencies or International NGOs** concern often vertical programmes. Sometimes they risk not to be integrative part of the existing health services

- **Contracts** may be used as a tool to improve performances and should also be applied between governmental purchaser and provider.

- **Contracts between Government and private Institutions** are the main focus in our ongoing discussions. A prerequisite for contractual partnership are the criteria for accreditation. Governments will have to distinguish between:

  - **Private for profit** and
  - **Private not for profit with public purpose**

**II. The main partners of Medicus Mundi are the local Non Governmental Health Institutions, which are not for profit and have a public purpose.** Most of them are at district level, a great number are church-bound.

**What do they need in view of “Contracting”?**

First of all the owners of these institutions must understand the paradigm changes due to the growing process of globalisation, of democratisation and decentralisation.

The NGO-leaders have to reach consensus on a common policy, install co-ordination among themselves and build up or reinforce structural co-operation with the governmental counterpart, knowing that all this is a learning process, both sides being aware that “there is no equity without the private provider, nor without the state” (Dr. Janclos, WHO, Addis Abeba). In many countries the already existing partnership is proceeding towards “Contracting”.

**What was the role of Medicus Mundi in this process?**

Let us have a look back into the past years,. May I just mention some highlights:

1. In 1984 MMI together with the Christian Medical Commission of the World Council of Churches organised an international seminar on strengthening co-ordination of health activities by local NGOs towards Health for All. Representatives of MOH and the Co-ordinators of local NGOs of more than 17 African countries as well as WHO were present. The seminar confirmed the consensus that NGOs and governments should move from simple collaboration and exchange of information to true agreements on common action at all levels, national, regional and local and that implementation of PHC needed urgently such an approach.
2. In 1985, in Dodoma, Tanzania, a **Churches Consultation on PHC** was held uniting the owners, administrators and doctors in charge of all church hospitals of the country together with the MOH and several International Donors and NGOs. More than 20 MM-Doctors took part. **As a consequence of this meeting MMI sponsored some subsequent regional seminars and financed the training of 3 doctors in international public health courses in view of their future engagement in the Christian Social Services Commission (CSSC) of Tanzania. (Dr. Matamora, Dr. Haule in the Antwerp school and Dr. Nangawe in the Amsterdam course.)** During the following years, up to now, Co-ordinating Agencies of Church related Health Services have been supported by Medicus Mundi Branches,

3. In the **WHA 1985**, by initiative of MMI and some other NGOs, the Technical Discussions dealt with **the importance of the NGOs contribution for the implementation of PHC in a national health policy.** MMI was given the presidency for some of the meetings.

4. Meanwhile the **World Bank** speaking of a “Better Health for Africa” (1992) recognised International NGOs, inviting them as “development partners” 1998 to a meeting in Dakar, discussing the **“Contractual Approach as a Tool for the Implementation of National Health Policies in African Countries”**. Medicus Mundi International, i.e. Prof. H. van Balen, was given the honour to preside the discussions. In this meeting, the large local not for profit NGO community and their Co-ordinating offices, was not present not having been officially recognised by the organiser. MMI insisted that these NGOs be integrated in the process of “Contracting” because of their potentiality for assuring better coverage of essential health needs of entire populations, and because of their shown capacity, commitment and sustainability, offering in some countries up to 40% of the health services.

5. In 1999 MMI had the possibility to organise a **Technical Meeting** on “Contracting NGOs for Health” with assistance of WHO during the **World Health Assembly (WHA)**, as well as to submit a statement to the plenary meeting itself. (see Newsletter MMI Summer 1999)

6. At the end of 1999 MMI held, with the help of MEMISA, two **Partner-Consultations in Africa**; the one in **Conakry** for some 6 Francophone countries, the other in **Dar es Salaam** for 7 Anglophone countries. Involved were the respective Governments, the local NGOs and WHO representatives. A draft resolution for the WHO on “Contracting” has been revised and some first experiences in contracting were shared. (see Newsletter MMI Winter 1999)

7. Finally in the year 2000 the Government of Chad in close contact with MMI came up with the draft for a WHO Resolution entitled: **“Improving HFA, at district level, by formalizing Partnership with Non Governmental Institutions with a Public Purpose”**
8. At the end of the year 2000, at the occasion of Memisa’s 75 years jubilee considering that Church leaders as owners of so many Hospitals have the ultimate say, a Working Congress was organised in Soesterberg, the Netherlands, on the theme: “The church and its involvement with health: The healing ministry”. Bishops responsible for health matters within the Episcopal Conferences of eleven countries, their health secretaries and representatives from Cordaid/Memisa, Cafod, Misereor and Medicus Mundi International as well as various experts attended the work.


10. On October 2001 the Belgian Government and the Antwerp Institute of Tropical Medicine came up with a call for “Health Care for All”. About 12 participants have or had straight links with MM. Another 30 participants had formerly gone through the Internat. Course at the Tropical Institute, which formerly had been directed by “our” Prof van Balen.

A Conclusion of this Congress was, that without consolidating the medical structures the fight against poverty and the universal strategy against AIDS, Tuberculosis and Malaria will fail. Our ongoing promotion of the District Health System by the tool of “Contracting” has fully been confirmed.

11. On November 2001, in the Vatican an International Conference organised by the Pontifical Council for Health Pastoral Care in the Vatican, dealt with: ”Health and Power, norms determining the power of a private owner of a health Institution”. MMI has been given the possibility to illustrate the immense potential church health institutions have, in order to strengthen the District Health System. The Annuarium Statisticum Ecclesiae reports for the year 1998 that in Africa alone the Church is responsible for more than 800 hospitals and some 4000 dispensaries.

12. In November 2001 the WHO organised an Inter Country Meeting in Addis Abeba offering discussions on: “Lessons from health sector experiences in contracting in Africa”. (The local organiser himself, Dr. Janclos of WHO-Ethiopia, is a former MM-Doctor) Seven countries were involved, Government representatives and the NGO side as well as an MMI representative.

13. In the WHO Executive Board Meeting on January 2002 the final text of the Draft Resolution was presented under the title: “The role of contractual arrangements in improving health systems performance”, the WHO-secretariat having reformulated the text according to the proposed
amendments of the EB meeting 2001. Apparently Dr. Brundtland, has been personally engaged in it.

The draft resolution has been adopted by the EB on January 18th 2002 at 5.30 p.m.
The World Health Assembly has adopted the resolution in the WHA in May 2003

14. Finally, in autumn 2003 MMI has published: "Guidelines for Contracting"

What do “our” local NGOs need on their way towards contracting ?

Medicus Mundi International as well as its branches or member organisation may be needed in the further process towards “Contracting”, not so much as donors, but as experts. During the Partner Consultations, especially during the Addis Abeba-Meeting, these needs have been expressed.

1. Very few owners of Non Governmental Health Institutions have a clear vision and most of them lack the formulation of a policy- or a strategy-statement based on consensus among the stakeholders. The Uganda Catholic Medical Bureau is the exception.

2. The Co-ordinating bodies need strengthening of their capacity, as concerns human resources, know-how, equipment and budgets. They need clear mandates by the owners of the private hospitals As these are mostly Church hospitals the Church leaders therefore have to be involved. Among bishops specific seminars have to be organised. Their dialogue with the professionals of the co-ordinating agencies has to be intensified.

3. National or regional training courses should be organised
   for “partnership” and “dialogue in policy”, in order to acquire skills for equal negotiations.
   for “contract design” for “health economy “ for “good governance”

4. All the NGO-stakeholders need more specific information and sharing of positive and negative experiences within their country and with the neighbouring countries. Electronic-communication. publications, teaching modules, scholarships are needed. Seminars and workshops have to be organised, dialogue between North and South as well as between South-South, Private and Public, experts and learners has to be promoted. Networking is absolutely necessary.

5. In the North MM has to play a role as advocate for the needs of local NGOs through its links with the European Governments, the EU, the WHO, the World Bank and other UN-Institutions.
   In such a way Medicus Mundi would rather act as an expert than as a donor. Not being associated as a donor, it might be easier to bring partners together and to develop tools which are accepted by all.

The board of MMI as well as the board of MM Switzerland having asked me to make some proposals for our future engagement in “Contracting”, you may take these notes as a frame for further deliberations. It seems to me that we as MMI or as national branches and associated members should continue our efforts on a line which perfectly fits into the philosophy of Medicus Mundi.
From the Vatican, May 10, 1999

Lettera inviata ai Vescovi Incaricati di Pastorale Sanitaria per l'iniziativa che promuove l'Organizzazione Medicus Mundi relativa ad una collaborazione delle ONG no-profit con gli Stati e le Istituzioni Internazionali (Lingua Inglese)

Prot. N. 26.035/99

Excellency:

in his letter dated 29 March 1999 (N.2381- CR/99), the Rt. Rev. Giuseppe Bertello, informed us of the initiative being promoted by the Medicus Mundi Organisation, in relation to a new form of collaboration of the non-profit making NGOs with States and International Institutes.

As you are well aware, a reflection has been going on among Non-governmental Organisations operating in the health sector, seeking both better ways of effecting their non-profit mission in favour of "health of all", and the appropriate ways and means through which the collaboration with other institutions and bodies could be rendered more efficacious. These institutions and bodies could be having different objectives, however, they do contribute to the improvement of people's health conditions through the promotion of a lasting integral development.

The Medicus Mundi proposal, taken from its expressive title "The Contract for Health" (Le contrat pour la Sante), aims at bringing about a deliberation between the Sates and NGOs, and also suggest a strategy that would lead to the international recognition of the non-profit-making NGOs, thus passing from mere collaboration and exchange of information, to real agreements for common action.

As Dr. Edgar Widmer, one of the protagonists of this initiative emphasised, "the importance of their role as partners for development has never been officially recognised, despite the fact that their action constitutes a considerable part of the network of national health services. Since by means of contracts one could cater better for the needs of an entire population, it would be more than logical to take into consideration also these private organisations, which have given proof of effective undertaking, capability and reliability in pioneer initiatives in favour of basic health services, while conforming to the objectives of the national health plan."

Besides, a clear allotment between the public and the non-governmental sectors no longer exists - apart from their institutional membership. In effect, many services are rendered by NGOs for the public good, at reasonable costs.

Accordingly, Medicus Mundi would like to propose a declaration to the World Council for Health, aimed at the reinstatement of NGO hospitals into the concept of health districts, through well defined contracts and agreements. Such a declaration ought to lead to a resolution of the WHO, which will be possible only if it is supported by member states.

I will therefore, be very grateful to you, if you could set up activity within the circles of your local church, aimed at helping many to become acquainted with the initiative in question, and also win their support for it.

With best regards,

Yours,

+Javier Lozano B.
9. MMI and the Vatican

Historical Review

In 1964 MMI took part in the Tübingen Consultation, organised by the WCC and the Lutheran World Federation which declared: Churches in all parts of the world, at local, regional and national level, must increasingly join together in surveys, study and planning for the most efficient and effective carrying out of the healing ministry.

In October 1973 Cor Unum, a Pontifical Council for the promotion of the human and Christian development, founded in 1971 organised a meeting to study the co-ordination of Catholic initiatives in the field of medicine and health. Out of the 12 participant experts three were connected with MMI: Mgr. Dossing, Sr. Jane Gates and Dr. Schwonzen.

In October 1974 the Pontifical Council for the Laity, by the request of the Secretary of State opened a registrar of International Organisations in relation with the Holy See. Medicus Mundi answered the questionnaire, despite the fact of not having a confessionnal tye. Thereupon the Pontifical Council for the Laity on 24th of February 1975 gave us the following statement by its president, Cardinal Maurice Roy: “Le Régistre permanent étant jusqu’à present destiné aux associations catholiques, nous avons pensé qu’il était préférable de vous inscrire sur notre liste des correspondants parmi lesquelles nous comptions les associations d’inspiration et actions chrétiennes ayant des rapports suivis avec le Conseil Pontifical des Laics» Ever since MMI had been invited. to take part in meetings of Cor Unum dealing with health and development, while in the field MM had partnerships with more than 250 church-bound hospitals.

A highlight was the Seminar MMI held in Rome in May 1984 on “Strengthening Co-ordination of Health Activities by local NGO’s towards Health for All

The meeting confirmed the importance

--of co-operation between NGO’s (Church) and Governments,
- of shifting from simple collaboration to true agreements

Minutes of a meeting of Mr. and Mrs Widmer of Medicus Mundi with the Pro President of the Office of the Pontificio Commissio de Apostolatu pro Valetudinis Administrantis (Pontifical Commission for the Apostolate of Health Care), Archbishop Mgr. Fiorenzo Angelini. . Rome, October 14th 1985

The aim of the meeting was to get known to each other personally. Mgr. Angelini, since 1955 is the delegate for religious assistance in the Hospitals, Universities and Clinics of Rome. He is the National Ecclesiastical Assistant for the association of Italian Catholic Physicians, the President of the nurses School at the St. Johns Hospital in Rome, member of the promotional,
organisational and executive committees of international congresses of catholic doctors (the last was held in October 1982)

Dr. Widmer presented the following Medicus Mundi-publications:
- "Health for All and Oikumene" by E. Widmer,
- “North South Dialogue and Health, Medicus Mundi 25 years in the Field” by Gabriel Arnaud
- MMI-Newsletter No 19/20, with the following contents:
  1. Informations on the International MMI Seminar on Strengthening the activities of the Co-ordinating Agencies of Church related Health Services, Rome 1984
  2. The Technical Discussions of WHA on Collaboration between Governments and NGO’s
  3. The Results of the Churches Consultation on PHC, Dodoma, Tanzania, 1985.

Mgr. Angelini gave us the text of the Motu Proprio: “Dolentium Hominum”, by which Pope John II had instituted eight months ago the new office.

It is a pitiful fact, that apparently Mgr. Angelini had not had yet any contacts with Cor Unum and therefore does not know in which way Medicus Mundi during the last 10 years actively contributed to its working sessions.

The Prior General of the Fatebenefratelli, Fra Marchesi, on the other hand, the day before our appointment had informed Mgr. Angelini about the MMI Conference jointly organised with the Fatebenefratelli and the World Council Of Churches one year ago, held on the Tiber Island.

I explained, that although not being church bound, MMI is rendering services to Health Institutions of the Church by sending doctors to mission hospitals.

At the moment a main challenge would be the implementation of the conclusions of the above mentioned International Rome Conference i.e. to strengthen the co-ordinating agencies of church related health services in the overall effort of promoting “Health for All” and “Health for the whole Man”.

Then we heard that the new Pontifical Council was trying to establish a registrar of all existing Health Facilities of the Catholic Church.

I suggested that the Guidelines for Hospital Reports formulated by MMI and used by WHO might be useful for the Church in order to get comparable information.

Mgr. Angelini announced a “First” World Congress of Catholic Hospitals, for the coming month of November. I informed him, that myself, together with the secretary general of MMI,
Mr. Peter Sleijffers had participated in the year 1969 in such a Congress organised by the International Federation of Catholic Hospitals. Mgr. Angelini apparently was not aware, that such congresses had already been organised in the past. I promised to send him the reports of these former meetings.

To Mgr. Angelini’s request, whether MMI could sponsor his new Pontifical Council, I tried to explain, that we could offer professional expertise and that we were not primarily a money raising body. Our main contribution for church institutions besides procuring human resources were: the promotion of PHC strategies, operational research, exchange of information, offering platforms for dialogue and eventually investing into capacity building of the above mentioned co-ordinating offices of church related health services, offices Mgr. Angelini up to this day had never heard of.

10. MMI activities fitting into the Action Plan of the Pontifical Council for Health Pastoral Care,
Possible contributions by Medicus Mundi
(cf. MMI Newsletter Nr. 69)

When in 1983, the Pontifical Council Cor Unum had invited some personalities to discuss, whether there exists any Pastoral for Health, Medicus Mundi International (MMI) was part of the workshop.

The way the question was formulated, indicated that the organisers were aware that after Alma Ata an important paradigm-shift had taken place. It meant that not the sick or the disease was at the centre of interest, but health, the promotion of health as well as the human right for health. Apart from health services the engagement for peace, justice and the maintenance of the surrounding nature became just as important as factors for health. To the definition of health as the physical-, mental-, and social-wellbeing, spiritual harmony was added as a further important element for health.

The Cor Unum workshop’s plea for the creation of a specific Health Dicasterium was followed in the year 1985 by the Motu Proprio “Dolentium Hominum”, by which Pope John Paul II seventeen years ago installed the new Pontifical Council for Health Pastoral Care.

The Church’s engagement for health, for the single sick person as well as for those who work in the health sector, was summarised in the Apostolic Constitution “Pastor Bonus”. Apostolic
letters, such as “Novo Millennio Ineunte” and “Salvifici Doloris” are part of the Magisterium guiding the Pontifical Council’s actions, which consist

- in spreading specific messages of the Church’s teaching
- in promoting the Healing Ministry by Sacraments, which lead to reconciliation with God, the community and oneself
- in co-ordinating the activities of the different International Catholic Health Associations and
- in promoting within the Bishops’ Conferences the understanding of their responsibility for health care.

The Holy Father, in his address to the Council at the occasion of the presentation of the new Action Plan, on May 2nd 2002, encouraged the meeting to persevere in the defence of human dignity and to insist on the value of human life. He stressed that it is necessary to open up for generous collaboration with all kinds of international health organisations in order to reach these aims.

The new Action Plan describes about 50 different fields of actions. In the following text we will pick up those which already found our interest in the past or might be shared by Medicus Mundi in the future. The number indicates the number given in the Council’s action plan.

1. Theology of Health
   This topic has interested MMI especially at the Bishops Working Conference on the Occasion of MEMISA’s 75 years Jubilee presenting a paper on “The Healing Ministry”.

2. Health Faculties and Bioethics
   The former board member of MMI, Francisco Abel SJ has been one of the main pioneers in bioethics.

3. Publications
   On several occasions MM papers published the Council’s messages

4. WHO
   In 1998, when the Council discussed about the co-operation of International Catholic Health Associations with WHO, MMI strongly recommended official relationship.
   - Launching a WHO-Resolution on “‘Improving Partnership between Governments and NGOs’ by contracts” MMI promoted an important instrument for the survival of many church-bound health institutions.
   - MMI encourages the Council to deepen its dialogue with WHO not only on moral and ethical issues, but also on development strategies and on professional matters.

7. Conferences
The Council and MMI invite each other. Several MMI meetings were important for the church:

- 1985, Rome, Int. Conf. of MMI on “The Role of Co-ordinating Agencies of Church-related Health Services”
- 1985, Geneva, WHO Technical Discussions on the Role of NGO’s
- 1986, Dodoma, Churches Consultation on PHC
- 2000/2001 Consultations in Dar es Salaam, Conacry and Addis Abeba on “Contracting”
- 2000, Padua, Participation of the Council’s president in the CUAMM 40 year’s jubilee.

8. The Councils’ International Conferences.

MMI regularly participates in these Conferences. MMI has contributed papers to the theme: “Health and Power” in 2001 with articles by B. Pastors and E. Widmer

9. Research

MMI has tight links to Tropical Institutes and shares jointly published results, especially on Health Systems Research.

11. Dossiers

The Council elaborates inputs from the periphery of the Church as well as from other institutions such as MMI. It had immediately dealt with the Draft-Resolution on Contracting, recommending to all the Bishop’s Conferences to give their support.

19. Doctors

A main task of MMI was the support of developing countries with doctors, to recruit and train them, as well as to promote human resources development in general.

20. Nurses

The promotion of local nursing staff has for long been an important MMI engagement.

21. Pharmacists


23. Religious

Several Congregations working in the health field have been affiliated with MMI (Medical Missionaries of Mary, Medical Mission Sisters, Fatebenefratelli)
25. Catholic Hospitals

MMI had partner-relations to about 250 church hospitals
- MMI participated in the AISAC -meetings (Int. Fed. of Cath. Hosp) on May and Nov. 2000
- MMI is elaborating an Action Plan on Human Resources Development which will be of interest for the Council

27. Bishops responsible for health

MMI and Cordaid offer support for workshops dealing with the churches solicitude for health
- the importance of the healing ministry
- the decisive role owners have as stewards of church health institutions
  - MMI tries to promote diocesan health co-ordination
  - MMI supports national co-ordinating agencies of church-bound health services

33. Human Rights and Health

In the year 1999 MM Italia (Brescia) organised a workshop in Caserta on:"La tutela della dignità́ della persona” in occasion of the 50th anniversary of the proclamation of the human right. The report has been published and distributed at the general assembly of the International Federation of Catholic Doctors in the year 2000.

42. Updating contacts

MMI promotes the Councils' contacts with the Co-ordinating Agencies of Church related Health Services, just to mention here the Uganda Catholic Medical Bureau or AMCES (Association des Oeuvres Médicales Privées Confessionnelles et Sociales au Bénin).

45. AIDS

An MMI expert participated in the Councils workshop on Aids (cf. MMI Newsletter Nr. 65)

47. Mental- Health

MMI organised in 1996 a workshop on mental health in Padua (MMI Newsletter Nr. 58)

**Final remarks**

The council’s working plan is rather oriented towards theological and ethical issues than towards mission policies. We don’t find any indication on the former Pope’s’ Encyclical “Populorum Progressio”, nor any hint at Ecumenism nor consciousness of the revolutionary paradigm shift after Alma Ata. Strange is the rather weak representation within the Council of the more than 250,000 lady- religious working in the health field. No mention is made concerning relations to Catholic Donor Agencies, such as Cordaid,
Misereor, Fastenopfer or Catholic Relief Service or others. All of them might need some common rethinking on the importance of investment in health in order to re-align to what World Bank and EU propagate in the fight against poverty, health being the main entry point in the fight against poverty.

Medicus Mundi’s philosophy of health promotion, its effort to promote “Contracting” and to find new ways of Human Resources Development will fit into joint actions with the Church, be it in the field or in continuous contacts with the Pontifical Council for Health Pastoral Care.

Dolentium Hominum No 53

There we can read:

I. "Each representative of the various countries spoke about the situation of Pastoral Care in Health in his own specific nation.

Bolivia: The number of poor and marginalised people is on the increase. The level of infant mortality is increasing.

Canada: ethical problems are a main issue

Dominican Republic: the main problem is the extreme poverty; drugs are not affordable

San Salvador: accuses high cost of medicines and grave shortage of food

Honduras: the population living on a dollar per day can not pay any therapy

Nicaragua and Porto Rico: great poverty, high cost of medicines and inadequate health services are the main problems.

United States: the Catholic health care structures are at risk because of secularisation.

II. The definition for health pastoral care
as given to the meeting in Washington by H. E. Mgr. Lozano::

"Pastoral Care in Health involves leading Christians to defeat death through the conversion of death into the resurrection of Christ"

III. The Bishops meeting on February 9th 2003 gave the following Conclusions:

besides the above definition for Pastoral Care in Health:
ethical responses to moral, social and political situations concerning health are needed
diaconia for the world of suffering and pain is needed
closer co-operation between bishops conferences is necessary:
global solidarity must be advocated.

A Comment:
Washington has not given any answer concerning the question on how Catholic Health Institutions can better survive.
(remember: 10% of the 3000 Catholic Health Institutions in India alone had to be closed in one year)
The intention of those who initiated the Kampala Conference was primarily to give some realistic proposals for this very urgent question,
- explaining to the bishops the importance of strengthening the national coordination of Church Health Work in order to strengthen their role in the contractual approach having at hand the specific WHO Resolution (EB109.R10.)
- recalling that four years ago H.E. Mgr. Lozano had officially encouraged all the Bishops Conferences to give their support to the cause of “Contracting”

12. Why is Medicus Mundi engaged in the Kampala Working Conference

MMI is not church-bound, but has many links with church health institutions. MMI offers partnership and professional co-operation in about 60 developing countries.

The planned working-conference in Kampala is in a way a follow up of the Soesterberg Meeting organised by MM Holland in October 2000 among Bishops responsible for health matters during MEMISA’s 75 Years Jubilee.

The promotion of “Health for All” and Primary Health Care, the fight against poverty and the engagement for justice are among MMI’s main activities

Due to globalisation and the increasing eagerness for profit Christian values, such as serving the sick and defending the marginalised may be in danger and Private Not for Profit (PNFP) Hospitals may not survive unless both the partners, the private and public health institutions find a way to strengthen collaboration and come to clear agreements.

Therefore MMI has tried to promote “Contracting” at different institutional and political levels
with the result that the resolution:
“The role of contractual arrangements in improving health system’s performance”
has been approved by the World Health Assembly of May 2003.

The Pontifical Council for Health Pastoral Care as well as the Representatives of local Bishop’s Conferences sustain the process towards “Contracting”

For this reason it is vital to strengthen the National Co-ordinating Offices of the PNFP Health Institutions

This means that the owners of private hospitals, very often Bishops, have to give clear mandates and competence so that these bureaus in the dialogue with Government have a strong and equal position.

Anglophone African Bishops will discuss these matters in a working conference planned for 2004 in Kampala

MMI together with the Uganda Catholic Medical Bureau will organise this meeting under the patronage of the Pontifical Council for Health Pastoral Care and with the help of the Associations of African Bishop’s Conferences.

The Hierarchy’s confidence in MMI has grown through the years due to intensive collaboration at different levels.

It’s a moral capital we consider just as important as the rest of our investment into this project

E. Widmer


Miguel Angel ARGAL, Spain, Pamplona, Dr. theol et phil, Board Member of MM Spain, President of MMI


Mgr. Pierre CHRISTOPHE, France, Apostolic Nunzio in Uganda, promoter and councillor of the Uganda Catholic Medical Bureau

Guus ESKENS, Netherlands, Pharmacist, Board-member of MMI, former Director of MEMISA, Co-director of Cordaid, the Dutch Branch of MMI.

Daniele GIUSTI, Italy, MD, as CUAMM-Doctor in Ugandan Mission Hospitals (CUAMM = Collegio Universitario Medici Missionari= associate Member of MMI) Brother of the Comboni Mission Society, Executive Secretary of the Uganda Catholic Medical Bureau.

Mgr. Javier LOZANO, Mexican, Archbishop, President of the Pontifical Council for Health Pastoral Care.
Mgr. Jean-Marie MPENDAWATU, R.D. Congo, Responsible for Africa in the Pontifical Council for Health Pastoral Care, observer of the Holy See at the WHO.
Tom PULS, Netherlands, MD. As MEMISA Doctor in African Countries. Africa Desk Cordaid, Stand-by in the board of MMI.

Edgar WIDMER, Switzerland, MD Board Member of MM Switzerland and MMI, Liaison Person to the Pontifical Council for Health Pastoral Care

14. Participant Bishop’s Conferences

IMBISA (Inter-Regional Meeting of Bishops of South Africa)
Botswana, Lesotho, Namibia, Rep. of South Africa, Swaziland, Zimbabwe

AECAWA (Association of Episcopal Conferences of Anglophone West Africa)
Gambia, Ghana, Liberia, Nigeria, Sierra Leone

AMECEA (Association of Member Episcopal Conferences in Eastern Africa)
Eritrea, Ethiopia, Kenya, Malati, Sudan, Tanzania, Zambia

15. Reader and Bibliography.

Reader and exhaustive bibliography with directly attainable texts under the following address

www.medicusmundi.org/Kampala2004.htm

16. Final Conference Programme
Kampala, March 22-24 2004

<table>
<thead>
<tr>
<th>March 21</th>
<th>Time</th>
<th>Speaker/agency</th>
<th>Subject</th>
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<tr>
<td></td>
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<td>Host: AMECEA endorsed by Medicus Mundi Internationalis</td>
<td>Welcome dinner, getting acquainted</td>
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<th>Time</th>
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<tr>
<td></td>
<td>7.15</td>
<td>Holy Mass presided over by HE Cardinal Lozano Barragan on the site of Martyrdom of St Andrew Kaggwa</td>
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<td></td>
<td>8.45</td>
<td>Breakfast</td>
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<td>9.30</td>
<td>AMECEA/Mgr. Bakyenga</td>
<td>Welcome</td>
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<tr>
<td>9.40</td>
<td>HE Cardinal Lozano Barragan</td>
<td>Keynote address from the President of the Pontifical Council for Health Pastoral Care – Cardinal Xavier Lozano Barragan: “The identity of Catholic Health Care Institutions”</td>
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<td>10.30</td>
<td>René Grotenhuis Cordaid Director general</td>
<td>Welcome address</td>
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<td>10.40 – 11.00</td>
<td><strong>Coffee break</strong></td>
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| 11.00 | Facilitator: Dr. W. Ogara | 1. Conference agenda, methods, logistical issues.  
2. Inventory of expectations, striking situations and problems encountered in various church provinces in relation to healing ministry |
| 12.00 | HE Mr. Sigurd Illing European Union | Role of local civil society (structures) in service provision and their (conditional?) access to multilateral donors |
| 12.20 | WHO (A.D.G., Dr. Timothy Evans asked) | Evolution of public-private partnership in fostering public interest in private healthcare. Implications of SWAPs, PRSP’s and WB grants for NGO’s involved in healthcare provision |
| 12.30-14.00 | **Lunch break** |                                                                         |
| 14.00 | Facilitator: dr. W. Ogara | Discussion to help understand the external challenges and combine them with those volunteered during morning discussion |
| 14.30 | Dr. Edgar Widmer Medicus Mundi International | Evolution of Churches role in public healthcare development in Africa  
Present status, results and achievements |
| 14.50 | Mr. Jos Dusseljee | Business Administrative consideration. Fostering financial, organisational and technical viability in harmony with the underlying mission |
| 15.15 | Dr. Dan Kaseje Tropical Institute for Community Health, Kisumu | Strategic organisational and administrative choices of churches in healthcare provision |
| 15.40-16.00 | **Tea break** |                                                                         |
| 16.00 | Facilitator: Dr. W. Ogara | Discussion on the key issues brought in by the afternoon speakers and taking stock of the SWOT of faith based health care organisations and the challenges to face |

From 18.30 to 21.30 p.m. OFFICIAL RECEPTION

**March 23**

Facilitator: Dr. W. Ogara and/or Dr. G. Buckle

<table>
<thead>
<tr>
<th>Time</th>
<th>Speaker/agency</th>
<th>Subject</th>
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</table>
| 8.00    | Mgr. Jean Marie Mpendawatu Pontifical Council for Health Pastoral Care | Morning prayer  
Considerations of Pontifical Council in relation to the choices to be made |
<p>| 8.20    | Facilitators | Summary day 1, plans for morning session |
| 8.50    | Dr. Daniele Giusti Uganda Catholic Medical Board | Global SWOT analysis of faith based healthcare as observed by (Catholic) coordinating agency: evolution of Uganda Catholic health network |
| 9.15    | Facilitators | Discussion to pinpoint key elements |
| 9.45-10.15 | <strong>Coffee break</strong> |                                                                         |
| 10.15   | Dr. Gilbert Buckle Ghana Catholic Secretariat | How to establish effective co-operation between public admin. and private health care providers |
| 10.40   | Facilitators | Discussion to pinpoint key elements |</p>
<table>
<thead>
<tr>
<th>Time</th>
<th>Session Leader</th>
<th>Topic</th>
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<tbody>
<tr>
<td>11.00</td>
<td>Mr. Johnston</td>
<td>How to establish effective co-operation between public admin. and private service providers</td>
</tr>
<tr>
<td>11.30</td>
<td>Facilitators</td>
<td>Discussion on key elements. Particular attention to the issues pertaining to eventual structural and administrative reform</td>
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<tr>
<td>12.30-14.00</td>
<td>Lunch break</td>
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<tr>
<td>14.00</td>
<td>WHO (A.D.G., Dr. Timothy Evans asked)</td>
<td>Contracting, accounting, quality standards, providing evidence of output, etc. Discussion on key elements and challenges of partnership and contractual approaches</td>
</tr>
<tr>
<td>14.30</td>
<td>Facilitators</td>
<td>Questions for and WHO</td>
</tr>
<tr>
<td>14.50</td>
<td>Mr. Doug Reeler</td>
<td>Reconciling proper identity with OD and ID, Public Interest provision and contextual change</td>
</tr>
<tr>
<td>1510</td>
<td>Facilitators</td>
<td>Summary discussion to compile key elements on needs for and type of organisational reform</td>
</tr>
<tr>
<td>15.30-16.00</td>
<td>Tea break</td>
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<tr>
<td>16.00-17.00</td>
<td>Facilitators</td>
<td>Discussion to take stock of the days inputs and ideas shared on possible and needed innovative approaches in faith based healthcare administration</td>
</tr>
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</table>
### March 24

Facilitator: Dr. W. Ogara and/or Dr. G. Buckle

<table>
<thead>
<tr>
<th>Time</th>
<th>Speaker/agency</th>
<th>Subject</th>
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<tbody>
<tr>
<td>8.00</td>
<td>President AMECEA</td>
<td>Morning Prayer Summarising impressions and expressing felt needs for support in specific fields to achieve optimal administration, governance and effectiveness of institutions and networks</td>
</tr>
<tr>
<td>9.15</td>
<td>Facilitators</td>
<td>Discussion for clarification of Soesterberg/Rotterdam statement Introduction group discussion</td>
</tr>
<tr>
<td>9.30</td>
<td><strong>Coffeebreak</strong></td>
<td></td>
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<tr>
<td>10.00-12.30</td>
<td>Group discussions</td>
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<tr>
<td>12.30-14.00</td>
<td><strong>Lunch break</strong></td>
<td></td>
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<tr>
<td>14.00</td>
<td>Facilitators</td>
<td>Discussion to summarise conclusions and recommendations</td>
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<tr>
<td>15.00-15.30</td>
<td><strong>Tea break</strong></td>
<td></td>
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<tr>
<td>15.30</td>
<td>Mgr. Mensah and dr. G. Giusti (Uganda Catholic Medical)</td>
<td>Draft statement and action plan. Appoint editorial committee to make final drafts</td>
</tr>
<tr>
<td>16.00</td>
<td>Medicus Mundi International</td>
<td>Discussion on proposals for further action/follow-up of the Kampala conference and taking stock of additional suggestions. Word of thanks to all contributors</td>
</tr>
<tr>
<td>16.15</td>
<td>Mgr. Mpendawatu</td>
<td>Final remarks Pontifical Council for Health Pastoral Care</td>
</tr>
<tr>
<td>16.30</td>
<td>Mgr. Bakyenga</td>
<td>Closing, prayer, invitation farewell dinner</td>
</tr>
</tbody>
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*Preparations have been made to celebrate Mass on 23rd and 24th at 6.30 a.m. at the Hotel*
History and Evolution
“The Healing Ministry of the Church at the dawn of the Third Millennium: Challenges and Opportunities in English speaking African Countries”.
Kampala 2004
by Edgar Widmer
Medicus Mundi International

The history of the healing ministry brings us back to Paul’s letter to the Corinthians (Co. 12:28) : “God has given the first place to apostles, the second to prophets, the third to teachers; after them, miracles, and after them the gift of healing; helpers, good leaders, those with many languages.”

We have to note that while Paul singles out prophecy and teaching as the noblest gifts, he does not envisage them in a hierarchical order but rather regards all the various ministries – working of miracles, healing, helping, administrating, speaking in tongues – as a loosely connected set that complement each other.

An apostle, according to St. Paul was to command the obedience of his community, giving witness to the resurrection of Jesus and preaching his teachings; but he had to exercise his authority in fellowship with all the other members of the community remaining in communion with the other apostles.

Ever since the Church has been involved in healing and helping. By considering the inter-relationship of body and soul, of individuals and community, the Church’s approach was always a holistic one. The whole of man should become holy and overcome the miseries of earthly life.

Important for Africa was the Encyclical “Maximum illud” of Benedict XV in the year 1921, which gave the initial start for medical-mission-work. I just mention here MEMISA (now part of CORDAID) and other institutions like the German Medical Mission Institute in Würzburg, the Catholic Medical Mission Board in New York, the Congregation of the Medical Mission Sisters, the Foundation Ad Lucem in France/Cameroon and the Swiss Medical Mission Doctors Society, now called SolidarMed. All these Institutions of Catholic inspiration joined the work of Medicus Mundi in one way or the other.
They all have been mainly involved with Human Resources Development, adapting their policy to new needs and 

promoting:

1 Health care development in harmony with the socio-economic context
2 Early local capacity building in order to make assistance redundant in a given case

By and large the organization and its members have abided by this approach. This analysis is endorsed by numerous observations of events and developments in which a leading role was played by MMI and its member network. To name a few examples of such network results:

- The development of standard treatment methods for most common diseases
- Development of standards for hospital and health centre designs and equipment
- Development of outreach programs for prevention and treatment in thinly populated areas
- Development of health education as the prime tool for preventive health and community health
- Development of the essential drug concept
- Development of standards for hospital and health centre reports to enhance proper Monitoring and Evaluation
- Initiation of (public health oriented and often ecumenical) National health care associations, coordinating private not for profit providers per region and per country
- Development of the PHC-strategy and presentations in Alma Ata
- Contributions to the formulation of the District health approach
- Drafting of the first resolution in the World Health Assembly on the integration of the private (not for profit) sector in National health policies and planning (1986)
- The identification of AIDS as a leading public health problem for developing countries
- The development of the concept of public Private Partnership as a strategy to achieve both, decentralization and access to health care for all., leading to the WHO resolution on “Contracting” WHA 2003)
- Publication in conjunction with WHO of “Guidelines for the contractual approach” as a first manual summarizing underlying philosophy and practical working strategies.
  Organization of a Bishop’s Meeting, discussing the “Healing Ministry”
  cf. .”Soesterberg Statement”

Quite recently, namely in 1983, the Pontifical Council Cor Unum convened a consultation on the question on how to define Health Pastoral Care. Its conclusions became the starter for the Motu Proprio: “Dolentium Hominum”, by which two years later the Pontifical Council for Health Pastoral Care was founded. The above mentioned consultation responded to the paradigm-shift from the pastoral for the sick to a pastoral promoting health, which corresponds to St. Matthew’s chapter 25 (31-37), projecting a clear image of a dynamic Church-community at the service of all, contributing to the “good life” for all.
In 1985 the Tanzania Churches Consultation on PHC said: “Reflecting the comprehensive call of the Gospel, the Churches impel a concern for all people, especially the poorest members of society, to enable and empower them to play a direct role in the promotion and preservation of their own health and affirm that a people oriented concern by the Churches closely coincides with the objectives and approach of PHC (as declared by WHO in Alma Ata, 1978)

A seminar organised by Medicus Mundi International (MMI) and the Christian Medical Commission (CMC) of the World Council of Churches, hosted by the Hospitaller Order of Saint John of God (Fatebenefratelli) in Rome, 1984 on „Strengthening Coordination of Health Activities by Local NGOs towards Health for All” assembled Coordinating Agencies of Church Related Health Services from 17 African countries as well as the corresponding Ministers of Health. This seminar confirmed the consensus on the desirability of coordination between NGOs and Governments and suggested that one should move from simple collaboration and exchange of information to true agreements on common action at all levels, national, regional and local and that implementation of PHC needed urgently such an approach. At that time the „District Health Concept“ had not been born yet. WHO defined the role of peripheral hospitals in their district only in the year 1987. (Harare Declaration)

Most Church-bound hospitals fulfil their role at district level. Most of them are health care providers with public purpose and have a clearly defined ethical attitude of not for profit. Due to globalisation and due to the increasing eagerness for profit, such Christian values as serving the sick and defending the marginalised risk to disappear. Joseph Cardinal Bernardin, addressed in the year 1995 the Harvard Business School Club of Chicago: “Making the Case for Not for Profit Healthcare” He argued that the provision of health care is a “social good” and as such essential to human dignity and part of human rights and therefore can not be a mere commodity. According to him it is most appropriately provided in the voluntary sector. The Church plays an eminent role in defending these principles.

But when the World Bank spoke of a Better Health for Africa (1992) and when the World Bank together with WHO invited „development partners“ to a meeting in Dakar in 1998 discussing „The Contractual Approach as a Tool for the Implementation of National Health Policies in African Countries“, the large not for profit NGO community, in which Church Institutions represent the most eminent part, was not included in the discussions. Their important role as development partners was not yet considered nor officially recognised, although they play a dominant role in many national health-service networks. Therefore MMI in 1999 had decided to give a statement to the World Health Assembly with the proposal to better integrate NGO hospitals into the District Health Concept by
well defined contracts and agreements. This statement was meant to promote the issue of a resolution by the WHO in order to promote public/private partnership. Such a resolution could only be reached when Member-States of WHO endorsed the subject. Therefore, in order to get the necessary support MMI had to contact on the one hand those European Governments which already had links with its European branches as well as the Governments of those countries in which MMI cooperates with local partners. The Holy See demonstrated an eminent interest in sustaining this initiative. In order to strengthen the many Church bound hospitals also the Pontifical Council for Health Pastoral Care encouraged the Bishops’ Conferences to be engaged in the process of “Contracting”.

You may know that throughout the world there are 5200 Catholic hospitals, 840 of them in Africa and furthermore the Church is responsible for 12’200 hospices and 17’200 health centres. AISAC (Associazione Internazionale Istituti Sanitari Cattolici), the International Association of Catholic Health Care Institutions in the aim of contributing to the policy of the global network of Catholic health-institutions wants to be participant in decisions concerning international health policy.

The Aims of AISAC have been drawn up in a meeting in May and November of the year 2000. It says the following:

By the fact of the growing interdependence and the increasing speed of changes due to the paradigm-shift after Alma Ata and due to structural reforms in the field of health care due to Globalisation, there was a felt need within the Catholic World to share responses to these new challenges. Health promotion and engagement for sustainable development are important issues as well as codes of conduct, based on human rights and ethical values.

While recognising Governments’ responsibility for formulating health policies and for organising health services, the civil society with the increasing move towards democracy, plays an ever important role in its realisation, church health institutions playing certainly an eminent role in civil society.

The Nobel Prize Amantya Sen on January 14th 2004, addressing the Inter-American Development Bank in Washington on the theme: “Re-analyzing the Relationship between Ethics and Development” said, that the advancing of the use of ethical thinking and normative behaviour in the cause of economic, social and political progress broadens the intellectual horizon of economists and other social scientists. But he says that there is a risk that some of them tend to presume that the hard work of development demands only canniness and
prudence – not ideals or commitments or morals. According to Amantya Sen progress of knowledge needs continued scrutiny, because the world of knowledge does not stay stationary. Interdisciplinary scrutiny is needed because every action has an influence also in neighbouring fields. Disciplinary and interdisciplinary scrutiny has to lead to further propositions, dealing particularly with uses, applications and extensions. People’s socialising values may get more easily formed and more fully translated into values if the system is democratic and responsive to the citizens’ opinions and priorities. An intelligent state as well as an intelligent leader therefore will consider persons not merely as beings whose needs have to be fulfilled or whose standards of living must be preserved. but as reasoning persons who think and value and decide and act. It also identifies the importance of public participation not just for its social effectiveness, but also for the value of that process in itself.

NGOs, and among them Church-bound Institutions, due to their specific charisma, should have the capacity for smart thinking, innovative action, flexibility transparency and. the will to get things done. They have the potentiality to continue to contribute inputs in kind of services. More important will still be their engagement for solidarity and ethical standards.

In the Encyclical: „Sollecitudo socialis“, Pope John Paul II defined solidarity not as a mere feeling of compassion, but as a firm determination to commit oneself to the common good of each and all, because we are responsible for all.

In co-operation with Governments the mixed Public/Private and Non-Profit Health Care System should be clarified. Especially for Developing Countries the Pontifical Council and AISAC support therefore the proposal of Medicus Mundi concerning „Contracting“.

The proposal of Medicus Mundi Internationalis consists in improving public/private partnership for health care through contracts between Governments with non-profit NGOs that accomplish mission of public service and which are recognised as constitutive in the health sector. The recommendations in this context given by MMI are as follows:

- to classify the health care institutions according to their capacity and not to the belongings;
- to base the operational definition of services offered on the possibility of access to the entire population of a given zone without discrimination of sex, race, religion or social status.
- to define precisely the terms of collaboration between the local national health authorities and NGOs of public utility;
to include in the contract between the partners an agreement on the criteria for the proper evaluation concerning quality and efficiency of the care given

A decisive role for the improvement of partnership with Governments as well as with Donors play the Co-ordinating Agencies for Church-related Health Services. They exist now in more than 24 African Countries and they deserve our greatest interest. Defining properly their role, giving them a clear mandate and investing into their capacity and stewardship, the owners of Church hospitals will be able to talk with one voice and with professional knowledge in the ongoing dialogue with the Government's side.

The fact that our Kampala meeting is co-organised by the Uganda Catholic Medical Bureau (UCMB) is proof of the validity of such national co-ordinating bureaus. UCMB actually plays a pilot role among Co-ordinating Offices and it is worth while studying its Mission- and Policy Statement, its Standard Charter for Catholic Hospitals, its Manual of Employment of Medical Staff, its Constitution for Diocesan Health Departments and so on. Notably, these papers have been elaborated in a participatory process of involvement of all the stakeholders.

May I summarise:

The Church’s urgent challenge in the World of Health today and in the future is the coordination among Church Health Institutions, based on consensus of policy. Church-Leaders owning such institutions together with the professional decision makers have to join in order to be able to take part in defining health policy at national and international level, defending:

health and life, sense of life, ethics, human dignity, equity, accessibility, sustainability, and quality of services

27. 1. 2004
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
- rational
- Symptomatic treatment: by herbal medicines, hydrotherapy, diets, surgery, advice in lifestyle

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 Celcus, a contemporary and friend of Augustinus, published: "De medicamentis" 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, where as 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 philosopher and doctor. Here Gérard of Cremona translated Albuscasis’(940) Al Tasrif, 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 Constantine 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.

1100–1300 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*

**Mission-Encyclical of Benedict XV**: „*Maximum illud*”

*Catholic Medical Mission Work starts* as a testimony of Christian faith

**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.

**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 *Vatican* Conference, 1997 “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 on Church and Health**