

MMI Newsletter nr 71

MMI Newsletter on Internet

The electronic way of exchange of information is something most of you got used to. The easy access to it and the quick selection of information you are looking for, have changed our daily work and brought us a new lifestyle: the digital concept. A few years ago Medicus Mundi started her own website <http://www.medicusmundi.org>. All of the publications, MMI reports and the Newsletter, can be found on this website. Up to now the Newsletter was issued in a printed edition. To change to only an electronic edition was difficult for us. To have something physical in your hands, when you read and so communicate with Medicus Mundi, felt to be important and we would know the feelings of the reader before making a decision. Last newsletter, nr 70, we requested the reader to renew his free subscription to the Newsletter. More than 70 readers replied. The majority had no problems with the electronic version. Only a few, less than fifteen readers, preferred the printed version. So the decision we had to make was easier: the MMI Newsletter will be issued via e-mail and the MMI website. Send your e-mail address to info@medicusmundi.be and you will receive the Newsletter by e-mail.

Medicus Mundi 40 years celebration

The [40th anniversary of MMI](#) gave MMI the opportunity to present herself in Berlin to the members of the German Parliament who are engaged in development issues. This took place on the 24th of October 2003. You will find a selection of the presentations in this Newsletter. Professor Harry Van Balen describes the main fields of activities of MMI, Edgar Widmer the history and philosophy of MMI, Michael Steeb of AGEH looks to the future of MMI concerning the main objectives: PHC and Contracting, goal or slogan: Health for All, and Human Resource Development. The introductory speech of MMI's President you may not miss.

A second manifestation took place in Toenisvorst, Action Medeor, on the 28th and 29th of November 2003. A conference on [Human Resource Development related to HIV / AIDS](#) was the main issue. What is the effect of the HIV / AIDS epidemic on health personnel and how to face and tackle the growing workload of a diminishing health staff? The proceedings of the Conference are published on the MMI website

The Kampala Conference

As announced in the last Newsletter the Consultation of R.C. Bishops responsible for Health Institutions of Anglophone Africa took place on the 24th – 28th of March of this year. This conference was a follow-up of the Memisa conference (Rotterdam, Soesterberg) 2000 in order to discuss the role and engagement of the RC Health institutions for a sustainable integrated basic primary health care system. The proceedings will be published in a comprehensive report. This Newsletter just gives the [summary report and the statement](#) issued by the bishops.

The General Assembly of MMI took place on the 21st of May 2004 in Geneva. A new Executive Board was chosen. The MMI 5 year action plan was analyzed and further discussed. More news about this will be published later.

Sake Rypkema

40th anniversary of Medicus Mundi International

40 years of fighting global poverty by promoting health

Berlin, October 24th 2003

Speech of the President of MMI, Miguel Angel Argal

Ladies and Gentlemen,

It is a great pleasure for us to be with you today to present the Medicus Mundi International Association.

Medicus Mundi International is an international organization for cooperation in the health sector. It was founded in 1963 and has dedicated itself for the last 40 years to improving medical care services mainly in southern countries, but also those in the East. It has, moreover, been working in the field of sensitization and education for development in the North.

Medicus Mundi has maintained official relations with the World Health Organization for the past 20 years.

We have members in Belgium, Spain, the Netherlands, Italy and Switzerland. The following organizations belong to MMI: action medeor and AGEH in Germany, Fatebenefratelli in Rome, which is in charge of 200 hospitals in 40 countries, CUAMM: the International College for Health Cooperation in Developing Countries in Padua, Italy, the Foundation of Humanitarian Aid in Poland and the AMCES association in Benin.

MMI concentrates almost all of its efforts on structural improvement of the health sector from the perspective of integral development. If a disaster strikes an area, the organization will normally intervene only in those countries where it was present before the incident occurred. Some of the associations like action medeor, for example, intervene systematically in cases of emergency.

We participated in the Conference of Alma Ata and since then have continued to reflect upon the evolution of Primary Health Care. MMI has made its contribution to the list of essential medicines. The organization proposed parameters for writing reports about the activities of hospitals and their evaluation. The document, which summarizes these parameters and also contains proposals to finance Primary Health Care, has been distributed by the World Health Organization. The topics we have dealt with lately have been the contracting and development of human resources.

In 1998 MMI, its delegations and the members of the organization participated in 942

projects which were developed in more than 100 countries in the three continents of the southern hemisphere. Today it is no longer our principal aim to provide personnel assistance (in 1998 we sent only about 200 people to developing countries), but to cooperate with our partners, offering them our assistance, helping them with their education and maintaining an exchange. Our main intention is to support them and to encourage civil society to stimulate dialogue and democratization.

We have experienced not only considerable success in developmental tasks, but difficulties too. In future, MMI will not only play an important role in the North, but will also defend the South in debates which demand more justice and solidarity in the world.

One of the permanent tasks in our activities has been to reflect upon the best way of improving individual as well as community health. Our publications, congresses and seminars provide evidence of this.

We have always sought dialogue at all levels. We are convinced that the information exchange we propose is interesting and would like to invite you all to participate actively in it.

Miguel Angel Argal
President of Medicus Mundi International

Welcome speech AGEH Director 24.10.2003

Mr. President,
Ladies and Gentlemen,
Dear friends,

I am very grateful for the opportunity to welcome you all on behalf of AGEH here in our new, old capital Berlin. In the 1960s, MMI played an important role for catholic development organizations in Germany. As an eye-opener, MMI made us aware of the importance of health as a fundamental factor of development, just thinking of the late Prälat Dossing or Professor Dr. Heinrich Jentgens. At that time, MM Germany had its office on the AGEH premises. Later on, action medeor and AGEH succeeded MM Germany in the membership of MMI and in a rather friendly relationship our “advisory group for health issues” started to document AGEH’s active interest in the matter of health.

A 40th anniversary is not at all a reason to reflect about retiring from work. It might be a reason for looking back upon the past, but first of all a 40 year old, healthy boy should face the challenges of the future – and there are quite a lot.

Therefore, the future of MMI is promising and challenging. The new general director of WHO, Dr. Lee, emphasizes in his introductory speech: Commitment to improve Primary Health Care Commitment to the goal “Health for All” Human Resource Development is among the five key priorities for the coming action plans.

These have been objectives on the MMI-agenda for years.

- So, Primary Health Care has been a major objective for MMI since 1978. Contracting as a necessity to implement Primary Health Care services in a sustainable way at the local and district level has been the logical next step. Since the mid eighties, MMI has been the advocate of strengthening health services by promoting collaboration between national health services at the district/regional level and local NGOs through “contracting”. In this respect MMI has worked in close contact with the WHO. In spring of 2002 MMI published the “Guidelines for Contracting”. An official approval from the WHO has been achieved this year. A sustainable health system is essential for every country. We hope to count on MMI and its continuous further support for this important field.
- The MMI goal “Health for All”, was announced as WHO-goal in 1984 and was adopted by MMI. Health is an integral part of human life. Beyond the personal well-being it influences the ability of the individual to learn, to work and to play an active role in society. Being healthy is being capable of doing things. “Capability” and “capacity” are related terms. In this aspect promoting health is “capacity building” at a very basic, but very essential level. This was reflected in the MMI Symposium “Health Promotes Development” held in Krefeld in 1994 (organized by action medeor and AGEH). And a recent study of WHO also emphasizes that investment in health care has positive effects on economic growth. “Health pays”.

- Human Resource Development The World Health Report 2000 stated that human resources are the most important of the health system's inputs and human resources are a key determinant of performance of health care institutions. But human resources are also pointed out as the chief bottleneck in attempts to scale up interventions on the major health problems like AIDS, maternal health or Malaria. Human Resource Development has always been a main goal of MMI. In the beginning the partner organisations of MMI engaged successfully in the training of medical personnel. Many countries now can meet the necessary output of skilled staff.

The present holds new challenges: The number of highly qualified medical staff is still insufficient, the impact of HIV/AIDS and global professional migration as well as performance management are emerging topics.

MMI has already picked up the new challenge. This is shown by the recent publication (August 2003) of a study about MMI's role in Human Resource Development. MM Switzerland recently, in September 2003, held a workshop on Human Resource Development. There will be a conference in November 2003 in Tönisvorst on "Human Resource Development" as a next step.

But, as everybody knows, there are dark, dark clouds in the heaven of development strategies. Already in 1988, an old and wise Tanzanian witchdoctor told me, when neither the traditional witchdoctors nor the white man's modern medicine know a treatment against ukimvi, HIV/AIDS is nothing but death. Till today, in Africa his prophecy comes true in a terrible way, day by day.

Therefore, health for all in the light of HIV/AIDS has a new dimension. HIV/AIDS as a new challenge where MMI and its members are asked to engage their expertise in finding solutions to prevent AIDS and supply treatment to all who need it. MMI's long lasting work on contracting will be an essential element in combining all efforts to combat AIDS. This challenge will be the strongest proof of our thesis "Health promotes Development".

Congratulations to MMI, wishing you strength and energy in tackling the future tasks and we wish you a pleasant stay in Berlin and lots of fruitful discussions.

Thanks

Michael Steeb, Managing director of AGEH

History and Philosophy of MMI

In the year 2000, at the occasion of the 75 year jubilee of our Dutch Branch MEMISA, we realised that 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 of France active in the Cameroons, as well as the Swiss Medical Mission Doctors Society had started at the same time, long before they collaborated with Medicus Mundi. Their foundation at the time was probably the response to the Encyclica "Maximum illud" of Benedict XV which in the year 1921 gave the initial start for Catholic Medical-Mission-Work, while Protestants had much earlier engaged in health. Each one of the mentioned organisations worked on its own without actively sharing experiences, until 35 years later a first international gathering of medical mission doctors brought them together. They met in London in the year 1962. Exponents of this meeting were some heads of Tropical Institutes, such as Prof. Oomen from Amsterdam, Prof. Jannsens from Antwerp, Prof. Genitlini from the Salpêtrière of Paris and Dr. Jentgens from Cologne and Dr. Manresa from Barcelona, both surgeons and Tb-specialists. These men had gathered experiences from the Congo, Cameroon and East Africa to the remote islands of Borneo, Sumatra, Celebes, Flores and New Guinea. They were questioning whether the pure charitable activities of missionary hospitals had a real impact on the health conditions of the surrounding populations. They felt that apart curative actions a wider approach was necessary and practical work in the field had to be linked to academic analysis. Co-ordination was needed.

Let us remember, in 1955, at the Bandung Conference 29 countries denounced colonialism and launched the Non Aligned Movement under the guidance of the presidents: Sukarno from Indonesia, Nehru from India, Nasser from Egypt and Tito from Yugoslavia. A page was turned in world history.

The decade beginning in 1960 was crucial for the independence of the Third World. Rapidly throughout the former colonies new relationships were established between foreign technical assistants and local professionals.

These were the contexts within which Medicus Mundi had its origin, when one year after the London Conference the International Organisation for Co-operation in Health Care was founded. On December 8th 1963, Misereor hosted in Aachen the members of the organisation to be registered. Medicus Mundi International became a corporate body according to German law. Misereor had been created by the German Bishop's Conference just two years earlier as an institution for assistance to the Third World. Misereor and MMI became partners and its first chairman, Mgr. Dossing for many years was our senior councilor and supporter of MMI. France, Belgium Spain, the Netherlands and later Ireland, Italy, Poland and Switzerland became national members of MMI and several international professional groupings became associate members of MMI.

Some years ago in a booklet we described the vision, intentions and the proceedings of our organisation. From the very first meeting, the members of the organisation agreed on the first objective: *professional cooperation for development*. From that time onwards, the ideals of MMI have been very similar to those of the World Health Organisation. But just as WHO depends on governmental policies, the medical assistance provided by the

churches is not accepted everywhere. In addition nationalistic feelings which were very keen so soon after independence made it not desirable to employ doctors originating from the former colonial powers. This led MMI from the very beginning to the conviction that the organisation should be not only professional and international but also non-denominational and non-governmental. On the other hand, MMI wanted to be ready to offer its help to any private hospital or governmental service that could use it, given the great number of doctor posts which were vacant in the recently independent countries, and the dramatic absence of local staff to fill them in.

Another vigorously debated issue: Should MMI concentrate on financial and material assistance, or should it rather focus on personnel assistance? The first option was not rejected, since the material aspect can't be avoided, but the emphasis should be on human contact and personal commitment. The main objective should be stated as follows: Let us offer to the most needy populations in the developing countries the abundance of medical technology and share our experience of developed countries. This was the way in which European doctors felt to be able to participate in the struggle for social justice on a planetary scale. It was not surprising that more and more an identification between *Medicus Mundi* doctors and the need felt by the poor population became the background for MMI meetings.

This vision might have been generous and comforting, but there was a great gap between these intentions and hospital traditions in Africa which have been casting wistful eyes towards Paris, London and Lisbon. The doctor's role was before all charitable, at that time. First you had to be sick to be eligible for medical care. This system was widespread throughout Africa and tropical Asia, but had very little influence on the health status of the population. MMI wanted to change this approach by considering the community as a whole as the patient. No substantial improvements in health status could be expected without extending preventive care to all groups at risk, without protecting particularly mothers and children, without immunization campaigns, without recruiting local people coming from the community itself.

This new "mission" implies that hospitals had to open their gates and engage in '*extra-mural*' activities. *Curative work, as essential and inevitable as it is, had to go hand in hand with the prevention of disease and health promotion.* Finally the old question charity asked: "For whom?" was changing and became: "With whom?" The main concern was no longer to work *for* the most needy but to work *with* them on equal terms. '*Partnership*' became the new key word in international co-operation. This was also why medical and paramedical training had to be given priority. The objective of MMI, as of all technical assistance, was to work itself out of job, by helping to establish professional cadres in these countries. Discussions among ourselves and continuous dialogue with our partners at our international or national meetings, kept us à jour with the ongoing changes in health policies and development strategies. Free from centralistic bureaucracy our organisation remained flexible and able to actively participate in different world platforms, and keep being engaged in advocacy for the disinherited world. Throughout the past 40 years MMI had been working together with partners in more than 60 countries. We have not counted the number of expatriate doctors we have recruited and accompanied during their stay abroad. Even if this could be an indicator of our work, we think the most important challenge we had was to try to enable local

populations to become self sufficient partners in our globalised world.

Dr. med. Edgar Widmer
Member of the MMI-board

The Voices of MMI in the Choir singing the Gospel on ‘Health Care for individual well-being and harmonious development of the people’.

Why had MMI to join the choir?

In the epoch of community development, decolonisation and self-determination, all sectors of development, health care included, made a move from professionally defined actions towards activities resulting from an interaction between users and providers. In Congo, already in 1958, Jacques Meert stated that “a technical error is less detrimental than an error that jeopardizes the self-confidence of the local people”. So, even in the colonial period, to be an European was not necessarily an obstacle to catch the spirit of that epoch. The professors Janssens from Belgium, Jentgens from Germany and Oomen from Holland, belonged to those “catchers” and the document they submitted in London in 1962 to the International Association of Catholic doctors was a catalyst for the foundation of MMI: a group of public-spirited health professionals, grasping the spirit of the epoch, and realizing that their insights into the health system, gained by the reflection on their own experience in health care in developing countries, could contribute to a balanced development of the envisaged rapid change of the health system during the last decades of the 20th century.

How did we try to keep the voice of MMI adjusted to the changing system and to carry the message to the actors concerned?

From the very beginning it was obvious that the organisation should be professional, international, non-denominational and non-governmental. This definition has made it possible to create channels of communication at all relevant levels.

In order to remain professional, channels for continuous interaction with scientific institutions (Amsterdam, Antwerp, Basel, Barcelona, Nijmegen) were developed.

In order to keep in touch with the reality, encounters on the field and exchanges with local governmental and non-governmental authorities as well as with field workers were organised.

In order to keep pace with the worldwide health policies, channels for exchanges with international decision makers (WHO, European Union, Worldbank, UNICEF, Pontifical Council) were developed.

Since 1978 MMI is even acknowledged as an organisation in official relation with the WHO (resolution 63 r.27). This recognition procures the branches of MMI an official status for collaboration with their own governments, with Third World governments and with international organisations such as the European Union. In 1991 also the Spanish government recognised the merits of MMI, by awarding the Price of the Prince of Asturias. The contacts at different levels inspired the publications and meetings, realised by MMI, often in collaboration with scientific institutions or with WHO. During the years that the general assembly of the WHO, where we are officially invited, lasted two weeks, MMI organised its own general assembly on the Saturday of the first WHO week. It was an opportunity to invite, together with the national branches of MMI, official representatives of the countries where MMI members were active and confront each others view on experiences which were considered to be relevant in that stage of the evolution. Gradually these international colloquia were organised by the national branches. Since the duration of the general assembly of the WHO has been shortened,

official representatives do not have the time anymore to join a simultaneous MMI general assembly but, organised at an other period of the year, the colloquia with our members and guests from governments, churches and scientific institutions go on.

Our tune varied along those 40 years.

MMI's concern was and is to keep rationalisation and participation in balance in the continuously changing health system. Themes and melody were chosen in order to draw the attention of the branches and the local partners to variables of the system which had gained too much or not enough importance for the harmonious development of sustainable health projects.

During the sixties, the dramatic absence of local staff was the main matter of concern of MMI. We had to respond to the local requests for expatriate human resources, requests made as well by governmental as by non-governmental institutions. Great efforts were made to recruit medical and paramedical personnel able to keep the health facilities in the run and to organise the activities according to locally felt needs. In order to respond adequately to these requests the training of motivated candidates was entrusted to scientific institutions which offered a relevant curriculum.

The reflection on our own experiences and on those of similar organisations (e.g. by the Christian Medical Commission) and on publications such as Maurice King's 'Health Care in developing Countries', oriented the projects more and more to the emerging "Primary Health Care" approach.

In 1968, the publication by MMI of "Concepts 1" reflected this evolution. It was edited by professor Oomen and translated in French, Spanish, German and Portuguese. While it showed to be an excellent tool for exchanges of the MMI concepts with other governmental and non-governmental organisations and with fieldworkers, it was followed in 1975 by a complementary "Concepts 2" and in 1985 and by "North-South Dialogue and Health", an overview of 25 years experience on the field. Moreover, up to now 70 newsletters have informed our readers not only on the activities of MMI and its branches but also on our concept of an adequate health care system, which remains congruent with the PHC concept.

Allow me therefore to recall that, according to that concept, the adequacy of a health care system implies the preservation of a fair equilibrium between the following inseparable components:

- access to relevant care
- sustainability in an existing and evolving social, economic and cultural context
- scientific analysis and readjustment of effectiveness and efficiency
- dialogue as a basis for people's participation
- promotion of self-help and self-determination

The international office of Medicus Mundi conducted only one comprehensive field project. In 1972, the Ministry of Health of Niger, in order to strengthen the state owned health care system, requested, through the diocese of Niamey, international assistance. A project to assign physicians to several districts as advisers of the nurse practitioners in charge of these districts, was set up. It was financed by Misereor and the technical aspects were entrusted to MMI. In 1974 a change of regime went along with a

more realistic health policy. The new government made a very bright analysis of the undesired consequences the well-intentioned initial project brought along in that stage of development: it depreciated the esteem of the nurse-practitioner in the mind of local inhabitants and authorities; it created needs which exceeded the resources available at that level; it was not realistic to foresee in less than a decade the assignment of local doctors at that level. It was a lesson in how to initiate, in a given context, a long term sustainable health project and related training. Consequently the project has been renegotiated, appointing these doctors as team-members at a higher level, in the "direction départementale". In that position, the MMI doctors, respecting the national health policy and master-plan, contributed several years to the organisation of complementing levels of care and to the supervision and continuous training of the staff at district level. At the end of the eighties it became realistic to appoint local doctors at the district level and the experienced MMI doctors, jointly with senior local doctors, were asked to set up a practical training of district medical officers. It was a very instructive experience on the importance of the component "sustainability in an existing and evolving social, economic and cultural context".

Hundreds of other Medicus Mundi field projects, with governmental or non-governmental counterparts in Africa, Asia and Latin America, were conducted by the national branches. Since 1974 the approaches, observations, analyses and lessons learned are discussed in annual colloquia. Linked with the general assembly it is an opportunity to adjust the PHC inspired policy of the organisation.

So we come back to the tunes and melodies of MMI in the choir. From '74 to '76 the absolute priority to develop correctly functioning health centres and referral levels was stressed. It covered adjusted training; the way to show the relevance of these concepts to local health personnel; the delegation of tasks to less qualified but correctly supervised personnel; the participation of the population, based on dialogue with individuals, families and genuine representatives of the communities to be served; the respect for the traditional health care based on the local health culture.

In 1977 it was deemed necessary to highlight the role of the hospitals in the strengthening of the first line health services. This essential dimension of what later was called the health district would remain an important topic in the correlation with the WHO and scientific institutions. Testimonies to this are: in 1985, in collaboration with WHO, the spreading of guidelines for annual reports of hospitals committed to the strengthening of a two tiers system; the publication in 1990, in collaboration with the institute for tropical medicine in Antwerp, of the result of a mail survey in 25 sub-Saharan countries, addressed by MMI in 1988 to 173 hospitals, linked with national branches of Medicus Mundi. The booklet, entitled "District and first referral Hospitals in sub-Saharan Africa, an empirical Typology" contributed to the publication, also in 1990, of a WHO paper "The Role of the Hospital in the District: delivering or supporting Primary Health Care?" Later on this question on the role of the hospital forced itself to the African Brothers of Saint John of God. On their demand, MMI organised for the Brothers in 1994, in Asafo (Ghana), a workshop on this theme.

The Alma-Ata declaration on Primary Health Care has taken place in 1978. Being in official relation with the WHO and as member of the NGO-group for PHC, MMI has participated in may of that year, in Halifax, in a workshop, charged to produce a document on the role of non-governmental organisations in the realisation of Primary Health Care. In September the document has been submitted to the Alma-Ata

conference where MMI was also invited. In 1981, based on this idea, MMI organised in Yaounde, in collaboration with the ministry of health of Cameroon, a workshop on “NGO Support for the Strengthening of PHC”. This initiative met with a wide response, not only in Cameroon: the workshop document was further used via the WHO and via the Institute for Tropical Medicine in Basel.

In 1979 MMI made a plea for the financial support of European governments to NGO's who adapt their activities to existing master plans for the implementation of the national PHC policy. The theme was also elaborated in an article published in 1985 in the WHO magazine “World Health”. It was drafted by MMI as member of the NGO-group for PHC and entitled: “Guiding Principles for external Financing of Health Services”.

More specific topics have also been developed:

When in 1980 action medeor organised the annual colloquium, the possibilities to realise the indispensable access to essential drugs was the theme. While the procurement of reliable essential drugs became more problematic, the topic was put again on the agenda in 1994 and in 2000. The problem of counterfeited drugs and the dilemma between the economic and the social goals of the pharmaceutical industry has then been analysed.

During these two decades other specific aspects, important for the harmonious development of the health care system, have been debated: culturally different concepts of health and ethical choices; the resistance to change as well from the side of the population as from the side of the administration and the professionals; the structural difficulties of doctors from developing countries to commit themselves to PHC; interference of emergency with the development of sustainable general health services; mass media and the South; how to face the HIV problem; how to integrate mental health care in general health services.

But efforts converge more and more to essential conditions for successful Primary Health Care

During the WHO conference in Harare in 1987, the realisation of health districts was considered to be an essential condition for successful Primary Health Care. Gradually MMI as well as its member organisations focussed their efforts more and more on the development of adequate health districts where state owned and non-for-profit private health institutions coordinate their activities in order to function as an integrated system. The proposed model was indeed very inspiring for the implementation of Primary Health Care. In that challenging model four components are considered to be essential:

- traditional and modern home care and community care
- first line health care facilities, technically and culturally acceptable, interacting with the individual users, their families and representative groups of the population
- district hospitals, acting as referral level and technical support for the first line
- a district management team, able to conciliate top-down and bottom-up planning

During the colloquia of 1989, 1990 and 1993 the MMI members, joined by guests from developing countries, compared the proposed model with the health districts they were familiar with. Special attention was given to the training requirements for the staff. Invited by WHO, MMI participated in 1995 in a study group preparing a report on "Improving the Performance of Health Centres in the District".

In course of time the inevitable role of non-governmental health care facilities for the normal functioning of health districts was accepted by all parties. But, local NGO's needed a responsible common spokesman in order to negotiate with the national authorities. Therefore, more attention was given to the strengthening of national coordinating agencies of church-related NGO's, able to identify and support reliable local partners. In most of the African countries those coordinating agencies became the interface between local NGO's and the members of MMI. In 1999 the Anglophone agencies have been invited to a MMI partner consultation on "Updating Health Care Co-operation" in Dar-Es-Salaam, the francophone ones in Conakry.

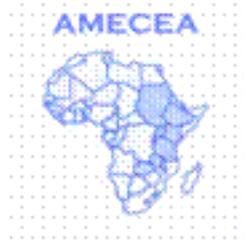
The consequences of real partnership and the successes and failures in the implementation were analysed.

The need to involve the concerned non-governmental partners in all stages of policy development and in all stages of the organisation of the district emerged. But good intentions alone do not suffice to succeed.

Without clear contracts between the official authorities and the private partners the result of the coordination was too hazardous. During the WHO General Assembly of 1998 MMI was authorized to organise, in the Palais des Nations in Geneva, a round table on "Contracting in Health Care". Great efforts were made to consult and to brief during and after the assembly, representatives of governments who manifested interest for the topic. One year later the delegation of Tchad drafted a proposal for a WHO resolution recommending governments the contracting with reliable private partners. The resolution was finally accepted by the general assembly of the WHO in 2003. In the meantime MMI had informed African church related coordinating agencies on this matter. In 2000, during the colloquium organised by the Dutch branch on the occasion of the 75th anniversary of Memisa, a workshop with African bishops dealt with "The Church and its Involvement with Health: The healing Ministry". The statement and the commitments formulated by the participants at the end of the workshop pave the way for transparent contracting with national and local authorities.

An even more compelling problem, due to the living conditions in many countries in Central Africa, is the threat on the quality and quantity of well performing health personnel. For the coming years MMI will focus its efforts mainly on these two issues: contracting and human resources development.

Prof. Dr. med. Harrie van Balen
Member of the MMI-board



Conference

**The Healing Ministry of the Church
in English speaking African Countries at the Dawn
of the Third Millennium: Challenges and
Opportunities.**

***Kampala
Speke Resort and Country Lodge – Munyonyo
22nd to 24th March 2004***

CONFERENCE REPORT

1 Introduction

From the 22nd and 24th of March, AMECEA (the Association of Members of Episcopal Conferences of Eastern Africa) and Medicus Mundi International hosted a conference in Kampala.

The conference was open to Episcopal Conferences of Anglophone Africa. In all, nine Episcopal Conference sent their delegates.

The Pontifical Council for Health Pastoral Care from the Holy See expressed its sincere interest in the Conference, considering its subject highly topical. His Eminence Javier Cardinal Javier Lozano Barragán, President and Rev. Msgr. Jean Marie Mpendawatu, Official represented the Pontifical Council. HE used the occasion to present the Medal of the Good Samaritan, bearing the logo of the Pontifical Council to the representative of the UCMB, bro. Daniele Giusti and to Bishops representing the three regions in Africa: AMECEA, IMBISA and AECAWA.

Furthermore, representatives of AMECEA and SECAM (Symposium of Episcopal Conferences of Africa and Madagascar) attended the conference, as well as representatives of Medicus Mundi International, and others, including facilitators and speakers. For a complete list of participants and other attendants, see the Appendix to the Kampala Statement.

The three-day conference has been a great success. The challenges church health care faces at present have been discussed in a very open atmosphere. The participants demonstrated great absorption capacity and acknowledged the need to develop the Healing Ministry to the full through structural reform and development. The Statement, which is one of the outcomes of the conference, reflects the positive attitude towards “guided evolution”.

The participants left the conference with a reconfirmed and enlarged commitment to assume and express a stewardship role in catholic health care provision.

This report contains a condensed reflection of the presentations and discussions. For the full text of the presentations one is referred to the Appendices.

We hope and expect that the proceedings of the Kampala may receive a wide distribution and may inspire those who hold leading positions in church health care.

2 Executive Summary

From the 22nd and 24th of March, AMECEA (the Association of Members of Episcopal Conferences of Eastern Africa) and Medicus Mundi International hosted a conference in Kampala. Nine Anglophone African Episcopal Conferences sent their delegates. A representation from the Pontifical Council for Health Pastoral Care underlined the importance of the theme of the conference: *“The Healing Ministry of the Church in the English speaking African countries at the dawn of the third millennium: challenges and opportunities”*.

The conference discussed the viability and sustainability of catholic health services, admits rapid changing circumstances, in the awareness that there is a persistent need for the church’s contribution to health care. The need was felt to preserve and promote the Church’s contribution to cater for unmet needs for health care, particularly aiming at the poor and the vulnerable, and to promote exercising the basic right to health. This requires structural reform and professionalism, calling for a new leadership role, with “stewardship” as the preferred style.

The conference was concluded with the compilation of the so-called Kampala Statement, containing a number of commitments.

The Kampala Statement acknowledges the 2000 Soesterberg Statement and endorses it. It reconfirms the unique identity of Catholic health care that is linked to the Ecclesial Mission. However, in view of recent developments in the environment in which church health services operate, a more pro-active attitude of the church is required.

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

- To foster stewardship as the most appropriate way to exercise the function of ownership that the church leaders have inherited;
- To install professional coordinating bodies and equip these with a strong mandate to define a vision and a mission of the Church's role in health care;
- To design strategies aiming at developing institutional capacity with the ambition to guarantee an acceptable quality of health care, accessible to all who are in need;
- To engage partnerships with various stakeholders in the field of health care, and in particular with the Government, using the "contractual approach". This may, however, not compromise the Church's identity.
- To engage in lobbying and advocacy, addressing the right to health, and to seek participation in debates on health policies on the national level.

The implementation of these resolutions not only requires a strong coordinating mechanism at the national level, but also service facilities at the regional and continental level for the purpose of collecting, filtering and exchanging relevant information and experiences.

The Kampala Statement contains an agenda for action, describing strategies for dissemination; implementation strategy; monitoring. The agenda for action provides a time schedule and assigns responsibilities for the implementation of the agenda to individuals and institutions.

The delegates of the nine Episcopal Conferences represented, under the leadership of Msgr. Bakyenga, President of AMECEA, and convenor of the conference, have endorsed the Kampala Statement.

3 Background of the Conference

3.1 Sketch of the current situation faced by church health care

Church health care contributes in an essential and meaningful way to the delivery of essential services to the population, in particular in those countries that face economic hardships and subsequently a great deficiency in the provision of health care services.

The Catholic Church conceives the Healing Ministry as part and parcel of the church's mission to healing and wholeness in accordance with Christ's mandate. The Church wishes to enhance her contribution to health service provision, complemented by lobbying and advocacy for the right to health.

However, church health care finds itself increasingly being subjected to developments on which it has little control. These concern international and local changes in thinking on health in respect to socio-economic development, on the approaches regarding the delivery of health services, on new funding arrangements and priorities. These developments impose new demands on church health care; amidst a situation that many institutions already for years are forced to persevere, due to lack of finances and human resources. The challenges are even greater due to the fact that in many countries a large part of the population has lost connection to socio-economic development and/or are facing hardships due to HIV/AIDS.

This situation calls for new and renewed concepts on church health care, requiring new ways of leadership and new mechanisms to promote church health care, with a specific emphasis on the plight of the poor and vulnerable. New opportunities avail themselves as the international community has underlined the necessity to include civil society in poverty reduction strategies. New concepts on

arrangements between the Church and the Government are gradually being adopted, formalizing the contribution of the Church to health care provision. However, it is essential that the Church enhances its institutional performance in terms of accountability, transparency and quality of care. In short, the need to professionalise is paramount.

3.2 Objectives of the Conference

The Kampala Conference is to be regarded as a follow-up of the Soesterberg Conference in 2000, which discussed the involvement of the Church with health and health care. Based on the assumption that Episcopal Conferences across Africa are coping with to a large extent identical situations, the conference aimed at:

- Reviewing aspects of viability and sustainability of health services and programmes, including their administration and management;
- Understanding the impact of current changes in the environment in which catholic health services operate, in particular related to the demands posed on the organisation and management of the institutions by various stakeholders;
- Increasing the awareness of opportunities and expectations lying ahead, as well as of potential risks and pitfalls in the absence of any change;
- Reaching an understanding on possible gains of a reform process and how this process can be implemented through capacity building and organisational development;
- Discussing and reaching a common and operational understanding of the difference between the role of owner and that of a steward of catholic health care institutions;
- Arriving at an action plan to disseminate renewed understanding on church health care and to implement necessary reforms agreed upon.

3.3 Methodology

The conference has been set up in three distinct parts, each roughly covering one day:

- *Opening ceremony.* This was followed by a *sensitisation process* assisting participants in conceptualising the challenges church health care faces, while appreciating the Church's contribution to the Healing Ministry;
- *Discovery of solutions.* There was room for exchange of experience with strengthened coordination structures in a number of countries; examples from other sectors, an exposure to the concepts of change, and contributions from multilateral organisations complemented the presentations;
- Reaching at a *consensus* on the advancement of the Healing Ministry, by collectively working on actions plans. *Closing ceremony.*

The conference gave room to presentations, plenary discussions and structured group work. There were opportunities for side meetings and interactions, used to express opinions and experiences and to arrive at a consensus on a final statement.

Drafting the statement was entrusted to a small committee, which presented the outcome to the full meeting for receiving comments and providing clarifications. The action plan was based on the contributions made by small committees that drafted action plans for their respective countries.

The final document was presented to Msgr. Bakyenga, convenor of the Conference, for his endorsement. The ownership for the Kampala Statement lies with the signatories, who are the delegates of nine Episcopal Conferences and are identified by name at the end of the document. This is notwithstanding that all participants contributed to the Statement.

Copies of the Kampala Statement will be dispatched to all conference participants through the office of Msgr. Bakyenga. In addition, letters have been drafted to disseminate the Kampala Statement to a much wider audience, particularly to those Episcopal Conferences that did not manage to be represented at the Kampala Conference.

The process followed proved to be just as valuable as the Conference Statement itself, which can be regarded as the first tangible, and collectively achieved result of the conference.

In addition to discussing the future of the Healing Ministry, there has been ample room for devotion, setting the right climate for the participant to hold their discussions. A particular and impressive moment of togetherness was offered by a Mass conducted at the shrine of one of the Uganda Martyrs, which is situated nearby the conference venue. It was an overwhelming experience that the word of God does not require cathedrals, but can also be found in a simple shrine.

Lastly, the conference was adequately facilitated and closely monitored, using participative techniques for setting expectations, for developing views and action plans through working groups and for evaluation.

4 Summary of presentations

4.1 *Rt. Rev. Archbishop Paul. Bakyenga, AMECEA President*

“Word of welcome”

Msgr.

Bakyenga particularly stressed the method of Communion. As Episcopal Conferences all over Africa are experiencing the same challenge in rendering health services, they can be inspired by each other in finding solutions. “Exercising the Healing Ministry at the dawn of this Millennium, remaining faithful to its demands, requires a clear vision”. “One source of inspiration has already been offered by the gift of the presence of the President and a member of the Pontifical Council, witnessing the fact that we have responded to a need that is felt by the entire Church.”

He then opened the Conference by stating that the Conference is an Ecclesial Event, not only a technical Conference.

4.2 *His Eminence Cardinal Javier Lozano Barragán, President of the Pontifical Council for Health Pastoral Care*

“The identity of Catholic Health Care Institutions”

His Eminence called for attention for the characteristics of Catholic health care. He referred to three indispensable elements, including: service to the sick; institutionalised relationships between those people who provide this service and the patients themselves, which must be indeed something special in character; the management of health care services.

The identity of Catholic health care is linked to the Ecclesial Mission, “calling upon the ecclesial community to extend its range of action and increase its bonds of communion with the sick people.” “Church health care should occupy itself with the overall health of the person, that is to say the health of both the body and the soul.”

His Eminence stressed that professional excellence is required, which should go hand in hand with a demonstration of the Call to integrate professional treatment and the psychological, spiritual and religious dimensions of the patient. The professional excellence includes the need for accountability. It is stressed, that the *Christian communion of goods* is the norm, whereby patients contribute according to ability. Formalized cooperation with other stakeholders may be required in order to preserve the involvement of the Church, which should not be abandoned. This, however, may never come at the expense of Catholic morality.

4.3 René Grotenhuis, director Cordaid

“Welcome address”

Mr Grotenhuis addressed the conference on behalf of Medicus Mundi International as well as on behalf of Cordaid. He conveyed the vision that health is never a single issue, but is to be considered as part of the broader struggle for development and poverty reduction. The challenge is to make health care available and affordable for the millions of people who are still deprived of adequate services.

Catholic health institutes should seek ways how they can relate to their surroundings, to the social, economic and political environment in which catholic health care is situated. This includes: positioning itself in the public health system; to be active members of the civil society movement; using lobbying and advocacy as means to guarantee access to health care for the poor. An additional challenge is to seek the *added value of catholic institutions*, by combining professionalism with the richness of our spiritual attitude which is demonstrated in the institutionalised attention for all aspects of human life.

4.4 Edgar Widmer, representative Medicus Mundi International

“History and Evolution of the Healing Ministry”

The Healing Ministry has a history right from the start of the Church. During the last 40 years Medicus Mundi International (MMI) has been one of the leading organisations in innovative approaches to promote health care development in harmony with the socio-economic context. At all times, specific emphasis has been given to building up human resources.

In the most recent years MMI has been advocating for a better integration of church institutions in the District Health Concept by well defined contracts and agreements. Eventually this resulted in a resolution on the *“Contractual Approach”* which was adopted by the General Assembly of 2003, and therefore recognized by the member-states of the WHO.

Both the Pontifical Council and AISAIC (the International Association of Catholic Health Care institutions) recognised the value of this approach and encourage the Episcopal Conferences under the operational leadership of their national coordinating offices to be engaged in the process of “contracting”.

“Contracting” is based on a number of principles, including:

- The classification of health institutions according to their capacity and not by the status of their ownership;
- To base the operational definition of services on equitable access to the entire population of a geographical area;
- To define the (reciprocal) terms of collaboration between the health authorities and the private institution;
- To define criteria for monitoring and evaluation of issues such as quality and efficiency of care.

4.5 Jos Dusseljee, consultant ETC-Crystal

“Search for (financial) sustainability of Catholic health care services.”

One of the biggest challenges facing the church health sector today is that of *sustainability*. Contributions by the Government and user charges brought in by patient are seldom sufficient to cater for even the marginal running costs of institutions. Yet these marginal costs averagely constitute not even half of the real costs. Hence, there is widespread dependence on donations, which force many institutions to persevere. As there is a huge unmet need, this points at a wasted potential.

It is inevitable that church institutions seek new avenues to achieve sustainability. Raising fees is rarely an option, as this will impact so-called equitable access, i.e. that utilisation of the services by the poor and

vulnerable is guaranteed. Moreover, a vicious circle is looming: an increase in fees will lead to a reduction in utilisation, necessitating yet another increase in fees, etc., until in the end the hospital resembles a private institution, only accessible to those who can afford it. Other options for increasing income exist but are hard to achieve.

Similarly, there are options to reduce costs that need to be explored. Comparing data of different institutions will single out differences in cost structures, which may indicate options for cost reduction. As most church health institutions are already on a survival mode, this may not solve the problem of sustainability in the long run.

It is concluded that church health institutions may not achieve sustainability, unless they engage themselves in contracts with the national Government and/or international organisations. However, in order to do this, church institutions will have to improve on their accountability, transparency and quality standards. It is recommended that church health institutions subject themselves to *accreditation against minimum standards of performance*. By doing so, and based on the fact that church institutions often have better quality services particularly related to their identity, church health institutions may qualify for additional Government funding and/or achieve inclusion in new funding arrangements installed by the International Community.

4.6 Dick Jonsson, WHO Uganda

“Public Private Partnership in health for Africa”

Poor countries face tremendous health system challenges. To name but a few: poor health indicators; weak national health systems; lack of equity in the financial resource mechanisms; human resource crisis, particular in terms of professional capacity; lack of health system coordination.

Yet opportunities are availing themselves, both on the national and international front. In order to access these, new ways of collaboration between stakeholders need to be designed. National policies are instrumental for establishing public-private partnerships, with defined roles and responsibilities. These partnerships should be based on complementarity, identity, autonomy, equity, transparency, accountability and continuity. The underlying health care financing mechanisms should promote the delivery of equitable quality health care services by different providers, particularly arranged in a decentralised system.

In the 2003 World Health Assembly, the WHO adopted “Contracting” as the preferential approach for enhancing public-private cooperation. Contracting is defined as a voluntary alliance of independent or autonomous partners who get involved with reciprocal assignments and obligations and who each benefit from their relationship. The arrangement can include: delegation of responsibility (e.g. for providing public service); purchasing of services; contractual cooperation (based on synergy).

It needs to be understood that the contractual approach is a *systemic approach*, requiring a conceptual framework on which different actors are in agreement. It is here that stewardship comes in as the preferred regulating style. Being a new approach, a learning attitude and adaptation to local circumstances as well as preferences should be paramount.

4.7 Sigurd Illing, Head of Delegation of the European Commission in Uganda

“The role of civil society in service provision and their access to multilateral donors”

The role of Civil Society in cooperation with the private sector and local Government in health care and related sectors cannot be overemphasised. *Church institutions play a crucial role in Civil Society*, in health and in many other (social) sectors for that matter.

The relationship between the European Union (EU) and civil society organisations is a long standing one. The EU has been on the forefront of supporting numerous civil society led initiatives, which are geared

towards transforming communities for the better. The 2000 Cotenou Conference emphasised the importance of non-state actors in the development process. They are considered crucial in holding Government to account, and in monitoring their ability to implement the policies adopted as well as participating in the implementation of these policies.

The EU is currently transforming itself to become more effective. Project support is replaced by time-framed and output oriented programme support. This requires more coordination, cooperation and advocacy between the service offering institutions. Investment in the organisational capacity building is crucial.

Church organisations are called upon to join this transformation, and subsequently engage in public-private sector cooperation to create a “win-win situation”.

4.8 René Grotenhuis, Director of Cordaid, the Netherlands

“Donor strategies in partnership, the challenges for Cordaid”

Donors, Cordaid inclusive, have gradually changed their policies and strategies on supporting development processes in the poorest countries.

Issues concerning sustainable development are approached from a much wider perspective than before. Fundamental questions are being asked about the *root causes of poverty*. There is discussion on the relevance of “good governance”, “peace and stability”, as well as a more “equitable distribution of resources”. These discussions are not isolated to countries in the “South” but evidently do regard the “North” as well.

For donors it is increasingly relevant to be able to prove that their input, which consists of tax-payer’s money and private contributions, does lead to results in terms of structural development. If they fail to be convincing, their resource base will dwindle and they may not render the same assistance anymore. Due to this as well as based on the new understandings on fighting poverty, technical concepts like the “*value chain*” are introduced. The concept of the “value chain” refers to basically four levels at which donors can provide support:

1. the level of service-delivery
2. the level of institutional and coordination capacity
3. the level of policy making
4. the level of strategy from a broader perspective, including lobbying and advocacy

In general, donors – Cordaid inclusive – are looking beyond merely rendering support to service-delivery. The main reason is that “filling gaps” only does not attribute to sustainability. Whereas it may be necessary to render support at the service level, particularly regarding social services, this cannot be done without attending to the other levels too. Increasingly, donors will designate their resources to the higher levels in the value chain.

These choices evidently influence donor-partner relations, and pose a challenge to both. Seen from this perspective, conferences like this may have an evident strategic impact.

4.9 Bro. Daniele Giusti, Executive Secretary, UCMB

“The evolution of Uganda Catholic health network”

The Uganda Catholic Medical Bureau (UCMB) is the coordinating umbrella for the Catholic Health Network in Uganda, the second largest health care provider after the public sector.

Worn-out by twenty years of crisis, the need arose in the mid-nineties to rehabilitate the health services, albeit not without vision. Catholic health services existed merely as a loose common affiliation of service providers. The institutions were merely responding to the struggle for survival without a clear sense of direction, sound and informed strategies and the capacity of effecting changes. They operated on the sense of duty for providing services to the people, yet often failed to reach those who were most in need of the services.

In order to transform the Catholic Health Network, an external assessment was done. This brought out the need for a strong and professional coordinating body, with a re-defined mandate and staffed by highly professional technical advisors. With external financial support a process of reform was initiated, which among others led in 1999 to the approval by the Episcopal Conference of *“the Mission and Policy of Catholic Health Care”*.

Guided by this document as well as a 5-year strategic plan, years of gradual transformation of catholic health services started. Attention was given to the establishment of well-defined guiding principles. The health units were exposed to a process of accreditation, which allowed the Bureau in collaboration with Diocesan Health Coordinators to issue *“Certificates of Faithfulness to the Mission”* to those institutions that met the requirements. Emphasis was placed on a process of change of the respective organisational structures and (health resources) management, supported by well-targeted information. The latter refers to an information and communication strategy, which facilitated the provision of feed-back on performance to the health units, based on statistical evidence.

After some 5 years in the process results become evident: units are performing better; and stewardship is taking root as the preferred style of management.

Concerns still remain. First of all there is concern about the long-term sustainability of the Bureau itself. Dependence on external inputs, both in terms of finances and human resources, seems inevitable in the foreseeable future. The transformation process is evidently a “long-haul process”, requiring concurrent ownership by the Bureau, the Dioceses, the health institutions, the donor and many other actors.

In conclusion: *“we are mere servants to do whatever we can to improve serve the health needs of the population. Only when we have done this, we may step back and give room to His Power to show.”*

4.10 Gilbert Buckle, Executive Secretary, Health Department, National Catholic Health Secretariat

“Summary report of the Accra Conference”

From August 19th – 21st 2003 the Episcopal Conference of Ghana organised a conference on Catholic Health Care, inviting secretaries of coordinating bureaus, representatives of congregations and others involved in daily management and coordination of institutions, from Ghana as well as other African countries. The Conference referred to the Soesterberg Statement (2000) and its implications for strengthening the Healing Ministry.

Quite similar to the Kampala Conference, the Accra Conference aimed at a review of experiences in order to learn for them. The objective was to promote church leadership in the health sector in Africa.

The conference addressed questions starting with: “What is...?” singling out the most relevant issues at stake, followed by “How can ...?” aiming at finding possible solutions. Various themes were addressed, dealing with the principles of the Healing Ministry, public-private partnerships; institutional development of catholic health care.

The conference led to a number of recommendations to national Episcopal Conferences, among which:

- To remain mindful of the Church’s mission, despite the numerous challenges it meets. Ongoing formation of health staff on the Church’s philosophy and social teaching is essential to achieve this.
- To establish formal structured health services through formal, documented processes, procedures, operational guidelines, and especially professional staff;
- To engage innovative partnership with national Governments, local and international agencies, ecumenical institutions, and within the local Church itself;

- To establish a continental forum to allow for discussions by the church on health issues in Africa.

4.11 Sr. Raphael Händler, Director of Catholic Health Service Commission, Namibia

“Catholic Health Services – from Department of Health to Non Profit Company”

The organisation of catholic health care in Namibia has seen important changes in the last 8 years. After a lengthy process of negotiation, an “*Agreement of Partnership in Health*” between the Ministry of Health and Social Services and the Catholic Church was signed in 1998. The agreement states that the Government subsidizes fully the running costs and part of the capital costs of church health services. An important issue that had to be dealt with was the legal liability. Bishops as the owners of health institutions faced charges in the event of incidents occurring in the institutions that they “owned”. Examples of incidents were given, such as maternal death and fresh stillbirth, whereby professional negligence was suspected. Other incidences referred to grievances of employees.

A new legal framework was designed to reduce the vulnerability of the bishops. Guided by civil law, catholic health services were integrated in one nation-wide system, so-called “Company-not-for-gain”, and named “Catholic Health Services” (CHS).

The legal protection made it possible to professionalise management and administration, and to introduce unified policies for all catholic health units. Moreover, it provided a base for negotiation with the Ministry of Health and Social Services.

An adequate management structure was put in place; all health workers in catholic institutions received a new employment contract with the CHS, including a job description. Each bishop signed an agreement with the new company stating that the physical property remains with the diocese, while health services management is carried out by CHS.

Although the structures are now in place, a lot of institutional strengthening is still required. New challenges are being faced, such as securing funding for Anti Retroviral Treatment programmes, as well as negotiating a better agreement with the Ministry.

4.12 Mgr. Jean-Marie Mpendawatu, Official of the Pontifical Council for Health pastoral care

“Concerns and considerations of the Pontifical Council”

The Pontifical Council for Health Pastoral Care is of the opinion that the Kampala Conference deals with very important issues for the Church’s Healing Ministry in Africa. These include the policies governing health care in Africa and the effective management of catholic health care institutions.

The Pontifical Council is aware of the creasing complexity of managing health institutions. Nevertheless, it strongly recommends that these institutions should not be abandoned as caring for the sick is an integral part of the mission of the Church.

Instead, church health care should reinforce itself by building up the capacity of national coordination offices and equipping these with adequate mandates. In this respect, the developments at the Uganda Catholic Medical Bureau should be taken as an inspiring example.

Moreover, the Church needs to establish a vision and a mission. This is required for involving itself in the debate on health policies at the national and international levels, represented by their national offices.

Speaking with one voice will evidently attribute to the success of the negotiations. An example is given regarding the need to secure resources to provide Anti Retroviral Treatment.

Lastly, there is a general need to build up capacity in various relevant professions and organise formation in Pastoral Health Care.

4.13 Nathan Johnson, Catholic Institute for Education, South Africa

“Establishing effective cooperation between public administration and private health care providers”

Two cases were presented, situated in another social services area, i.e. education.

The first case centred on the establishment of a religion & education policy in South Africa at a time when the Ministry of Education actively pursued secularisation. As the new policies, which were imposed on church-owned institutions, were perceived to be too restrictive, a strategy was followed to curb the harmful Government policy.

Firstly the Catholic Institute of Education (CIE) was mandated to participate in a consultative process with the Ministry, which resulted in obtaining a seat on a Ministerial Committee. Collaboration with other faith groups (that faced similar problems) was actively pursued. CIE participated in a National Curriculum Statement process; the development of curriculum outcomes and assessment criteria; and the development of an accredited training programme. Eventually, a new Government policy on religious education was drafted with input from CIE resulting in removal of restrictions applied to church-owned schools on religious education.

Another case was presented on the establishment of a HIV/AIDS & Gender Unit within CIE that dealt with a HIV/AIDS prevention programme, targeting 250 Catholic Primary Schools.

Relevant conclusions to be drawn from these examples are:

- the necessity to set up a coordinating body that receives an adequate mandate, equipped with professional leadership and management capacity;
- The installation of sound administrative and financial systems, including a sustainability plan.
- The appointment of experienced staff, adequately remunerated with attention for human development, as well as an appropriate mix of religious and lay-staff, and of local and expatriate staff.
- The necessity to secure credibility of the Government by solving some of its concerns.
- The relevance of ongoing operational research.
- The relevance of a strong local, international collaboration network.

These conclusions can also be applied to the catholic health services sector.

4.14 Gilbert Buckle, Executive Secretary, Health Department, National Catholic Health Secretariat

“Public-Private Partnerships in health care: Church-State relations in Ghana: who wins, who loses?”

Attention should be given to defining the fundamental roles of State and Church in health care. This particularly concerns the power and authority base they operate from. In history lack of mutual understanding at times severely strained relationships, at the expense of the service provision to the population. As the church basically operates in a secular environment, it can only continue its essential services that complement state services, if it is in touch with its (political) environment.

Ghana has seen a gradual evolution of church – state interaction on the provision of health services, from which a number of lessons can be taken:

- The Church will have to accept the legal base of the State and will have to adhere to it; yet the State needs to affirm the autonomy of the Church and accept the restrictions in service provision following the Church’s teachings;
- The Church and the State need to interact to establish a plan for complimentary health services, which are of adequate efficiency and quality. The Church will have to adhere to State regulations on accountability and reporting, concerning finances as well as health services provided. Based on this the State will have to contribute to the operating cost of church health services;

- The Church will have to improve its management performance. This particularly concerns uniformity of standards and procedures and centralised negotiation and planning capacity. In order to make this feasible, a professional central coordinating unit has to be installed and adequately mandated with a policy that is endorsed by all members of the Episcopal Conference. This will allow for collective decision making and support, at the national level, but also between dioceses that are each too small to effectively manage their health services;
 - Transparency in the funding base of the Church needs to be provided to prevent mistrust;
 - Inter-denominational cooperation will create a stronger negotiation base with the State.
- “In the end, it will be the people who win, as they are more assured of adequate health services.”

4.15 Doug Reeler, Community Development Resource Association

“Sustainable organisations and healthy change processes”

The Episcopal Conferences present at the Kampala Conference have convened to discuss opportunities and threats experienced by the Church while fulfilling its Healing Ministry. It is therefore helpful to identify key factors which enable *sustainable organisations and health processes of change; of leading or stewarding organisational transformation*.

In order to do so, three core dimensions of the *Learning Organisation* (an organisation that consciously and continuously learns from its experience and proactively responds to its changing context) have to be explored:

- *The practice*. This focuses on understanding who we are; where we find ourselves; what do we want to achieve; which strategies do we use; which resources and skills do we apply;
- *The organisational forms that best support this practice*. This focuses on the (strategic) processes that are in place; the organisational culture; the support systems that are required;
- *The forms of Leadership that best support this organisation and practice*. This focuses on visioning the future while energising the present and learning from the past; challenging and supporting people.

Once this is done a *process of change* can be entered:

- The *first stage* basically is what this conference is about: facilitating a common understanding of the situation or crisis, exploring the current practices; testing the will to change; engineering new foundations of beliefs, values, principles and leading ideas; creating new visions or leading images; developing concrete plans of actions, while identifying those that will implement them.
- The *second stage* refers to managing the transition. This is a difficult phase, where one easily is confronted with uncertainty, fear and confusion, aggravated by loss of productivity and met by resistance to change.
- The *third stage* refers to consolidation of new change and managing ongoing change. It has to be anticipated that there are no definite answers; there is need for continuous learning (from each other) while implementing; there is need for willingness to continually re-strategise in response to changing contexts.

The second stage and third stage lies ahead of the Episcopal Conferences, which will immediately start once the bishops present at the Kampala Conference will have returned to their respective countries. There is evident need of leadership and endurance, which needs to be complemented by technical input and a variety of resources.

An additional challenge to the practice of Catholic Health Service was briefly touched upon. This refers to the need to think beyond mere service delivery, and to incorporate more developmental and rights-based approaches to health care into the challenges of professionalisation. This is not just based on evolving donor preferences, but also on an empowering population that will demand new ways of accountability as well as leadership. Although there will always be a place for service delivery, we are seeing developmental and rights-based approaches to health care taking centre stage.

4.16 Rt. Rev. Thomas Mensah, Bishop of Obuasi Diocese, Ghana

“Healing Ministry today, new challenges in Ghana; reference to Soesterberg Statement”

The fundamental guiding policy of the Church's Healing Ministry today is to support and complement the Government of Ghana's effort at providing health care to all people. The Ghana Catholic Bishop's Conference is aware that 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. Through its Department of Health, it is at the forefront of health care, providing for an estimated 30% of all health services.

Encouraged by the Memisa Jubilee Conference in 2000 resulting in the Soesterberg Statement, a process was started to review the Policy of the National Catholic Health Service in Ghana. The new Policy was endorsed in 2002 and provided guidance for reforms. New principles of partnership with the Government were adopted, based on the *“contracting approach”*. There was appreciation for the need to professionalise the coordinating bodies, the service units and the training institutions. Renewed emphasis was placed on the Catholic identity and ethics in health care, including the fundamental attitude based on the *“dignity of the human person”*. In particular attention was given to the plight of caring for the people living with HIV and AIDS. Moreover, the need to improve on norms and practices of financial management of health care institutions was stressed and given the right attention.

“The health of the people is our individual and collective responsibility. Together, let us work and respond to the new challenges regarding the health of our beloved people.”

4.17 Closing ceremony

Closing remarks, made by Rev. Mgr. Jean-Marie Mpendawatu, Official of the Pontifical Council for Health Pastoral Care.

Mgr. Mpendawatu called for increased efforts in training of personnel; the need for the establishment of a health information network as well as the need for an office for information and consultancy. Reference was made to the celebrations of the World Day of the Sick 2005 will take place in Yaoundé, Cameroon on February 11. This great event will offer another opportunity to make another step ahead by strengthening our collaboration and working together on the continental level.

Words of thanks and encouragement

Mgr. Bakyenga, President of AMECEA and convenor of the Kampala Conference; Mr. René Grotenhuis, Director of Cordaid; Mr. Edgar Widmer, representative of Medicus Mundi International; Sr. Raphael Händler, Director of Catholic Health Service Commission, Namibia as well as the facilitators expressed words of appreciation and encouragement

Mgr. Bakyenga closed the Conference with a prayer.

5 Conclusion

The Kampala Conference resulted in a Statement that was endorsed by the representatives of 9 Episcopal Conferences who attended the conference. This statement is to be regarded as the main outcome of the conference.

But there is definitely more. In particular the attendance by HE Javier Cardinal Javier Lozano Barragán, President, and Rev. Msgr. Jean-Marie Mpendawatu, Official, of the Pontifical Council for Health Pastoral Care is of importance. The presence of the Pontifical Council reflects the value that is attributed to redefining the Church's implementation of the Healing Ministry, in view of new demands and opportunities.

The Kampala Conference not only triggered a general understanding of what was at stake but also contributed a common understanding on the actions to be taken and the need to show "*stewardship*". It will now be on the respective Episcopal Conferences, drawing on support by their regional bodies, to set in motion the proposed actions in their respective countries.

Similarly it is up to donors that support church health care to "walk the walk" with the Episcopal Conferences. This requires a will to sensitise office staff within the donor organisations so that they may understand the Kampala Statement and support its implementation. Moreover, it requires a will to make the required technical support and financial resources available. The expenses may not be little and the process of change may take a long time before it is completed or before it has gained its own momentum, with a reduced dependence on external inputs.

There is much at stake. The evidence of unmet health needs in African countries is overwhelming. The opportunities for the Catholic Church for playing a leading role in meeting these needs, while at the same time liberating the people of poverty and ignorance, cannot be overemphasised. This is what the Ecclesial Mission of the Church is about.

Let us all support the process of change to preserve and expand the Healing Ministry to the full!

6 Acknowledgements

We wish to acknowledge the following contributions to the conference:

- AMECEA for hosting the Kampala conference;
- The Pontifical Council for Health Pastoral Care for inspiring the conference;
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- Medicus Mundi International for conceptualising the conference;
- UCMB for the practical organisation of the conference;
- The facilitators, speakers, and reporters for their essential guidance and teaching;
- The participants who contributed to the full and facilitated a learning process that enriched all present.

7 Appendices

Full text of the “Kampala Statement”, including a list of participants

Full texts or slides of presentations

Ex-post programme of the Kampala Conference

AMECEA / Medicus Mundi International organised conference on:

“The Healing Ministry of the Church in the English speaking African countries at the dawn of the third millennium: challenges and opportunities.”

Kampala, Uganda
March 22nd – 24th 2004

1. Preamble

We, the Catholic Bishops who participated in this conference, have reflected together on the importance of the Healing Ministry in the evangelising mission of the Church. Inspired by the words of His Holiness, Pope John Paul II, “...we have bowed down in reverence before suffering with all the depth of our faith in the Redemption...” (Salvifici Doloris, 24).

We have considered how best we can as pastors of the people of God, face the challenges posed on us by the complexity of the Healing Ministry at the dawn of this Third Millennium. In addition to that, how we can support each other in our endeavour.

The words pronounced at the opening of the Conference by His Eminence Javier Cardinal Lozano Barragán, President of the Pontifical Council for Health Pastoral Care, have further strengthened us in our commitment.

“The Catholic hospital is included in what constitutes the Church, which realises itself through the calling that founds it. Given that today this calling is fulfilled fully by the Bishop in the Eucharist, the catholic hospital cannot be understood without having a bond with him, and at a practical level without reference to the celebration of the Eucharist. It is in the Eucharist that the Holy Spirit projects to the present the unique action of Christ of healing the sick, whereby the sick are taken care of as a sign of the advent of the Kingdom of God.”^{1 2}

We, therefore take this opportunity to reaffirm our commitment to the call of our Lord Jesus Christ to go out and heal (cf. Lk 9: 1, 2).

¹ Where “hospital” is mentioned, one should read health services in the widest sense. (addition made by this conference)

² Cf. M. Petrini, “Ospedale Catholico”, pp 800-804

The Soesterberg statement: “The Church and its involvement with health: the Healing Ministry.”

We see this Kampala Conference as a follow-up of the Soesterberg Conference, held between the 2nd and 4th October 2000 to celebrate the 75th Jubilee of Memisa Medicus Mundi³.

The Pontifical Council for Health Pastoral Care received the so-called Soesterberg Statement. When the Pontifical Council took notice of the Kampala Conference, it decided to participate.

We, Catholic Bishops, wish to adopt and endorse the Soesterberg Statement. We consider it an integral part of this Statement, compiled at Kampala, Uganda on the 24th of March 2004.

For this reason, the complete text of the Soesterberg Statement has been included in Appendix A.

However, as we particularly wish to reconfirm the commitments made in Soesterberg, we have decided to include them below.

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 work with the whole of civil society to remove obstacles (political, social, and economic) which oppress people and affect health care.
5. In view of the tragic consequences of the AIDS pandemic and the particular challenges it poses to the exercise of the Church Healing Ministry, we commit to bring the issue of HIV/AIDS in the agenda of our Episcopal Conferences in order to foster an active role by the church in the struggle against the spread of the disease and to mitigate its impact on the life of people, families and communities.

Change

6. We regard it necessary to start and sustain a process of change within our institutions and programmes, and commit ourselves to animate and empower people in our institutions and programs to be pro-active in this direction.
7. We recognise that it is indispensable that we should develop charters, guidelines, mission statements, policy statements, constitutions of health institutions and programmes to ensure that we achieve our common vision and aims in a transparent way.
8. We recognise the need to clarify the relationships between ownership and management of health institutions and 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 coordinating bodies, professional service units and training institutions. We commit ourselves to promoting professional

³ As from 2000, Memisa Medicus Mundi is an integral part of Cordaid, the Netherlands.

practice at all levels, with a particular attention for religious who assume managerial roles.

10. Professionals should be allowed to manage Church health services and programs with clear terms of reference and with maximum professional integrity. We commit to creating those conditions which professionalise the management function.
11. We find it necessary that different initiatives and institutions of the church providing training of health managers complement their efforts within the geographical context in which they operate.

Transparency

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

Partnership

13. We also need to ensure the participation of communities' representatives and other stakeholders in the governing structures of our health institutions and programs. In the understanding that women are key actors in the promotion of health, we shall pay particular attention to a balanced participation of women and men in the governing structures of our health institutions and programs to secure the formulation of gender sensitive policies.
14. We support "contracting out" as a way to enhance and formalise co-operation and integration between the various stakeholders, including (local) government and other providers, and church health institutions in order to offer essential health services of sufficient quality at an affordable cost to a population in well-defined geographical areas.
15. We commit to actively participate in health reforms in order to contribute our understanding and experience to health development.
16. We will engage in contracts with donor agencies which support the capacity of the church to foster health development within a shared framework for mutual co-operation with well-formulated objectives and specified results.

Follow up

As part of this process of change:

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

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

3. Update on the circumstances under which the Church delivers and strengthens the Healing Ministry.

Since the compilation of the Soesterberg Statement in the year 2000, there have been a number of developments, in particular on the international front, which ever more justifies a reflection on the contribution of the church to the Healing Ministry, on its mission, its vision and implementing strategies. These developments include tremendous challenges and opportunities that impact on the sustainability of church health care.

We will regard and appreciate these developments from the perspective of the teaching and values of the Catholic Church. Where there will be differences we will remain faithful to our evangelical mission, based on the gospel of life.

We wish to point out but a few of these developments on the international level:

- The so-called Millennium Development Goals (MDGs); these goals include a number of direct and indirect references to health parameters. International investments in development of health care are to a major extent tied to these MDGs.
- The Cotonou (2000) and Johannesburg (2002) Conferences; these have confirmed the role of the civil society in development, specifically including contributions by churches and associated organisations.
- The evolution of new strategies and approaches regarding the reduction of poverty and the relevance of investments in health care therein; these include among others Poverty Reduction Strategy Papers (PRSPs) and Sector Wide Approaches (SWAPs), which increasingly guide funding decisions by particularly bilateral and multilateral donors.
- The introduction of UN led funding initiatives that target specific diseases, such as the Global Fund on AIDS, Malaria and TB (GFATM) (2001) and the UNAIDS and WHO led "3-by-5" initiative (2003), which intends to upscale availability of Anti Retroviral Treatment (ART).
- The adoption by the WHO (2003) of the Medicus Mundi International (MMI) promoted resolution on contracting as the leading approach for public-private cooperation in health care provision.

The aforementioned developments call for pro-active action by the church, so that church health institutions may preserve and enlarge their unique contribution made to health service provision. We, Catholic Bishops, wish to reemphasize the "added value" of church health care. Catholic health care institutions and programmes add to the quality of care the richness of our spiritual heritage.

We feel strongly motivated not to abandon the role and position of the church in health care, exemplified through institutions and programmes. Moreover, we wish to give special emphasis to lobbying and advocacy for the right to health. We rather wish to undertake what is necessary to enhance this role.

4. New and Renewed Commitments

We, Catholic Bishops convened at the Kampala Conference, wish to emphasize issues that call for our attention and action. Willingness to change, where required, is the "leitmotiv". The Kampala Statement builds on the Soesterberg Statement by adding an agenda for development.

Mindful of the leadership role in the abovementioned Healing Ministry, we resolve:

a. in general

- To foster stewardship as the most appropriate way to express and exercise the function of ownership that church leaders have inherited. The ownership role implies direct involvement with the management of a health institution. However, the steward role stresses a situation whereby a proprietor creates a vision for direction, leaving the operational implementation to professionals, offering them a framework as well as a mandate. The stewardship role will have to be adapted to local requirements (related to both civil and canon law) and may evolve over time.

b. at national level

national offices

- To make sure that each National Conference has a strong Health Commission/Department with well qualified personnel, and equipped with a strong mandate;
- To make sure that our efforts in the Healing Ministry on the national level are led by a vision and mission, which will enable us to establish our objectives and to identify the means that will help us to reach them.
- To make use of the results of pioneering efforts of national offices which have evidently demonstrated a positive impact on the performance of catholic health services. The emphasis will be on institutionalising mechanisms of standardisation that guarantee an acceptable quality of health care. This will contribute to the promotion of catholic health care services to the public and other stakeholders, including funding agencies.
- To explore options for country specific legal arrangements that may prevent the church from liability risks.

partnerships

- To work together with stakeholders in the field of health care that demonstrate public utility, without compromising on the values of catholic health care.
- To work in an ecumenical setting where this is required or opportunities arise.
- To make agreements/contracts/MOU's⁴ between our Governments and the Church regarding health care provision and promotion, without compromising the Church's identity;
- To engage in ongoing dialogue with our Governments on behalf of our people to ensure the provision of high quality, accessible and affordable health care.

services

- To engage in lobbying and advocacy, addressing issues that affect the ability of the poor and vulnerable to exercise their right to health. The church will seek participation in debates on health policies on the national level;
- To involve ourselves in the promotion of the continuum of care (prevention, treatment and rehabilitation) offered to people living with HIV/AIDS (PLWHA), in collaboration with those infected and affected.

resources

- To continue in our effort to mobilise resources to mitigate the rising costs of health care for the poor and the marginalised;
- To improve on conditions of service, in particular those regarding professional health staff.
- To build up the capacity of health workers, through formalized and on-the-job training in a variety of specialisations, inclusive of institutional management and administration;

⁴ MOU's stands for Memorandums of Understanding

formation

- To create opportunities for ongoing formation of church leaders with responsibility for health care institutions.
- To extend our pastoral ministry to our health workers with a view to equipping them with catholic medical ethics through the appointment of hospital chaplains and other trained staff;
- To improve upon and strengthen the relationships with the health workers in catholic institutions, so that they continue upholding Christian values of love, integrity, dignity, justice, equity and having an open heart for the poor and the vulnerable;
- To promote the involvement of religious congregations in church health institutions complementing the presence of lay-staff, in view of enriching the Healing Ministry with their specific charisma.

c. regional level

- To create a health service facility for the purpose of collecting, filtering and exchanging relevant information;
- to share and exchange personnel;
- To use key staff in national offices to act as resource persons at plenary assemblies of the Episcopal Conferences at national, regional and continental level.
- To foster communication with and among governmental, supranational and civil society representations.

d. continental level

- To implement a mechanism for the purpose of sharing information and experiences
- To facilitate communication between SECAM and Regional Conferences, the African Union, the Holy See and international donor partners;

e. in respect to countries in or emerging from conflict situations, and/or countries where the Church is persecuted

- To endeavour to develop solutions that enable the church to exercise its Healing Ministry in innovative ways;
- To promote the role of the church in rehabilitation efforts in collaborative engagement with the (emerging) authorities or the international community
- To design health care interventions that complement those aiming at conflict-prevention, peace and reconciliation;
- To advocate for international attention for these countries, so that they may solve their problems in full respect of human rights.

5. Agenda for action

An action plan consisting of three components has been prepared using input from respective Episcopal Conferences represented at the Kampala Conference.

We, Catholic Bishops, will commit ourselves to implement the above. Focussing on three separate elements: dissemination, implementation and monitoring; we will adapt the generalized action plan presented below to suit our specific situation.

5.1 Dissemination

Dissemination will stress the value and importance of the outcome of the Kampala Conference and may contribute to the implementation of the action plan.

We will distribute the outcomes of the conference within the Church, to as many people and institutions as possible, using various ways.

The distribution list will include:

- The Pontifical Council for Health Pastoral Care
- National Episcopal Conferences in Africa
- Regional Conferences in Africa
- Symposium of Episcopal Conferences of Africa and Madagascar (SECAM)
- African Conferences of Major Religious Superiors (men and women)

- African institutions of study and higher learning of the Church, such as major seminaries, catholic universities etc.

We consider the following ways for dissemination:

- Writing letters to inform, sending emails and copies of the conference statement and report to respective individuals and organisations;
- Presentation of conference outcomes at appropriate forums, such as meetings of the national Episcopal conferences, regional and continental conferences. Where relevant, we will seek technical support from resource persons who are familiar with the Statement and its relevance in various respects.
- Publication in national, regional and continental media such as newsletters, magazines, radio and television where available.

5.2 Implementation

We will guarantee implementation of the resolutions and recommendations of this conference by:

- The President and Secretary General as well as the Chairman and Executive Secretary (or similarly designated officer) of Commissions for health of national Episcopal Conferences (at the national level)
- The President and Secretary General of Regional Conferences (at the regional level)
- The President and Secretary General of SECAM (at the continental level)

Where structures do not exist to facilitate the implementation of the resolutions and recommendations of the conference, we may choose to establish at the respective levels alternative mechanisms, both temporary and permanent. We will facilitate these mechanisms by providing them with a clear mandate, clear focus and necessary support by the respective level Episcopal Conference.

We will plan, at all levels, specific activities to induce the above intentions. We will seek the assistance of experts in the development of these plans, where required and/or desired in order to maximise the outcome.

In order to expedite the implementation of this plan, we resolve to adhere to a timeframe of maximum one year.

5.3 Monitoring

We will assign the responsibility for the monitoring of the dissemination and implementation activities of the respective conferences at the national level to the Chairman of the Episcopal Commission for health and his departmental Executive Secretary or similarly designated officer.

We will assign the responsibility for the monitoring at the regional and continental levels along similar lines.

“That they may have life, and have it in abundance.”

John 10:10

Statement agreed upon on the 24th of March 2004 by:

Rt. Rev. Archbishop Paul Bakyenga, Uganda (AMECEA President)
Rt. Rev. Bishop Thomas K. Mensah, Ghana
Rt. Rev. Bishop Remi Ste-Marie, Malawi
Rt. Rev. Bishop Josef Shikongo, Namibia
Rt. Rev. Bishop George Biguzzi, Sierra Leone
Rt. Rev. Bishop Aloysius Balina, Tanzania
Rt. Rev. Bishop Michael Cleary, the Gambia
Rt. Rev. Bishop Patrick Mvemve, South Africa
Rt. Rev. Bishop Henry Ssentongo, Uganda
Rt. Rev. Bishop Caesar Mazzolari, Sudan
Rt. Rev. Bishop Daniel Adwok Marko Kur, Sudan
Rev. Msgr. Michael Charo Ruwa, Kenya (AMECEA Secretary General)
Rev. Fr. Peter Lwaminda, Ghana (Secretary General SECAM)

Appendix A The integral Soesterberg Statement: "The Church and its involvement with health: the Healing Ministry", 2000

Appendix B: Complementary list of participants at the Kampala Conference

Appendix B

Complementary list of participants at the Kampala Conference

In addition to the Bishop, who have endorsed the Kampala Statement, the Kampala Conference has been attended by other participants, resource persons, observers, etc., including:

HE Cardinal Javier Lozano Barragán	President of the Pontifical Council of Health Pastoral Care, Vatican City	Participant on the 22 nd
Rev. Msgr. Jean Marie Mpendawato	Pontifical Council for Pastoral Health Care, Vatican City	participant
HG Archbishop Christophe Pierre	Apostolic Nuncio, Uganda	participant on the 22 nd
HE Cardinal Emanuel Wamala	Archbishop of Kampala, Uganda	participant on the 22 nd
Rev. Br. Simon Bekaar Zaato	Provincial Superior, The order of St. John's of God, Ghana	participant
Rev. Br. José Maria Viadero	The order of St. John's of God, Ghana	participant
Rev. Br. Leopold Gnami	Councillor, The order of St. John's of God, Benin	participant
Rev. Sr. Dr Raphaela Händler	Director of Health, Catholic Health Services, Namibia	participant
Rev. Bro. Dr Daniele Giusti	Executive Secretary, UCMB, Uganda	participant
Dr Edgar Widmer	Medicus Mundi International, Switzerland	participant
Mr René Grotenhuis	Director General CORDAID, the Netherlands	participant
Mr Sigurd Illing	Head of Delegation of the EU Commission, Uganda	Resource person, present on the 23rd
Mr Doug Reeler	CDRA, South Africa	Resource person
Mr Nathan Johnstone	Catholic Institute for education, South Africa	Resource person
Mr Dick Jonsson	Health Economist, WHO, Uganda	Resource person, present on the 22 nd and 23rd
Dr Gilbert Buckle	Executive Secretary, National Health Secretariat, Ghana	facilitator
Dr William Ogara	CORAT Africa, Kenya	facilitator
Mr Jos Dusseljee	ETC-Crystal Consultant, the Netherlands	rapporteur
Ms Marieke Verhallen	UCMB, Uganda	secretariat
Dr Peter Lochoro	UCMB, Uganda	secretariat
Fr Charles Namugera	Uganda	observer
Dr Paul Mundama	DR Congo	observer