MARYKNOLL HISTORY IN AFRICA
CHAPTER FIFTEEN

ARCHDIOCESE OF MWANZA, TANZANIA

Maryknoll never worked in the Mwanza Archdiocese prior to 1984, with the exception of two Maryknollers assigned to the Bukumbi Pastoral Centre in the 1960s, Frs. Alden 'Mike' Pierce and Frank 'Ace' Murray. Their work in catechetics and organizing the Seminar Study Year has already been treated in Volume Three on Musoma Diocese.

Despite Maryknoll not working in Mwanza there was always a close relationship between the White Fathers in Mwanza and the Maryknollers in both Musoma and Shinyanga Dioceses. Both dioceses, of course, were divided from Mwanza. Maryknollers from Shinyanga in particular made regular forays to Mwanza for shopping, vehicle repair and a few days of relaxation. Mwanza had a decent hotel in the 1950s and 1960s, where one could get a cold beer and a hot shower, making it an attractive place to spend a few days. Those from Musoma did not need to go to Mwanza as they lived closer to the Kenya border.

On trips to Mwanza many of the Maryknollers also visited any of the White Fathers they knew, to socialize and discuss matters of missionary and pastoral nature. Seminars were held for priests, particularly in the years right after Vatican II, usually at Bukumbi Pastoral Centre and many Maryknollers participated in these learning events. In addition to this, in the early years Nyegezi Seminary was the only secondary school seminary in that area, to which boys from parishes in Musoma and Shinyanga were sent, until St. Pius Seminary in Makoko was built and then upgraded to a secondary school.

The Maryknoll Sisters had been officially stationed in Mwanza going back to 1961, when Rosary College, a secondary school for girls, was established. Sisters also worked at the Bukumbi Pastoral Institute, especially during the Seminar Study Year in 1969, at the Mwanza Government Hospital (Sr. Mary Reese) beginning in 1967, and at Bugando Hospital beginning in 1971. Sisters in the 1970s additionally worked in social projects, such as the Nyegezi Social Training Center, the Agricultural Training Institute at Nyegezi, known as MATIN, and did pastoral and youth work in the city of Mwanza. Since then the Sisters have continued to have a presence in Mwanza, carrying out various ministries, not least of them being an outreach to people with AIDS beginning in the 1990s. (For further information cf C. Erisman's volume on the Maryknoll Sisters Mission in Tanzania from 1948 to 2010.)

In the 1970s and 1980s, when Tanzania's economic fortunes dipped drastically, Maryknollers from Shinyanga could still get supplies in Mwanza, including petrol for their vehicles, and continued making trips to Mwanza. However, lack of maintenance led to inexorable decay in the city of Mwanza. The main road in the center of town had a pothole so gargantuan that a car could disappear from view if driven into the crater after heavy rain. The hotel also became dirty, uncared for and uninviting.

Mwanza only began to rebound in the late 1980s, when Tanzania opened its economy to neo-liberal structural adjustment policies. In the 1990s there were many Aid workers from the UN and other organizations working in the refugee camps in Ngara, on

the border with both Rwanda and Burundi, and they made regular trips to Mwanza for supplies and some days off, enabling Mwanza's hotel industry to revive. As the new century dawned, Mwanza had again become a thriving city – with plush houses, a marina on the lake, rehabilitated roads, hotels, restaurants, shops, supermarkets and eventually a mall. The airport had daily flights to a number of cities in East Africa. Ferries came in to Mwanza's port from other cities along the lake, from both Uganda and Kenya. There were also mushrooming settlements for the poor, places that lacked basic services. And eventually traffic jams; ah, the wonders of urban progress.

In the 2012 census the city of Mwanza was listed as having 706,543 residents and Mwanza Region (which no longer included Geita District, which had split off forming a new Region) had 2.773 million people. In both cases, the official tally was substantially lower than the estimates of people living in the city and Region but the official figure is seen as quite accurate. In Mwanza Region, over one-third of the people live in urban areas. As of the end of 2016, a realistic estimate for the city is somewhat over 800,000 people. It is Tanzania's second largest city, with almost twice as many people as Arusha, the third largest.

Agriculture, engaged in primarily by small-holder farmers, is the mainstay of the Region's economy. Cotton is the main cash crop and Mwanza Region is the country's leading producer of cotton. The Region has sixteen cotton ginneries. However, production of cotton has declined in recent decades, due to the low price paid to producers and inefficient marketing arrangements. Many food crops are grown, with the three most prominent being maize, cassava and sweet potatoes. Mwanza Region can not feed itself, due to drought and meager use of irrigation (only six percent of agricultural land), despite Lake Victoria's proximity. Livestock raising is the third component of agriculture in the Region, with over three million animals, over half of which are cattle. Traditional herding practices, however, minimize the economic value of the herds and in some places tsetse fly is still a problem.

The Fisheries Industry is another prime economic contributor to Mwanza Region and a major source of employment. Official figures claim there are 56,000 fishermen, using 17,000 boats. In 2006 there were 148,000 tons of fish pulled from the lake, of which Nile Perch made up close to half, followed by the tiny fish called Dagaa (used as an indigenous food staple and also for fertilizer). The Tilapia, Lake Victoria's most famous fish, has seen its numbers decline precipitously, victim of the carnivorous Nile Perch. Processed fish contributed the most to Mwanza's export income, with over 40,000 tons exported every year to Europe and Asian markets, having overtaken cotton as the main export item from Mwanza Region in recent decades. The government of Tanzania claims that eight thousand people benefit directly from the fisheries industry and another 300,000 benefit indirectly.

Lake Victoria's fisheries' potential is seen as a prime natural resource for the three countries of East Africa, provided they can manage the potential sustainably and to the benefit of the indigenous fishermen. Tanzania would also like to increase the number of fish processing plants at the local level and modernize them. Boatyards that can build safe, secure boats and keep them maintained are also needed. In addition, there are environmental problems in the lake itself that need urgent attention, such as pollution, siltation, deforestation in shore areas next to the lake, lake weeds and the water hyacinth.

High level training of Tanzanian experts in all aspects of the fisheries industry is also needed.

Because Geita District has separated from Mwanza Region, mining is no longer a significant industry in Mwanza. The Geita Gold Mine Ltd. produced $222 million worth of gold in the year 2007. Gold is the major mineral resource in that part of Tanzania, other than construction material and a very slight amount of diamonds in the Mwanza area.

Mwanza's proximity to both Lake Victoria and the Serengeti Plain has made tourism another potential income earner for the city. As of 2007 there were thirty hotels in Mwanza Region and the city alone has close to a dozen tourist class hotels. Tour Guide companies have also opened in the city. However, there is no clear guidance how Lake Victoria, a beautiful lake that unfortunately is infested with the snail fluke that causes bilharzia, can be profitably utilized by tourists.

Forestry is another important element in Mwanza Region's development goals. There are 25 forest reserves in the Region, encompassing 130,000 hectares. Administration of the reserves is divided between the central government and local government. People are also encouraged to have small-holder forests at their homes, of a one-half hectare to up to ten hectares in size. These are called *Ngitiri* (meaning 'my forest'). The purpose of both the home forests and government forest preserves is to provide firewood and thatching for roofs. Ninety percent of the population depends on firewood, primarily charcoal, for cooking. In addition Mwanza Region has embarked on a mandate to plant one million trees every year.

There are four forms of modern transport available in Mwanza: air, marine, rail and vehicular. In 2006 only 3.5% of roads were tarmac, but this has been increased since then. The airport's runways have been expanded, although the terminal is still quite small. There are forty-two ships with over 50-ton carrying capacity, although there is no shipyard that can do maintenance on these ships. With regard to the railway, which comes from Dar es Salaam via Tabora, the engines, wagons and rails are all old and in bad condition. Uganda is one of the land-locked countries that uses the central railway from Dar es Salaam to carry goods to the port in Mwanza on Lake Victoria, from where the rail wagons can be put on ferries to Uganda. Rwanda, Burundi and eastern Congo can also benefit from this form of transport, but both marine and rail transport are in need of huge outlays of money to modernize them.

Since 2002 there has also been serious effort to establish both Export Processing Zones (EPZ) and Special Economic Zones (SEZ) in Mwanza as well as in neighboring Bunda and Shinyanga. As of 2013 there were 10,000 employed in EPZs in Tanzania and land had been set aside to establish zones in these three places near Lake Victoria. As of 2017 it is not known whether any factories have been constructed and started production in the zones. Export Processing Zones, in which today almost all apparel is assembled throughout the world, have dubious benefits for the developing countries seeking to establish them. For sure, jobs are created, but there are few additional benefits, as the factories do not pay taxes, salaries are very low, and almost all jobs are low-skilled, limiting the advancement of employment skills. Most employees are young women who on average remain working for only four years, eventually quitting with no long-term benefits.

In the city of Mwanza there are 155 primary schools serving 94,500 pupils (Standards One to Seven) and 20 secondary schools, of which ten are government schools. Of the 6,300 secondary school students over sixty percent are in private schools. (Statistics date from 2005. In 2017 we can presume the figures are higher than those given here.)

The above introduction indicates that Mwanza is almost a case study in the potential for and challenges to a city attempting a rapid transition to a modern economy, in a highly undeveloped country that has many resources but minimal infrastructure, limited education and low-level job skills.

The city of Mwanza was established by the Germans in 1892, as the place to build the railway terminal next to Lake Victoria. Prior to that the caravan route bypassed Mwanza, going from Tabora to Ujiji (Kigoma) on Lake Tanganyika, where Dr. Livingstone was operating his medical clinic. When Germany established Tanganyika as a territory under its control it made every effort to control marketing of cash crops. Already cotton was being produced in the lake area and the German East Africa Company wanted to control the export of this valuable crop. Germany set about building the central railway to Mwanza, which with both a railhead and large harbor on Lake Victoria would be the ideal place to administer trade of this commodity. In 1978 it was given the status of a Municipality and in the year 2000 it was raised to a City, governed by a Mayor and City Council.

With regard to ecclesial administration, the area east of Lake Victoria was a part of the Vicariate Apostolic of Nyanza, which was broken off from the Vicariate in Sudan in 1880. In 1883 it was renamed the Vicariate Apostolic of Victoria Nyanza and the seat of the Vicariate was located in Uganda. Finally, on April 10, 1929, the Vicariate Apostolic of Mwanza was erected and the first Bishop was Anton Oomen, of the White Fathers. (Cf Volume Two) He retired on June 13, 1948, and was succeeded by Bishop Joseph Blomjous. On March 25, 1953, Mwanza was made a Diocese and on November 18, 1987, it was raised to an Archdiocese.

Blomjous resigned in October, 1965. Subsequent Bishops, all Tanzanians, were: Renatus Lwamosa Butibubage, from January, 1966, to November, 1987; Anthony Mayala (the first Archbishop) from November 18, 1987, to his death on August 19, 2009; and the current Archbishop, Jude Thadaeus Ruwaichi, of the Capuchin Order, who was appointed on November 10, 2010.

After the establishment of Musoma-Maswa Vicariate in 1946, which eventually became Musoma and Shinyanga Dioceses, two other dioceses have been established, taking territory from Mwanza: Geita in November, 1984, and Bunda in November, 2010.

The statistics for Mwanza Archdiocese at the end of November, 2010, after Bunda's parishes were removed, listed the total number of Catholics at 627,000, about 24% of the total population. The parishes in the Ukerewe Islands have a large number of Catholics and when these parishes were included in Bunda Diocese the percentage of Catholics in the remaining part of Mwanza Archdiocese dropped from over thirty percent to the current 24%. In 2010, there were 27 parishes served by a total of 73 priests, of whom 41 were diocesan. The ratio of Catholics was 8,600 per priest and 23,200 per parish.

The Archdiocese has several important Catholic institutions, such as Bukumbi Pastoral Centre, Nyegezi Seminary, St. Augustine University, the Social Training Centre at Nyegezi, and a guest house used by many priests, Religious and other Catholic pastoral workers. The Catholic Church has also provided medical personnel and substantial financial assistance to Bugando Hospital and the Medical Training College.

FR. JOHN EYBEL, SUPERVISOR OF CLINICAL PASTORAL EDUCATION:

Fr. John Eybel was ordained in 1970 and assigned to Tanzania, where he first learned the Luo language. He worked in Kowak Parish for four years and then went back to Makoko Language School to study Swahili. After filling in at several parishes he was assigned to teach at St. Pius Seminary in Makoko in 1976. In 1980 he was mulling over what future direction he might take in ministry in Tanzania, when Brother John Linhart, a Christian Brother, came to East Africa to lead seminars in career choice. (This was Eybel's term for the seminars. The actual import of the seminars was on recognizing one's skills and aptitudes and making ministerial choices in accordance with one's natural abilities and preferences.)

Even when he was in the Maryknoll seminaries in the 1960s, Eybel was interested in psychology and counseling, took Clinical Pastoral Education (CPE) for two quarters in successive summers, and also attended special seminars at the Carl Rodgers Training Center and the Esalen Institute, both in California, Eybel's home State. While teaching at St. Pius Seminary in Musoma he was appointed the Spiritual Director for the fourth year students and found himself doing a lot of one-on-one talking with them about their own internal conflicts. The combination of this counseling work with seminary students, Linhart's seminars, and his own predilections led him to request permission to do a course in pastoral counseling.

Beginning in June, 1980, he studied pastoral counseling at the Graduate Theological Union in Berkeley, CA, followed by nine quarters of CPE at the Veterans Hospital in San Francisco, the Presbyterian Hospital in San Francisco, and at Loma Linda Hospital. From January to June, 1983, he worked as the Pastoral Minister at St. Joseph Hospital in Orange, California. In June, 1983, he returned to Tanzania and was at first assigned to Zanaki Parish, which was in need of assistance. Finally, in August, 1984, Eybel moved to Mwanza and took up residence in a house provided by Bugando Hospital, where he set about organizing a course in CPE for Tanzanians. He originally thought it would be a course for Tanzanian priests, but he explained what happened.

> I talked about this course with Bishop Anthony Mayala (still Bishop of Musoma in 1984), who was very encouraging. I thought first of having the course at Zanaki but Mayala, who was head of the Bishops' Conference, encouraged me to go to Bugando. I prepared to have a number of priests coming for the course, but I had to do some recruiting. CPE was very new in Tanzania and there was only one other place, in Moshi, where there was any CPE training.
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> We recruited primarily through all the dioceses in Tanzania, through the Bishops and the Vocations Directors. We also recruited through the heads of Men's and Women's Religious Orders in Tanzania. We did some recruitment in

Kenya and Uganda. Others came by word of mouth. And there were a few expatriates.

I was finally able to start the first program in January, 1985.

There were priests who took the CPE course, but in fact most of the course participants were catechists, Sisters or other lay men and women who were interested in the skill of counseling. In every course the majority of participants were men.

Eybel said that he immediately became aware of several aspects of the course at variance with the previous assignments he had in Musoma Diocese. First of all, the participants came from all over the country and some came even from Kenya and Uganda. Prior to this he had a rather parochial vision of the Tanzanian Church, having worked solely in Musoma. Secondly, the course became ecumenical, open to non-Catholics, which is typical for CPE courses in the United States.

The purpose of the course, which was conducted entirely in Swahili, was to help the participants to be able to listen to the emotional content of the counselees' narrative and enable the counselees to gain insight into issues underlying strong or conflictual feelings. The hospital setting made it conducive for the participants to engage in opportunities to counsel people.

Eybel said that his presence in Mwanza was the first instance of an individual Maryknoller in Tanzania being in a non-Maryknoll diocese, although Mwanza is not very distant from either Shinyanga or Musoma. (Since so many Maryknollers had worked in Dar es Salaam, Eybel considered this one of the Maryknoll areas.) In 1986 Eybel was elected Assistant Regional and he felt his distance from Musoma, where the Regional Superior Fr. Ed Hayes resided, was a drawback to his effectiveness in assisting Hayes. [Editor Note: this should not have been a concern because many parts of Shinyanga are further from Musoma than Mwanza and Dar es Salaam is much further away.]

In the beginning there were two courses a year, each for four months or sixteen weeks. Later, in the 2000s the course was shortened to twelve weeks and three courses were offered each year. Most participants took only one quarter, but a few took the full two-year course in order to be supervisors or to assist Eybel in supervision at Bugando. One was Maryknoll Sister Lei King, who joined Eybel on the staff.

Two IHSA Sisters from Musoma came to take the course and then went on for the full course: Sisters Clare Nkambi, who took CPE after finishing her term as Mother General of the IHSA Sisters and who completed her CPE training in Chicago; and Sabina Nyanchaba, who postponed her training to be an assistant medical officer in order to complete the two-year CPE course. These two and Lei King were all on the staff with Eybel at Bugando for several years in the mid-2000s.

Two people on the original staff of Mabatini Parish, Fr. Jim Eble and the secretary Natalia Kadio, who was formerly a nun, were course participants. Kadio took the full two-year course, spurred to do so after volunteering in the camps for Rwandan refugees in Ngara. She actually assisted in the CPE supervision when Eble took the course for two quarters. (There will be more information on Mabatini later in this chapter.)

Others who took the full course of two years were two Sisters from the Huruma Sisters of Mount Kilimanjaro, a priest from Mtwara Diocese in southeastern Tanzania, and most importantly Fr. Matthias Maufi from Sumbawanga Diocese in southwestern

Tanzania, who also did some training in the United States, and who took over as Director of the Bugando CPE program when Eybel was assigned to the U.S. in 2007.

There were several trans-cultural issues that Eybel encountered early in the course that he found sensitive. Tanzania is an overwhelmingly patriarchal society. Swahili has a very apropos word to express this – *ubwana* – which literally translates as manhood or maleness, but implying the right of men to dominate in the household and in society in general. Eybel talked about how they had to deal with this.

> We're conscious of it, talk about it, even joke about it, and we accept that there are varying degrees among groups of how they perceive women. Traditional tribal African men expect women to do everything inside the household and would not offer after a meal to help clear off the table or wash dishes.
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> Right now we have the unique opportunity of having Bill Tillson (a Maryknoll OTP student assigned to Tanzania in 1989) here taking the course. He would feel uncomfortable not helping to clean up the dining room and kitchen after eating.
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> So, the differences in values are there and we have become conscious of them.

A very important African cultural trait, which Eybel quickly recognized, required delicate sensitivity – the importance of saving face. He had to do a lot of soul-searching in how to handle this issue, as he explained:

> I had to reflect deeply before making a confrontation whether the person was going to be able to accept it or not. I made a lot of mistakes. Usually something came of it in the long run, but I had to be careful. I found that I had to bring in discussion of values and human relationships in the early parts of the course by using examples of patients in the hospital. Talking in front of all the members of the CPE class about their own relationships and how they relate to people was threatening and frightful.

Eybel said that in the 1980s there were some priests and ministers sent to Bugando for rehabilitation, usually from dependence on alcohol, but it could be for other behavior issues. Working with them was another aspect of Eybel's ministry in Mwanza. In most cases Eybel supplemented his direct ministry in rehabilitation with referral of the clients to appropriate services.

The CPE course in Mwanza had to meet international standards, according to Eybel.

> This means that the students have to learn what is necessary to be ministers. When they start their practice of ministry it is based on certain assumptions: knowledge about themselves, a skillful way of learning about others, and having the flexibility to adjust to how to meet the particular needs of others.
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> The course is in conformity with the standards in the United States, according to the National Associates of Catholic Chaplains.

Eybel went on to explain that the Bugando program was never actually accredited with any Supervisory hospital in the United States, unlike a CPE program run in Nairobi, Kenya, by Sister Janet Crane, a School Sister of Notre Dame from St. Louis. Her program, which was done in English, was accredited with the Association of Clinical Pastoral Education centered in Atlanta, Georgia. Eybel said that the accreditation process was cumbersome and very expensive. Thus, he joined with Sr. Crane and two other programs, one in Limuru, Kenya, and another in Uganda, to form an East African association called the Organization of Professional Chaplains in Eastern Africa. This organization was functioning very well when Eybel went to the U.S. in 2007, but later he thought that due to distance and lack of money it was less effective. The purpose of this organization was to ensure that international standards were met in each CPE Program in eastern Africa, so that there would be certainty that chaplains assigned to hospitals had the requisite skills and knowledge.

In 1987 two Maryknoll priests who were medical doctors came to Bugando Hospital, Frs. Scott Harris, a surgeon, and Pete Le Jacq, a general practitioner who served in the Departments of Internal Medicine and Community Medicine. Not long after they arrived, Dr. Homer Smathers, who was a mentor for Harris at Mercy Hospital in Detroit in the early 1980s, also came to Bugando Hospital to do medical work. Thus, there was a small Maryknoll community living at Bugando. It was also at about that time that AIDS was finally being acknowledged as present in Tanzania, even though it had come as early as 1983. We will have a long discussion about AIDS in the Lake Victoria area and Bugando's role in responding to this pandemic later in this chapter.

Eybel had other interesting relationships develop in Mwanza. One was with George Weber, who had been a Maryknoll priest and who started the Mipa Catechist Training Centre. In 1964 he was assigned to the United States and was made Rector of the major seminary at Maryknoll, NY. In 1967 he withdrew from the priesthood, married and moved to the midwest. In 1990 Scott Harris invited a team from Mercy Hospital in Detroit to come to Mwanza to consult with and advise the leadership at Bugando Hospital. Weber was at that time working with the Mercy group in Iowa and he joined the team in Mwanza in 1992 or 1993, citing his previous experience in Shinyanga Diocese. His wife and children stayed back in America, as the children were in high school and college. After a couple of one-month trips to Mwanza, Weber decided to remain living there, assisting the hospital and local NGO groups. He took up residence in a hotel in Mwanza. Since Eybel was alone in his house, he invited Weber to come live with him.

One NGO that Weber was connected with had been organized by a Swiss volunteer who was an architect. It had formed groups of young men to do construction work. At that time, 1996/97, there was not enough room at Bugando for the students coming to learn CPE because the nursing quarters were full. Eybel asked if one of the construction teams could build a dormitory, which was readily agreed to. Pete Le Jacq helped Eybel in writing requests for funding grants and the Maryknoll Funding Desk in New York, staffed by Fr. Norbert Rans, also sent money. Weber continued living at Eybel's house for some more years and on at least one occasion his wife came to visit. She helped the CPE program, because she had skills and an interest in this field.

Eybel's newfound skill in writing funding requests came to use in another circumstantial relationship he developed. While flying on an airplane from Mwanza to Dar es Salaam he sat next to a Teresian Sister from Bukoba, named Sr. Esther Buberwa, who was the newly assigned Headmistress of Hekima Girls Secondary School in Bukoba. The school was a former primary school that had recently been turned into a boarding school for girls. It needed dormitories, rehabilitated classrooms, a library and science laboratories. When she heard Eybel talking of how to write funding requests she asked for his help. Eybel knew the Teresian Sisters well as several of them were working at Bugando Hospital and lived close to his house. Sister Buberwa went on to build a beautiful and functional school in Bukoba, which attracted many visitors to view a model of a girls secondary school.

Another positive relationship developed in Mwanza as a consequence of Eybel's reputation as a boxer and the boxing lessons he started in Musoma. A couple of months after he moved to Bugando an Army officer from the Army Camp near Nyegezi came to Bugando and knocked on Eybel's door. His name was Michael Changarawe and he requested Eybel to start a boxing club in Mwanza. The two of them were able to start a club and promote boxing as a recreational sport in Mwanza from the mid-1980s right up until Eybel left for the U.S. in 2007. In fact, they were able to organize the national boxing championships in Mwanza in 2007, a change from the normal routine as the championships were annually held in Dar es Salaam. Some of the best boxers in the country were from Dar, although in 1984 seven of the eleven Tanzanian boxers who went to the Olympics in Los Angeles were from the Musoma area. Thus, it was a thrill to have the championships in Mwanza at least once.

Eybel said that there was a side benefit to boxing. This connected him to many different Tanzanians, from other religions or those with no religion or faith at all. In conversations with them, Eybel learned much about actual life as lived by average Tanzanians.

AIDS, of course, was the crisis of gravest concern in Mwanza and in the whole Lake Victoria area from the mid-1980s to the mid-2000s, when finally the Anti-Retroviral Therapies (ARTs) became widely available for free (i.e. free for the individuals receiving them every month). This pandemic touched all facets of life and the Church was not spared. The road from Nairobi via Musoma to Mwanza and then on to countries to the west carried innumerable large trucks (lorries) and the lorry drivers, loaders and the women they met along the way were the primary spreaders of AIDS all along the route – which became known as the "AIDS highway."

It should be noted here: in the 1990s, when AIDS was at its peak, a diagnosis of HIV/AIDS was a death sentence. There was no cure. Young and middle-aged adults who were bread-winners for their families were dying in droves. Families were devastated; even whole communities were devastated.

Before we look more in depth at this grim event, we will just list some areas in which Eybel joined with others to try to provide some consolation to all the people affected.

We started an organization just for AIDS counselors in Mwanza called the Mwanza Counseling Association. They were not only good listeners but also

pastoral care givers who dealt with stigma, death, dying, and with families. They also supported one another, so that they would be good listeners. They also gave material support to the families, such as tea, sugar, or other simple foods.

There was another group in Mwanza made up only of people with AIDS that met once a month. When they gathered together, they had simple refreshments and used this as a chance to talk with one another. It was run by Peter Sanjo, a male nurse at Bugando. That was a successful group because it brought those people together and their solidarity was a comfort to them.

The AIDS counselors did not get much money so they had to have adjunct work in the hospital to get a sort of a salary. In the 2000s the government took over care for people with AIDS, hired counselors and paid them salaries.

Eybel was a member of the Archdiocesan AIDS task force, which asked for money from overseas funding agencies to provide money for counseling. They devised a plan to pay nurses a salary to do counseling work at the hospital in after-hours when they had finished their normal duties. There were not enough nurses to allow any time for counseling during work hours. "Most people have an extra money-making project, but in this case they worked in the hospital to earn supplemental income. That was an effective program."

The AIDS counselors, through the Archdiocesan Task Force, were able to get money to buy a car, in order for counselors to do home care. Much of the AIDS counseling took place in Bugando Hospital, which became a center for treatment of AIDS (actually for extraneous symptoms of AIDS, not of the disease itself, for which there was no treatment back then), but almost all the people diagnosed with AIDS sooner or later went to their homes. The counselors met every week to discuss their visits and other matters of a business nature. Eybel said that he also invited some people with AIDS to join the counseling team, "because they're going to be the most compassionate towards those who have the virus."

One emotion that counselors had to deal with was shame. Eybel mentioned the example of a successful businessman, who travelled a lot but contracted the virus through sexual activity. He then had to go home and be dependent on his family to care for him. That was psychologically devastating for him. Some people committed suicide when they received the diagnosis.

In the early 1990s several medical personnel joined the CPE course. "It was the only training that was supervised and systematic for people who will be working with people who have AIDS." Eybel hoped that some Muslims would eventually join the course. (He said this in 1993, and it is not known if any Muslims ever did take CPE.)

Burn-out was an occupational hazard for those doing counseling work with AIDS patients, especially since all the patients were eventually going to die. Eybel said that he never overtly felt any symptoms of burn-out, due to several factors. He mainly did CPE supervision rather than direct counseling with people with AIDS. He had a Spiritual Director, whom he met with regularly. And he took occasional renewal courses, which rejuvenated him.

In the fall of 2006 Eybel was assigned to do formation work at Maryknoll's House of Formation in Chicago, where he later became the Director of Formation. As

was mentioned above, Fr. Matthias Maufi became the Supervisor of the CPE Program at Bugando Hospital.

BUGANDO HOSPITAL MEDICAL WORK:

Several Maryknoll priests in Tanzania in the 1950s and early 1960s had been medical doctors, Fr. Ed Baskerville in Kowak and Fr. John Bergwall in Shinyanga, but it was to be over two decades before three other priest/doctors came to Tanzania: Frs. Scott Harris, Pete Le Jacq, and Bill Fryda. The latter had actually been the first one to come to Tanzania, in 1981, but as a lay missioner. Fryda went back to the U.S. to do theology in the Maryknoll seminary and was ordained a priest in 1988. He first worked as a priest/doctor in Sengerema Hospital, across the bay from Mwanza, which we will look at later in this chapter.

As was noted in previous volumes, Le Jacq first came to Tanzania in the summer of 1983, to do medical work in Ndoleleji Parish, filling in for Fryda. He attended medical school at Cornell University School of Medicine in New York City, while in the same years completing his novitiate year and two years of theology with Maryknoll, alternating studies between Medical School and the seminary. He completed his residency at St. Vincent Hospital in New York City. As noted in Volume Three, Le Jacq did OTP for two years, from 1984 to 1986, at Mugumu in Musoma Diocese, where there was a Mennonite Hospital just a few hundred yards from the parish. Le Jacq was ordained in 1987. He returned to Tanzania several months later and was assigned to Bugando Hospital.

Harris had been ordained nine years earlier than Le Jacq, in 1978, but had done OTP in Peru in the early 1970s rather than in East Africa. After his ordination he continued with medical school till 1980 and then did residency at Mercy Hospital in Detroit from 1980 to 1986. He arrived in Tanzania in January, 1987, studied Swahili at the language school and then went to Bugando in April of 1987, several months before Le Jacq arrived there.

Both Harris and Le Jacq were interviewed several times and much of the interviews were on the AIDS epidemic in Mwanza. We will put off these comments till below and just make a few comments here about the general situation in the hospital.

Harris said that he had never entertained thoughts of going to Africa in mission or of seeking a medical career. However, while on OTP in Peru he began to learn about the indigenous worldview of healing, which inspired him to pursue medical studies. After ordination and while doing residency in Detroit, where almost ninety percent of the people were African American, he began to consider working in Africa, as it seemed to him that Africa had the most needs. In 1986, while Le Jacq was doing OTP in Mugumu, Harris visited Tanzania, spending several weeks in Mugumu. This was right when one of the Kuria tribal wars had occurred and there were many people severely wounded. Harris said, “For ten days we did surgery pretty much straight through.”

From Mugumu Harris and Le Jacq visited Bugando and talked with the Medical Director, who convinced them that this was the best place for them to work, as Harris explained.

> We found out how many patients there were and how few doctors. At around the same time the Tanzania Bishops Conference had just been given

> charge again of Bugando Hospital and they put out a call for personnel. They were very interested in having us go to Bugando, because I was a specialist (surgery) and Pete already had quite a bit of experience in Africa. We also came because it was the most difficult place we could find, the most desperate.

Bugando Hospital was constructed between the years 1968 and 1977 and officially opened in November, 1971. It was built by the Tanzania Catholic Church with funding primarily from Misereor of Germany. In 1972 the hospital was nationalized by the Tanzania government, which then handed back governance of the hospital to the Tanzania Episcopal Conference in October, 1985. The Bishops were considered the owners, with an agreement to run the hospital in partnership with the government to provide government services as a referral and consultant hospital for the lake zone. In the 1970s and early 1980s the hospital had degenerated, due to bad governance and the country's economic collapse. Funding through Catholic sources beginning in the second half of the 1980s rehabilitated the hospital, so that by 1990 it was functioning effectively.

The hospital sits on top of a large hill with panoramic views of both Lake Victoria and the city of Mwanza. The hospital has about eight floors above ground and three or four below ground level. In the early 1990s LeJacq said it was an 800-bed hospital, but as of 2016 it had 900 beds and 900 employees. The hospital is a referral center for tertiary care for six Regions in the lake area with a combined population of fifteen million. It also receives over 250,000 patient visits per year, with over 43,000 admissions. The hospital also has a large and very active outpatient HIV clinic that is the referral clinic for the entire lake zone. There is also a large chapel inside the hospital. One of the Missionaries of Africa (White Fathers) was the one Catholic Chaplain for the whole hospital, until he retired in the mid-1990s. At that point all the priests in the area served as part-time chaplains, with John Eybel facilitating the chaplains' schedules.

Bugando now has a medical university, complementing the medical training of Muhimbili Hospital in Dar es Salaam. (Cf ahead)

Harris described the work routine after he had arrived at Bugando in April, 1987.

> On Monday and Friday we would do surgery here at Bugando, starting at 8:00 am and doing surgery straight through till 3:00 or 4:00 pm, without breaking for lunch. On other days we had clinics and training rounds for nurses, assistant medical officers and many others. There were 350 people being trained here, so every day I would be doing some amount of classroom teaching. There were formal rounds that took about three to four hours, three days a week, formal teaching rounds following the British model.
>
> In the first year Dr. Homer Smathers came here from Detroit for one year. While he was here we would go out three days a week to other hospitals, such as Sengerema, Sumve and Bukumbi, doing surgery straight through and making rounds.

In 1988 Harris discontinued doing surgeries in the outlying hospitals because they lacked the ability to test blood for the HIV virus. Harris explained that "doing elective surgery using untested blood was neither ethical nor fair." Patients for elective surgery

had to come in to Bugando. This requirement plus the general lack of surgical items put extra pressure on Bugando, which was supposed to be a consultant hospital. Harris exclaimed that "these cases should have been done at the local level but couldn't because the district hospitals lacked the necessary capacity."

In addition to surgery and hospital rounds, Harris also had meetings and used to go around to various departments to ensure that essential supplies were available. When they first started working at Bugando, Harris and Le Jacq used to dispense medicine at their house in early morning or evening hours, but they quickly stopped that, as the house was getting overwhelmed. In late afternoon Harris and Le Jacq celebrated Mass with the Teresian Sisters and a few other people. Thus, they had a long day. Even in the evening after supper they had things to do. Harris used that time to prepare lectures or write letters to people or groups overseas, requesting funding or medical supplies.

Harris commented, when interviewed in April, 1989, that although hospital administration and organization had improved greatly there were still drawbacks. One problem at that time was "Bugando had no inbuilt system for ordering." This created serious difficulties during operations, if essential equipment or supplies were unavailable. Complicating matters was a steady increase in the number of patients in the late 1980s, as people came to realize that the hospital had improved.

Responding to an interview in 1993, Le Jacq described his work at Bugando.

> This is an 800 bed Catholic teaching hospital, in a city where twenty percent of the adults are HIV positive, half men and half women, and there are thousands of orphans. So, most of my work is chaplaincy and teaching in and around AIDS. I have training in tropical medicine, so I teach the physician assistants their tropical medicine section. We have 400 different kinds of students at this hospital.
>
> I also work in the community health department, which is a lot of outreach. I fly around the country, usually with people who are HIV positive, to give workshops to people who are HIV negative, which include information on what it is like to be HIV positive. To date we work mostly with religious: Bishops, priests, Sisters and lay leaders. The government is doing the same for the medical workers.
>
> We have focused on the pastoral workers, but I never anticipated this kind of work. This is a perfect job for a priest/doctor because there is no cure for AIDS. I don't anticipate a vaccine in my lifetime. What the priest offers is a change of heart and a change of life. Since people are dying, doctors can not offer hope, but the Church can offer Christ as our hope.
>
> Doctors, though, can alleviate some of the pain and suffering.

When Le Jacq was on OTP in Mugumu in the years 1984 to 1986 they never diagnosed a patient with HIV, but on hindsight he realized that some of the patients were infected. It was only in 1987 that AIDS was becoming officially acknowledged by the Tanzania government. For his first two years in Bugando Le Jacq practiced internal medicine but then he realized he needed training in tropical medicine. He did this training in 1990, in conjunction with his furlough, at the Royal College of Physicians and

Surgeons in Dublin, Ireland, where one of the teachers was Dr. Kevin Cahill of New York City, Maryknoll's consultant on tropical diseases and also a friend of Le Jacq's family. In the early 1990s Le Jacq was the only one of the twelve Medical Doctors at Bugando who had Diplomas in International Health and Tropical Medicine.

From 1990 to 1993 Le Jacq's work at Bugando was almost exclusively in teaching tropical medicine and doing preventive medicine in the Community Health Department, which he called Public Health. He also did some patient care, primarily treating severe tropical illnesses suffered by expatriates in Mwanza or in the general lake area. Another of Le Jacq's roles was liaising with the Flying Doctors, arranging air evacuations, mainly for religious. These evacuations were not solely for severe tropical infections; in the 1990s many expatriate missioners were in their sixties and seventies and western diseases, such as heart disease, were being diagnosed. The Flying Doctors made it possible to fly them to large hospitals, mainly in Nairobi, for excellent care.

Harris and Le Jacq were members of the Mwanza Deanery and attended deanery meetings. There were White Fathers, Jesuits and diocesan priests in the deanery, in addition to the Maryknollers at Bugando. Harris commented that all the priests had good relationships and frequent social contacts. They also had good social relationships with both the Teresian and Maryknoll Sisters, who lived very close by. Harris enjoyed the friendship he had with other doctors and the Regional Medical Officer, all Tanzanians. He also revealed that he had a very good friendship with a Shiite Muslim family in Mwanza, whom he visited on a regular basis. In addition to sharing the life of the community in Mwanza, both Harris and Le Jacq participated in outreach on the issue of AIDS, locally, regionally, and at international conferences, which will be covered in more detail below.

Le Jacq mentioned that although he did not have a parish to work in, he celebrated Sunday Mass regularly in the Bugando Hospital Chapel. He was additionally invited by the Jesuits and others on occasion to give a special Sunday sermon on AIDS from a Catholic theological and spiritual perspective.

Harris felt that he had insufficient preparation for working in an Africa setting. He did well at language school, but did not have time to adequately use the language once he went to Bugando. Cultural preparation was not sufficient, in his estimation, although Harris was grateful to Fr. Joe Healy, who was living at the language school while Harris was studying Swahili, for taking time to give him reading material and discuss African culture with him. A third weakness during his time at Bugando Hospital was that despite his superior medical training he was subordinate to Tanzanian doctors, who had less training and at times made decisions that Harris thought were wrong.

Both Harris and Le Jacq, as well as John Eybel, felt somewhat disconnected from other Maryknollers in the Tanzania Region, although Maryknollers travelling through Mwanza would often stop for a visit. The doctors were far too busy in the hospital to be able to visit either Shinyanga or Musoma. Harris said that their community was with the other religious groups in Mwanza, even including some Protestants with whom they had good relations. [Editor note: this form of intercongregational and interfaith collaboration is being promoted as normative for missionaries in the 21st century. The Maryknollers in Mwanza experienced this earlier than Maryknollers working in other dioceses in

Tanzania and Kenya, where Maryknollers found community within their own internal structures.]

When Harris was interviewed he talked about the state of the Catholic Church in Mwanza and in Tanzania in general. He felt that missionaries were not essential to the life of the church, as the local church was established and taking charge. At the same time, he said: "The question we have to ask is what does the local church need for its ongoing development. And that I think is a thorough mission question. I would say ongoing education is one, the AIDS apostolate is another, and an effective Catholic presence with youth in the whole city is something we want to look at."

Although Tanzania was emerging from socialism in 1989, Harris was astounded at the shortages of basic goods and simple consumer items, as he explained.

> Quite bluntly, I don't think socialism works. Production is down on every front, foreign exchange has decreased, and a generation has grown to live with bribery as a way of life. Over the two years that I have been here their standard of living has decreased. We have hunger in Mwanza now, because people can't make it on their salaries. I am flabbergasted at the resiliency of the Tanzanian people in putting up with things.

The Maryknollers at Bugando likewise had to struggle at times to obtain necessary items, although living in Mwanza made it easier for them versus being stationed in a rural mission. With regard to some necessary hospital items Harris ordered blood testing equipment, gloves and gowns from overseas, in great part to improve security for the surgeons doing operations. Even with these items, patients undergoing surgery were only 99% guaranteed that blood being transfused into their bodies was free of the HIV virus; in other words, there was still a one percent risk that the blood was tainted. However, the items that Harris provided from the U.S. greatly enhanced the safety of the surgeons.

Even with these improvements Harris had a poignant decision to make as his furlough drew near at the end of 1989: whether to remain in Mwanza doing surgery with all the risks this entailed in the context of AIDS or to return to Bugando because of the essential medical work he was performing, in many cases for very poor people. He elaborated on the turmoil churning inside him.

> I have done 500 to 600 operations. I know that with a random sample of ten percent of the people HIV positive, if I do 2000 operations it would be like playing Russian roulette and I would become HIV positive. In most of the operations the gloves we wear are our main safeguard against being infected, but there is always blood left somewhere, because of a needle or bad equipment. Most of our equipment is aged, the hospital is not well organized, and we don't even have new gloves for every operation, which is mandatory according to the Center for Disease Control (CDC). You add up all those factors, it is very risky.

Harris' family in the United States was very worried. His sister-in-law, a doctor for the Air Force, who was reading all the information about AIDS from the CDC, stopped writing to Harris, claiming he was in effect committing suicide. After going on

furlough in 1990 and taking some further courses, Harris made the decision not to return to Bugando. In his last year in Bugando a constant low-level sense of dread was sub-consciously gnawing at him, affecting his nerves, and as this emotion welled up into his consciousness he realized that he could not continue doing surgery, with its constant exposure to blood and other bodily fluids, in the context of AIDS and Tanzania's very limited medical infrastructure.

One thing that kept Harris balanced was his faith life. He had an active spiritual routine, including meditation, reading the breviary, reciting simple prayers, sometimes the rosary, and being conscious of being in God's hands during the day. Furthermore, his faith was bolstered by a profound sense of gratitude. Harris was grateful for the good community life he had in Mwanza, the support he received from the Maryknoll Region, particularly Fr. Ed Hayes, the Regional Superior, the expressions of gratitude he received from the Tanzanian people and for the good support he got from Archbishop Mayala. The massive interest of people in the U.S. and other places with regard to his critical work and of their offers to help in practical ways likewise helped him to maintain hope. Harris said of his years at Bugando:

> I feel my time here has been eminently well-spent. Painful at times, painful most of the time actually. But nonetheless I look on it as very productive time up to this point.

The importance of spirituality was also emphasized by Le Jacq. John Eybel was his Spiritual Director and Le Jacq met with him monthly, to discuss matters of spiritual and pastoral nature. In 1993 Le Jacq also took the spiritual renewal program in the Holy Land. It had been six years since his ordination and others from Tanzania were going for this program and they encouraged Le Jacq to join them. He said, "I am glad I went. It also helped me to mull things over."

There were two groups that Le Jacq belonged to that also provided community support and encouragement: a Yesu Caritas group, made up of priests, which met every month; and a Medical Pastoral Theological reflection group, which included all Maryknollers doing medical ministries. This latter group met after two or three months, for a day similar to a retreat day. Le Jacq also belonged to a Journal Club, in which members exchanged medical information. In addition, to bolster his spiritual and psychological equanimity, he made an annual Jesuit eight-day silent retreat at a different place each year, in either Kenya, Ireland or the United States.

Le Jacq's family paid for him to go to the United States for vacation every year. He used this time to educate people about AIDS in Africa and raise funds. "Bugando Hospital needs a lot of infrastructure repair. The American Church, Maryknoll, and my family have all been very generous."

Tanzania's economic predicaments created great pressures on the country's medical systems, particularly with regard to low salaries for doctors and nurses. Le Jacq admitted that some doctors sought positions outside the country, for understandable reasons: to obtain sufficient income to properly care for their families, which included a decent house and full education for their children – i.e. university education.

With regard to what was called bribes to nurses and doctors in hospitals, Le Jacq gave a measured, nuanced response. He explained that even in the United States, hospitals and doctors applied a sliding scale to billing of patients. He said that he counseled Tanzanian medical people, including in confession, to use this same rule when they either sought or were given bribes: namely to charge middle-class or wealthy people high amounts, and those who were poor a very small amount. At one point in the early 1990s, nurses on government salary were earning only about fifty U.S. cents a day! A nurse can not feed her family on that. Le Jacq said that it would be advisable for a family with a patient in the hospital to give the nurse fifty cents to care for their loved one. (Don't look on it as a bribe; call it a tip or a supplemental stipend.)

However, Le Jacq adamantly rejected the notion that this state of affairs was due to socialism. He pointed out that the Scandinavian countries had socialized health systems, i.e. government, one-payer systems, in which doctors earned salaries of over $100,000 a year and their health systems had the best results in the world in terms of overall health statistics. Tanzania's medical problems were due to lack of money.

At one point while being interviewed in 1993 about the state of Tanzania's health system, Le Jacq commented: "If you ask me enough questions you will find that the final answer to every one of your inquiries is that we have no money."

Poverty was an all encompassing syndrome, affecting all components of Tanzania's social systems. Due to poverty, children are often malnourished and don't do well in school. Books are almost non-existent. Only the very top university students are accepted at medical school, but due to factors linked to or caused by poverty, a large number flunk out. Poverty was also the major factor in the inability of East African countries to eradicate malaria, according to Le Jacq. America, Italy and other developed countries had malaria up into the 20th century, but were able to control the mosquito population and eliminate malaria.

Le Jacq said that in the United States there is one doctor for every 400 people. In Tanzania in the 1990s there was only one doctor for every 45,000 people and today it is only slightly improved to three doctors for every 100,000 people.

Poverty also affected hygienic conditions at the hospital. Mwanza did not have a working sewerage system while Le Jacq was at Bugando in the 1980s and early 1990s. Sewer water was just flushed into Lake Victoria, from whence drinking water was pumped up to reserve tanks serving the city and the hospital. In the hospital they filtered and boiled all drinking water.

Maryknoll Lay Missioner Liz Mach came to work at Bugando around the beginning of 1999 and she also commented on several issues affecting the hospital. She said that it was chronically under-funded and under-staffed. A second perennial problem was the effect of HIV/AIDS on staffing: "We keep losing staff to HIV. It's a high turnover. I would say that all the time we have at least one person on our staff that is dying." She added that most of them resigned from the hospital in order to go to their rural homes to die. Furthermore, she estimated that fifty percent of the patients in the hospital were suffering from AIDS related symptoms.

Bugando Hospital regularly was visited by doctors, surgeons and medical students from other parts of Tanzania, as Le Jacq explained.

> The doctors, especially the surgeons, would do a tremendous amount of good in a short time. The medical students would benefit a great deal and gave at least as much back by sharing with the physician assistant students on the wards. Each of the medical students can remember at least one patient whose diagnosis had been incorrect, which they corrected, and whose lives they, if not saved, at least improved by decreased suffering.

The role of the traditional health practitioner was commented on by Le Jacq. He felt they victimized people who believed in their healing abilities, by using clever manipulations. For instance, the healers knew that when one came down with malaria, it was accompanied with a malaria-induced psychosis, making the person feel extra sick. When the psychosis wore off after a couple of days the person felt better. The traditional healer could take credit for this "cure." Of course, they would also charge a very high fee for their services. As a result, Le Jacq preferred not to have any relationship with these healers.

Traditional healers used a variety of herbs, some of which may have had some beneficial effect. As of the early 1990s, however, research had not found any that were of such a significant help to be adopted by western medicine, according to Le Jacq. He did say, though, that traditional healers were effective in treating symptoms of psychological stress.

Inter-cultural perspectives were of concern to Le Jacq and he admitted that after only six years in Tanzania he was still learning about African culture. He offered the example of the doctor he worked under in the department of community health.

> He's the head of the Community Health Department and has his Masters Degree in public health from California. He has worked in Europe and in Dar es Salaam. He is a family man. He fills me in when I am not being culturally appropriate. And I fill him in when I think he is veering too much on the side of culture rather than on technical truth. So, we complement each other.

Le Jacq was able to recruit various missioners to come to Mwanza, primarily to work in the public health outreach to the AIDS crisis. Several Maryknoll Sisters came, two VMM missioners (Voluntary Missionary Movement), a doctor who came on his own as a lay missioner, and a Maryknoll Lay Missioner couple, Bill and Eileen Velicky. Later Lisa Jo Looney, a physiotherapist, and her husband Doug Looney, who was skilled in orthopedic engineering, also came to Mwanza. Dan Ford, a Maryknoll seminarian in Tanzania on OTP, spent part of his time at Bugando, but he did not continue on to the priesthood.

Le Jacq devoted extra time to Maryknoll Lay Missioners because he believed in the value of the contribution they could make to Tanzania, and to the broadening of the meaning of mission. The danger of malaria, especially cerebral malaria, in the lake area was of particular concern. If a single lay missioner was living on his/her own and came down with a serious bout of malaria, with excessive vomiting and diarrhea, Le Jacq would bring the person into his home to directly monitor treatment and care. As much as he appreciated their worth, Le Jacq commented that too many of the Maryknoll Lay Missioners were not continuing on after their one term of three years ended, a time that

was consumed by language-learning and often recovering from malaria or another tropical disease. A second term of three years would have enhanced their effectiveness, in the opinion of Le Jacq.

In 1996 Le Jacq was due for furlough again, after nine years at Bugando, and the fortuitous assignments of three new personnel to the hospital made it possible for Le Jacq to offer to stay in the U.S. and work for the Promotion Department. The three new people were: a Tanzanian priest assigned to be hospital chaplain; a Tanzanian MD with a Masters Degree in Public Health and Tropical Medicine, ready to take over the community health department; and another Medical Doctor from the Voluntary Missionary Movement (VMM), who could maintain the house Le Jacq lived in, which was a guest residence for visiting doctors and medical students.

When the VMM doctor returned to Europe, Maryknoll Lay Missioner Liz Mach came to live in the house and organized living quarters for medical guests. After a year or so, a second house became available and Mach arranged that medical students could live in both houses. She also did the bookkeeping for the funds coming from the U.S. for the medical school. She had training in bookkeeping and knew how to manage funds in a careful way. This was not always easy for a woman in a patriarchal society, and in a society that accepted and overlooked bribery as a way of getting things accomplished.

BUGANDO MEDICAL COLLEGE:

After six years on Promotion, stationed in New York City, Le Jacq received word that the Tanzania Episcopal Conference had decided to make Bugando the first Catholic medical university on the continent of Africa and Le Jacq was asked by Maryknoll's Superior General to involve himself full-time in fund-raising for the university. Le Jacq first went through his family and friends, as well as people he knew at Cornell Medical School. Maryknoll was the first organization to begin fund-raising activities for Bugando, but then the Cornell connections brought in big donors.

The chairman of Citigroup, Sanford I. Weill, and the Citigroup Corporation gave large donations, which had reached eight million dollars as of 2007 and well over twenty million by the 2010s. As a result, the name of the medical school was changed to Weill Bugando Medical College. Cornell's medical school had also received large grant donations from Weill and Citigroup, and Weill's name was added to the medical school in Manhattan. Through this connection, Bugando became affiliated with Cornell medical school. Le Jacq elaborated on the advantages to this:

> Professors, residents and medical students come out to Bugando, a half a dozen at any one time, on a rotating basis, and spend one to two months, working shoulder to shoulder with the Tanzanian medical students and doctors on the wards and in the classrooms.

Through family friends who worked with McKinsey and Company a foundation was formed, called TOUCH Foundation Now, standing for Training Our Underserved Countries' Healers. Fund-raising began in 2001 and as of 2003 enough had been raised to start the first year. Le Jacq explained, "You only need to build facilities for one year at a

time and thus you can open when you have very little." As the medical school became established they increased the intake each year, to 65 students joining in 2007, and an expected intake of 100 students the following year. The program is a five-year course, following the British system.

Consideration was given to having medical students on scholarship at Weill Bugando Medical College sign contracts stating that they would work in the country for ten years after finishing medical school, during which time they would not be able to get a passport. However, this provision was never implemented; instead, salaries for Medical Doctors in Tanzania were increased, making it attractive for MD graduates of Bugando to remain in practice in Tanzania. Le Jacq stated: "As a result, nearly 100% of Weill Bugando Medical College have remained in Tanzania."

In 2001 Le Jacq asked his ordination classmate, Fr. Dave Smith, to help set up a computer system for learning at Bugando Medical School. At that time Smith was still in Dar es Salaam doing the work of Regional Treasurer, unifying the accounting systems for all the African countries where Maryknollers worked, putting the unified accounting method on a computerized system, and setting up websites for the Africa Region, the MIAS institute in Nairobi, and for Bugando Hospital and Medical School. He narrated in length about his assignment to Bugando.

> I was asked to take on this project at Bugando University College because American medical schools are all teaching with computer-based resources. In the middle of 2001 Peter flew me to New York and took me to Cornell, where I interacted with the people of the Medical School's computer department for two weeks. I attended daily classes and talked with professors and students, trying to form a picture in my mind how this might be possible in Africa.
>
> A lot of my work in mission was medical oriented – running the hospital, being involved with the medicines, getting new doctors, and dealing with patients. In villages where there were no dispensaries, after Mass many times I talked with people who were having medical problems. These experiences made me keenly aware of the importance and need for quality medical care.
>
> My work at Bugando was a natural extension of many of the things I was doing but taking it to a different level. In many ways I was uniquely qualified. I majored in computer science in college before going into the seminary and given my involvement in various health ministries while in mission in Tanzania, it seems as if the Lord was preparing me for this position. I also had cultural knowledge. I've seen needless suffering, either through lack of medical care or incompetent medical treatment that made people sicker. I had the skills to train doctors in up-to-date modern techniques that they can continue to keep up to date by use of the internet and computer technology. And I came here because this is not just any school or college; we are doing this (i.e. medical care of very poor people) as a faith response.
>
> I see also a bigger possibility. If we do succeed with this computerized, internet-based mode of learning, then this model of education can be applied in many other areas, including in secondary schools. African schools don't have

libraries; they don't even have text books for students. A computer gives you access to a world-wide library that is tens of thousands of text books.

In 2002 Smith moved to Mwanza, where he continued to be Regional Treasurer while setting up the computerized medical library at Bugando Medical School. At this same time Fr. Jim Eble was starting a new parish in Mabatini (Cf below) and Smith helped out with Masses on weekends. He also said Mass for various communities of Sisters in Mwanza. Thus, he kept a foot-hold in pastoral work.

With regard to questions about the appropriateness of computer technology in a very poor country lacking even good telephone service (until the cell phone revolution swept through Sub-Saharan Africa in the mid-2000s), Smith commented:

> It is amazing how quickly new technologies are spreading in Tanzania. In Dar es Salaam there are over 500 internet cafes doing a brisk business, along with dozens of private computer schools. Most of our Maryknoll missioners use computers in their ministries, even in the remotest locations. The government is working to teach computer courses in all secondary schools. To encourage Information Technology industries, the government has removed all customs and taxes from computing equipment. The Medical School at Bugando can now buy complete computer systems for $700 each. Through the miracle of the Web, medical schools in the poorest nations can access the same information, including current texts and journals, as any medical university in the developed world. The World Health Organization has taken the lead in making this possible. It has been actively encouraging publishers of medical books and journals to make their online versions available free of charge to Third World medical schools.
>
> By its very nature, the Internet is ideally suited to offer equal educational opportunities to all people. Doctors will no longer have to leave their native country to avail themselves of the world's best educational facilities. Then Africa's sick poor will have more trained health personnel to treat them.
>
> Following a problem-based learning model of education that has been developed by Weill Cornell Medical College, the Tanzanian school will endeavor to train medical doctors, nurses, dentists and pharmacists to the same level of proficiency as their American peers. With Cornell providing the course curriculum, training for the professors, and computer equipment, my job will be to enable the African professors and students to utilize computer technologies in their teaching and learning. Approximately one-third of the course material is to be computer-based, including the problem-based learning labs in which the future doctors are taught the diagnostic process.

Smith remained living in Mwanza up till 2010. In 2007 he was elected the Regional Superior for Africa and followed the model initiated by Frs. John Sivalon and Tom Tiscornia, when they were Superiors, of keeping their apostolic assignments and living at their place of work rather than moving to the Society House in either Nairobi or Dar es Salaam. Smith was asked to move to New York in 2010 in order to become the

Chief Financial Office of Maryknoll and thus he served only one term as Regional Superior.

Over the years friends of the Le Jacq family, and friends of friends, were able to expand the number of donors to several thousand. Le Jacq gave them his card, saying they would have no need to call him unless there was an emergency requiring the services of a priest-doctor. He did not expect many calls, as all the donors were well-off. However, Le Jacq received many calls and he found himself engaging with donors in a pastoral manner. Some were truly tragic situations. Le Jacq said that often parish priests are too busy to do much more than the funeral and doctors never go to wakes or funerals, so he filled those dual roles. When there were funerals, people wrote in the obituary columns to make donations to TOUCH Foundation or to the Maryknoll Fathers & Brothers in lieu of flowers.

As was mentioned above, Liz Mach did the bookkeeping as the liaison between TOUCH Foundation and the medical school. She also was made head of the medical school's Office of Development, whose main task was to seek local Tanzanian benefactors. Although Tanzania is a very poor country there are a small minority who have wealth, such as businesses, banks and individuals. She said that the Bishops, who asked her to accept this position, wanted Tanzanians "to own the medical school project."

The property at Bugando was 100 acres but a number of squatters had moved into the plot. They agreed to move after an ample compensation package was offered and given to them. In addition to this payment, money from the U.S. paid for rehabilitation of the hospital and also for a library and laboratories.

There have been many more developments and improvements in the Weill Bugando School of Medicine, which is the prime educational institution at Bugando, situated under the overall title of the Catholic University of Health and Allied Sciences (CUHAS) at Bugando, Mwanza, Tanzania. In 2010 the enrollment for the first year class had increased to 150, and as of 2015 the total enrollment had reached 750 in the five-year program. The School of Medicine offers postgraduate degrees, Masters in Medicine (MMED), in five disciplines: Internal Medicine, Surgery, Obstetrics and Gynaecology, Pediatrics/Child Health, and Anesthesiology. In 2010 the school added a Bachelor of Medical Laboratory Sciences (BMLS).

In addition to the medical school there are also other schools: the School of Pharmacy, School of Public Health, and a nursing school named Archbishop Anthony Mayala School of Nursing. There is also a School of Graduate Studies, primarily to offer Masters Degree programs for those with Diplomas or Bachelors Degrees in the various schools, but also to offer select PhD programs.

The medical schools are complemented by the Department of Microbiology, Department of Parasitology and Entomology, the Institute of Allied Health Sciences, and the Institute of Infectious Diseases.

The medical library has been modernized in recent years and is fully automated to enable students, and others, to access medical information through computers. The library contains about 9,500 volumes of books, plus CD-ROMS and Videocassettes. It also has 150 journals listed in its database.

The school year runs from mid-October to mid-August. Being a Catholic-sponsored (but government administered) Hospital and Medical School, the school year begins with a special Mass.

The localized institutes at Bugando have had some notable successes. For instance, in December, 2015, the national newspaper of Tanzania, "The Citizen," reported on the isolation of a new form of bacteria that was infecting new-born babies at Bugando Hospital, with resultant death for a number of them. The scientists at the institute found that the bacteria was linked to milk powder. Immediately, actions and protocols were implemented to monitor products being used and improve hygiene in the maternity wards.

The important role that Maryknoll, and particularly Peter Le Jacq, has played in funding this crucial institution in western Tanzania and making it a modern hospital and medical school is inestimable. It is one of the mission successes that Maryknoll can be proud of.

THE AIDS PANDEMIC IN THE LAKE VICTORIA AREA:

Sometime in the 1930s a strain of the simian virus, Simian Immunodeficiency Virus (SIV), which is an ancient virus that has been in African monkeys and chimpanzees for centuries, passed from great apes in the forests of central-western Africa (Gabon, Cameroun, Central African Republic, Congo, and Equatorial Guinea) to a human or humans hunting for bush meat in the forests, which mutated to Human Immunodeficiency Virus (HIV). The HIV virus mutates quickly, compared to normal rates of evolution, and in the following decades other strains appeared, both in the central African forests and also in countries of far-western Africa (Senegal, Ivory Coast). However, HIV spread very slowly in humans from the 1930s to the 1970s and it was only when blood samples of people who had died in the 1950s were examined later that it was discovered that a few of them had contracted HIV/AIDS.

The strain that has caused the most severe consequences is labeled the M-group of HIV-1, which as of 2005 had infected sixty million people globally. This strain has sub-groups and it is one of the sub-groups that eventually was carried to Tanzania in the late 1970s. HIV-2 is less severe and is confined to countries of West Africa from Senegal to Ivory Coast.

It is not unusual for animal viruses to jump to humans, causing human populations to experience catastrophic epidemics – such as the Asian Flu Virus that so decimated the globe in 1918. But why in particular did the animal SIV jump to humans and mutate into HIV? One clue: the 1930s was the height of the European colonial incursion into the continent of Africa. In John Iliffe's book, "The African AIDS Epidemic: A History," from which most of the following historical statements have been culled, he states:

> The earliest known HIV cases in Africa all occurred in francophone territories, where colonial innovations might have converted occasional viral transmissions into a disease capable of epidemic expansion: penetration of the forest for hunting, rubber collection and logging; increased viral transmission

> through labor concentrations and vaccine campaigns against sleeping sickness and smallpox; and the adaptation of the virus to humans through rapid passaging by arm-to-arm inoculation that would have the effect of accelerating evolution.
>
> (This may have been accelerated in the 1950s by) the introduction of supposedly disposable, but often in practice re-used, syringes to inject penicillin and other new medications. Between 1952 and 1960 annual world output of syringes increased from 8 million to one billion.

But in 1959 there was no visible epidemic, even though there were people who had contracted HIV and died of AIDS, with the cause of death at that time unknown to them and those caring for them. Iliffe gives three reasons why it was not until the late 1970s that finally people started realizing that a new disease had appeared: HIV is difficult to transmit; it develops gradually in healthy adults, perhaps even up to ten years before symptoms appear; from the 1950s through the mid-1970s it did not breed a visible epidemic.

Kinshasa, formerly Leopoldville, the capital of the Democratic Republic of Congo (DRC), may have been the original epicenter of AIDS in the 1950s, during the chaotic transfer of power from the Kingdom of Belgium to the independent republic of Congo. Blood samples from that period that were later tested showed that several people in Kinshasa had contracted HIV, without it being recognized. From there, the disease slowly spread east and south – and throughout the globe.

What is AIDS? Iliffe gives the following description:

> The HIV virus is almost inconceivably small: one ten-thousandth of a millimeter in diameter. It consists of a package of genetic information (a genome) surrounded by a protein envelope, the whole containing nine genes, whereas a human being has 30,000 to 40,000 genes. Like all viruses, HIV has no life of its own but is a parasite of cells, drawing its life from theirs. Transmitted from one body to another by blood, genital fluids, or human milk, the virus becomes attached to certain types of cells, the most important being the CD4 helper T-cells that activate the body's immune system. The virus enters a cell and integrates its genetic information into its host, using the cell's life to reproduce itself, which is the sole function of a virus. In doing so the virus destroys the host cell – and hence ultimately the immune system – while producing an immense number of new viruses to attack further cells.

Shortly after being infected there may be feverish symptoms, easily mistaken for malaria. As the years progress there is a war between the HIV virus and the body's immune system. This incubation period can go on for five years to even close to ten years for a very healthy adult. Finally, the immune system is so weakened that the symptoms of AIDS appear, such as Kaposi's sarcoma and tuberculosis. People with full-blown AIDS lose weight rapidly, become very thin, lose their appetite, and develop uncontrollable diarrhea. Death, from the diseases connected with AIDS, not from the virus itself, usually comes in about one year.

As of 2017 there is still no vaccine to prevent HIV/AIDS, nor is there a direct cure of the virus. The opportunistic diseases related to the body's compromised immune

system can be treated, but generally this treatment is too late for someone with AIDS. In any event, it is these secondary diseases rather than the virus itself that kills the person. Even the Anti-Retroviral therapies (both the ARV and ART acronyms are used to refer to these treatments) do not fully eliminate the HIV virus from the body; they reduce the viral load to almost undetectable levels, enabling the person with AIDS to lead a full, productive life for many years. Exactly how many years a person can live without the disease coming back has not yet been determined, as not enough years have yet passed since inception of the treatments. ARVs seem to have their own side effects, the most disconcerting being a possible increase in diabetes.

In the 1990s another ARV, called AZT, was found to reduce the mother-to-child infection rate by two-thirds, without too great an expense. This enabled many more children to be born without AIDS, but the drawback was the impending death of the mother, which would leave the children orphans. The inexpensive distribution of ARVs in the 2000s has helped to reduce the number of new-born infants infected with HIV, but still in 2015 one-fifth of all new infections in Tanzania were newly born infants. Elimination of mother-to-child-transmission (MTCT) is one of the main priorities of the Tanzania government. Ninety percent of women are now tested for HIV at ante-natal clinics, which reduced MTCT by 48% between 2009 and 2012. Remaining obstacles to this are insufficient capacity in Tanzania's health system and ineffective use of treatment regimens.

It seems that AIDS first made its appearance along the Uganda-Tanzania border west of Lake Victoria in the late 1970s. In 1982 several young businessmen died of symptoms characteristic of AIDS in Kasensero, a small fishing village on Lake Victoria in Uganda. In 1983 three people with AIDS were hospitalized in Kagera Region in Tanzania, but hospital staff reported that others with the same symptoms had been seen as early as 1980. Other deaths from the late 1970s were also eventually recognized as from AIDS. It was first called 'Slim' disease, as the wasting away of the body was the first noticeable symptom. Although the Tanzania government was unwilling to publicly announce the presence of the disease, in 1984 two percent of stored blood in Dar es Salaam was infected with HIV. By August, 1986, Muhimbili Hospital in Dar es Salaam had patients in the hospital with AIDS from every Region of the country.

HIV in Mwanza probably came from Kagera, whereas Iliffe has concluded that Mara Region's epidemic probably was linked to that of Nyanza Province in southwestern Kenya. Musoma is the capital of Mara Region. The disease was carried by mobile traders who frequented bar girls (i.e. sex workers) and then carried the infection into rural areas. Arusha and Kilimanjaro probably received the disease from local traders who travelled to Kenya, Dar and Regions west of Lake Victoria. Mbeya and Iringa, which lie along the Tanzam Railway between Dar es Salaam and Zambia, had their own unique form of HIV outbreak. Iliffe states: "Because HIV entered Tanzania from all directions, the country had an unusual diversity of subtypes and unique recombinant forms." (Recombinant refers to being infected more than once, often with different strains of HIV.)

Advances in transport and mobility were one factor in the spread of AIDS. Major highways became the locus of HIV infection. Another factor, paradoxically, was the advances in medicine, such as vaccinations and treatments for many diseases that previously killed young people. Death rates went down and life spans increased, resulting

in people living long enough to both die of AIDS and infect others. Refusal to acknowledge AIDS and lack of general awareness of the disease were other factors that hastened the rapid spread of AIDS, so that by 1990 most Regions of Tanzania had HIV infection rates of five to fifteen percent. Weak public health capacity was also an important component of inability to adequately confront the growing epidemic. There was also the belief in the early and mid-1980s that AIDS was linked with homosexuality in western nations and therefore less likely to develop in Africa.

After the year 2000 the rate of HIV infection in Tanzania gradually but steadily decreased, from 7% in 2003 to 5.3% in 2012 to an estimated 4.7% in 2015. However, the percentage of women who are infected is almost twice that of men. The Region with the highest rate of infection is Njombe, southwest of Iringa, which coincidentally is one of the Regions where male circumcision has not traditionally been practiced. The Tanzania government introduced a voluntary male circumcision program that has been very successful in Njombe and Iringa, another Region that did not traditionally have male circumcision, but other Regions have lagged behind. Male circumcision can reduce the chance of being infected by up to sixty percent.

Although very few men in Tanzania practice homosexual sex, those who do have a far higher chance of being infected with HIV. In 2015 it was estimated that 25% were infected, a decline from 42% prior to the year 2000. Part of this decline is attributed to condom use, although it is estimated that only half of these men actually use condoms.

People who inject drugs are also very susceptible to HIV. In 2014 it was estimated that there were 30,000 people who injected drugs in Tanzania, of whom over one-third were living with HIV. In Mwanza, a study in 2015 found that of 480 drug users 13.5% injected drugs and that two-thirds of this group shared needles, greatly increasing the risk of contracting HIV. The study also proved that drug use, especially of heroin, was a major problem limited not only to Dar es Salaam and Zanzibar, but also to Mwanza and maybe to other urban areas as well.

In 2011 Tanzania, with assistance from PEPFAR, became the first sub-Saharan country to institute a 'harm reduction' program for drug users. Methadone clinics were started in two large hospitals in Dar es Salaam and needle exchange centers were opened through which clean syringes were distributed for free. So successful was this program that Tanzania became a model for neighboring African countries.

The relationship of migration and mobility to HIV infection is demonstrated not only by truck drivers but also men who travel to work in mines, agricultural plantations, and in the coastal fishing industry. Fishermen along the Indian Ocean coast travel up and down the coast, stopping overnight in various fishing villages. Additionally, women who travel away from home five times a year have been found to be twice as likely to be infected as those who do not travel. Other sectors at risk include police officers, prisoners, and military servicemen and women.

High income is also related to a greater risk of infection. The top twenty percent of Tanzania's income earners have the highest rate of infection. In Tanzania there is a co-relationship between mobility and higher income.

Zimbabwe was the first African country to implement a policy of screening all blood before transfusion, in July, 1985, and in January, 1986, Uganda organized a national program of public education, condom supply, and blood screening. All of these actions contributed to Uganda's infection rate dropping in the 1990s, but the intense

public education campaign may have reaped the most rewards. Uganda was an exception, unfortunately. Throughout the 1990s the rate of HIV infection continued to increase in Tanzania and in most of Sub-Saharan Africa.

MARYKNOLLERS IN MWANZA AND AIDS:

As was mentioned above, Tanzania did not begin to officially acknowledge the presence of AIDS until sometime in 1987, at the same time that Frs. Scott Harris and Pete Le Jacq arrived at Bugando Hospital – only to discover to their amazement that up to half of the patients admitted to hospital beds were afflicted with AIDS. The priest/doctors believed that the government was loathe to publicize the presence of AIDS for fear of losing tourists. Tourism is a major source of foreign currency.

Le Jacq talked about how they began working in the field of AIDS care and prevention.

> The first thing we did was start identifying HIV positive people on the wards, counseling them, speaking to their spouses, and having a follow-up plan for when they went home, anticipating an early death.
>
> Shortly after that we developed a counseling program, where through John Eybel's CPE program his chaplaincy students were made sensitive to HIV and taught specifically how to do pre- and post-test counseling, crisis counseling, and after care counseling.
>
> We then expanded our program to prevention and reached out to grammar schools, high schools, parishes and seminaries. We included HIV positive people in the program, which was slow going at first. It took one year to get any HIV positive person to agree to do it, as it was not popular in Tanzania to stand up and say publicly that one has a sexually transmitted disease.
>
> We used some audio/visual programs, which were enjoyable for the Tanzanians and effective, because we could show them to many people at a time. Then we liaised with the Maryknoll Sisters in a diocesan home-care program. And finally we moved to orphan placement.

In addition to training student-chaplains to do AIDS counseling in his CPE program, John Eybel also procured funding to pay nurses to counsel patients with AIDS during after work-hours. The Archdiocesan AIDS Taskforce was also able to purchase a vehicle, in order to do home visiting of AIDS patients who had left the hospital for their rural homes. Eybel also invited some of the patients themselves to join the counseling program and gave them basic skills in empathetic listening.

In Eybel's opinion, those with AIDS would be the most compassionate listeners and would be more adept at advising others where to find an agency that could give them services, how to look for and obtain financial assistance, especially for medications, and about many other issues specific to their condition.

Shame and stigma were inveterate side-effects of an HIV diagnosis. Eybel talked about one man who received a diagnosis of AIDS, Michael Binamungu, who decided that his redemption would come from two complementary actions: first, raising educational awareness by giving public talks about AIDS and prevention; and secondly by reaching out in a caring way to HIV positive people experiencing guilt, depression and isolation.

He would invite them to join a group of HIV positive people, so that together they could overcome their feelings of shame and loss of self-esteem. Through Binamungu's intervention they resumed social relationships, conquered their shame, and were able to face the inevitable future with some sense of joyful hope. Pete Le Jacq became a good friend of Binamungu and did everything medically he could to prolong his life. Binamungu lived about five years after receiving the diagnosis of full-blown AIDS and worked tirelessly in trying to prevent this disease from crippling others.

Unlike Binamungu, for most people social stigma from outside, accompanied by internalized feelings of guilt, produced the desire for secrecy. Ten to fifteen percent of women in Tanzania have reported that health workers have attempted to coerce them into not having children, accepting sterilization, or terminating their pregnancies, reasons why many women hide their HIV status. One young girl was quoted as saying: "At home my mother and I have been tested and been found to be HIV positive. She told me to not even tell my relatives and not even my own sister, because she is afraid I will be stigmatized."

Stigma is exhibited by HIV negative people, by avoiding those who are infected and expressing strong negative attitudes towards them. Many people have called for HIV positive people to be quarantined, although fortunately this type of extreme action never was enacted.

The Maryknoll Sisters came to Mwanza in 1992 to help with outreach and ministry to people with AIDS. The first one was Sr. Veronica (Roni) Schweyen, who did AIDS ministry in the parish of Nyakato outside of the city of Mwanza, working with a team that did counseling and education. Several people from the team took the four-month CPE course at Bugando Hospital. After a visit to Mwanza by a training team from Uganda, the Nyakato Parish team started a Behavioral Change Program, running seminars for youth, adults and teachers within the parish and in other parishes. Schweyen remained in Nyakato until 2003. The program is still in operation in Nyakato.

From Nyakato Schweyen moved to a parish in the city of Mwanza, Nyakahoja Parish, where she organized a training program for people chosen by their Small Christian Communities to be Visitors of the Sick. In the city, Schweyen also became aware of the huge number of AIDS orphans and much of her efforts were with them and their families. Schweyen finished up in Mwanza in 2010 and returned to the United States.

Also in 1992 Srs. Katie Erisman and Katie Taepke moved to Mwanza and joined the Archdiocesan AIDS Taskforce, which included Sisters of Our Lady of Africa (MSOLA, formerly known as White Sisters), Sisters from several Tanzanian congregations, and laity. This group visited patients in hospitals, did counseling, went to homes, distributed medicines (both Maryknoll Sisters were nurses), and helped to form support groups.

One action urged by the Taskforce was for AIDS patients to write a will. The Sisters cited a least one case in which a woman widowed by her husband's death from AIDS would have had all her property taken by the man's family had it not been for the man's will decreeing that she should retain the land, house and furnishings. Dying intestate has been a problem in many parts of East Africa because the legal system has deferred to cultural law, which grants greater legal recognition to a deceased man's

brothers (i.e. the clan lineage) than to his widow. This is one area where International Law is in conflict with Traditional Law in Africa, and the conflict has not been fully resolved yet. However, if a man writes a will then this takes precedence over cultural law.

Erisman also worked with the Behavioral Change Program of Nyakato, which included taking seminars to parishes in Musoma and Shinyanga Dioceses. After several years, both of these Maryknoll Sisters moved into other ministries, but the AIDS Taskforce remains in operation.

Another Maryknoll Sister who came to Mwanza, in 1997, was Rosemary (Ro) Milazzo, who had previously worked in northeastern Kenya. She settled at Ilemela Parish in Mwanza, near the airport, and engaged in many forms of AIDS ministry, such as home visiting, counseling and group formation. A major effort of Milazzo's was in organizing assistance to orphans and the families taking care of them. In 2003 Milazzo returned to the United States.

Others who came to Ilemela were Maryknoll Sisters Pat Gallogly and Celeste Derr, along with Maryknoll Lay Missioner Joanne Miya. In addition to AIDS ministries, which by the mid and late 2000s had become focused on orphans, they also did general pastoral work.

Other Maryknoll Sisters worked in Mwanza city in the 2000s, such as Ann Klaus, Li Ching Chen and Marian Teresa Dury.

One special program, called Capacitar, was begun in the early 2000s with the help of three Maryknoll Sisters, Pat Gallogly, Peg Donovan, and Roni Schweyen. This program trains workshop leaders in innovative new educational methods that work to alleviate trauma, stress and emotional pain.

For more detailed information on the ministries of Maryknoll Sisters in Mwanza please refer to the book by Sr. Katie Erisman.

With regard to orphans, in 2012 the Tanzania government counted 1.3 million children throughout the country orphaned by parents dying of AIDS. Le Jacq was asked in an interview whether opening orphanages was a viable response to this problem. He replied 'No,' with the following explanation:

> Orphans are being care for by their extended families. We do not have orphanages anyway. But we have to search out the most healthy extended family and give them some kind of self-help project, so they can support an extra half dozen children.
>
> Orphanages are inhuman anyway. They are a necessity in a culture that does not have extended families. They are a potential aberration in a culture where you do have a network of extended families.

Le Jacq further explained that he and others advocated against some religious who wanted to build and open orphanages, primarily because it made the religious feel good. "One of the things we have been fighting against is the building of orphanages."

The issue of condom use as a means of protecting oneself and one's partner from contracting AIDS has persistently been debated in the Catholic Church, as it is seen as a form of artificial birth control. Governments promote its use because it definitely reduces the number of new infections nationally. Both Harris and Le Jacq commented that

condoms were not 100% effective – in the 1990s; its effectiveness in the 2010s was not commented on – and Le Jacq said he did not recommend condom-use to HIV-negative people. He encouraged fidelity within marriage as the safest method to avoid infection; marital fidelity also serves couples that want to grow their marriage in a holistic, spiritual manner. Harris did add that from a scientific viewpoint the Church's opposition to use of condoms was not the most enlightened position that could have been taken. Both he and Le Jacq referred to the rule of double effect within moral reasoning: if the primary intention is to perform an act with a necessary and good effect, then a secondary, unintentional effect can be tolerated. As a priest, though, Harris followed the policies of the Tanzania Episcopal Conference when he was working at Bugando Hospital.

The importance of awareness-raising and education about AIDS for youth was stressed by all the Maryknollers who worked in Mwanza. In 2014 the percentage of adolescents, aged ten to nineteen, who were HIV positive was 6%. Factors included risky sexual behavior (i.e. not using condoms), having multiple sex partners, and first having sex before age fifteen. Emphasizing the importance of education, the organization AVERT stated: "Comprehensive knowledge about HIV is low; less than half the young people have adequate knowledge." Scott Harris stated that youth work, with special emphasis on AIDS awareness, should have been one of the foremost priorities of Maryknoll in Tanzania in the 1990s.

In fact in the late 1980s general awareness of AIDS was so low in Tanzania that Harris wondered whether his own priority should have remained doing surgeries or doing public education work. He explained: "For me this is a divergence after six and a half years of studying surgery. But we know how AIDS is transmitted and we know that the likelihood of it being stopped is almost nil, unless massive, intensive, culturally sensitive efforts are used. And so far they're just in the beginning stages in this country." (1990)

One specific syndrome of AIDS in Tanzania (and in all of East Africa) is what is called the 'Sugar Daddy' culture, i.e. the practice of adolescent girls and young women to offer sexual favors to older men in return for gifts or money or social advancement. This practice, the social inferiority of women, prevalence of gender violence waged against women, and earlier introduction to sexual intercourse for girls, in many cases by force, have led to the higher rates of HIV infection in girls and women when compared to men.

When Le Jacq was interviewed the American interviewer was not aware of the sugar daddy culture, as it had not been reported in American medical journals. Le Jacq assured the interviewer that it was a well-known practice in East Africa and had been well reported in East African medical literature.

The Maryknollers were interviewed in the 1990s and early 2000s, when the darkest consequences of the rapidly growing AIDS pandemic were at their peak, accounting for the bleak assessment of how to properly respond. Since the early 2000s two crucial advances have profoundly changed the atmosphere surrounding AIDS, giving people hope: Anti-retroviral therapies (ARTs) and Voluntary Counseling and Testing sites (VCTs).

In 2015 there were 2,137 VCTs in the country and over 90% of people knew where to get an HIV test. In 2013 Tanzania introduced home-based and community testing, and made testing in health clinics routine, unless the patient declined. Over half

of Tanzanians as of 2011 had been tested at least once, but only slightly over a quarter of the population had taken a subsequent test in the previous twelve months. Of concern, studies in 2012 indicated that the percentage of the population going for testing was decreasing.

The provision of ARTs through the VCTs and other community-based programs was greatly expanded beginning in 2004, in great part due to the United States PEPFAR program. [Editorial comment: this program has saved millions of lives in Africa and is the positive legacy of President George W. Bush. Perhaps later in this century this legacy will override, in historical accounts of his presidency, the disastrous effects of the never-ending Iraq and Afghanistan wars and the collapse of the American economy in 2008.]

In 2015 53% of adults in Tanzania living with HIV were receiving ARTs, which are distributed each month for free at the community level. This was a total of 688,600 adults, an increase from 500,000 in 2013. Furthermore, 56% of HIV positive children aged 0 to 14 were receiving ARTs, a total of 51,400 children. There were 1,209 facilities providing HIV treatment – equal to three facilities for every 100,000 people. (In 2013)

The AVERT website stated: "The Tanzanian government has begun to simplify drug regimens, moved to fixed-dose combinations (FDC), and has phased out toxic drugs such as Stavudine. In addition, new guidelines are being issued to increase eligibility and access to ART to sero-discordant couples (i.e. in which one spouse is positive and the other negative), all pregnant women living with HIV, and key affected populations."

In Sub-Saharan Africa an innovative Cash Transfer program has been implemented in certain places. In one Tanzanian pilot program cash incentives of $10 to $20 were given to young adults aged 18 to 30, as long as they were free of sexually transmitted infections (STIs) for one year. Results showed that this program reduced the risk of STIs by 25%. The Tanzanian government said that increased condom use was the chief means by which the young adults achieved this gain.

Although the prevalence of HIV has decreased in the past fifteen years and the number of people dying has dropped dramatically, there remain many challenges, such as: a woeful lack of doctors; discrimination against people with HIV/AIDS, sex workers, and men who practice gay sex; gender-based violence (GBV); stigma; and economic poverty. The Tanzanian HIV response is heavily reliant on outside funding, with 97.5% coming from foreign donors.

In any event, in 2015 there were 1.4 million people living with HIV in Tanzania, 4.7% of the population, indicating a drop from 1.6 million in 2011. In 2015 there were 54,000 new HIV infections and 36,000 AIDS-related deaths. 53% of HIV infected adults were on ART treatment.

Thus, even though the necessity of a comprehensive Church response to AIDS is not as crucial as was the case in the 1990s, in fact this pandemic has not gone away and prevention and treatment are still unavoidable. There are fewer Maryknollers in Tanzania in 2017 than there were in the early 1990s, but the response to AIDS continues to be a part of their ministries, whether in Mwanza, Dar es Salaam or in rural parts of the country.

<u>MABATINI, TRANSFIGURATION PARISH:</u>

After having worked at Issenye Parish in Musoma Diocese for six years, Fr. Jim Eble then returned to the United States and worked for Maryknoll's Vocations Department from 1997 to 2000. In April, 2000, he returned to Tanzania without a clear idea of what he wanted to do, but even then he was contemplating some kind of work in spirituality, such as in a retreat center. He was invited by Fr. John Eybel to take the CPE program at Bugando, which Eble did for two years. In 2001, while still taking the CPE program, Eble started helping Bugando Parish by saying Mass at Mabatini, which was an outstation of Bugando. After finishing the CPE program in 2002, Eble asked Archbishop Mayala if he could work full-time in the Mabatini area to see if it could be developed into a parish. He was living at Bugando, but at some time between 2002 and 2004 he moved into a rental house in Mabatini, about a half mile below the parish property.

The plot had an existing church that at that time was sufficient, with two Masses on Sunday, to serve the Catholic community. After two years of developing Mabatini it was officially established as a parish in August, 2004. In 2004, Eble was joined by Fr. Don Larmore, an Associate Maryknoll priest who had been the pastor in Issenye in the 1990s. Eble said that starting a parish at Mabatini was not a Maryknoll initiative.

> It was my personal initiative. I was the one who talked to the Bishop. Later on Maryknoll came in to make it official. So, it was not a Maryknoll commitment.

One of the original obstacles they ran into was the presence of scores of families that had moved onto the parish plot as squatters and built simple mud houses. It was extremely difficult to get these people to move away, even with ample compensation, as there were not many places for them to move to. The diocese had been granted the plot many decades earlier in the 20th century, a plot lodged between two primary schools. However, as the decades passed and little was done on the plot except for the medium sized church, squatters continuously kept moving onto the plot. Larmore said that the parish had a lawyer helping them, who told the priests that if they weren't attentive to what was happening it would get increasingly difficult to evict people. Because of socialism and nationalism of all the land, there were not clear legal protections for private plots as in other nations which recognize private land holdings. Even though the plot was not private land (as understood in the United States), it was recognized by the Tanzania government as allocated for church use under the auspices of the Archdiocese of Mwanza. Thus the Church was legally allowed to remove the squatters.

For Larmore, one thing that helped was that many of the squatters, in particular many Kuria people, came from Musoma Diocese, where he had previously worked. He felt that he could talk with them more easily and fruitfully. Eventually the compound was cleared of squatters, the boundaries demarcated and the plot fenced.

In 2003, before the parish was established and a rectory built, Eble mentioned the sundry challenges he foresaw.

> This is an inner city parish in one of the poorest areas of Mwanza. It has different ethnic groups, a lot of young people, a big mixture of people, some educated and some not educated. The challenge is to enable us to move together as one community, because we have different views.

There are also pastoral challenges: a big one is marriage. Men in the city don't practice polygamy in the traditional sense, but have what is called "a small house," that is a woman and maybe a family in the city, in addition to his formal marriage to a woman living at the rural home.

Another is the traditional ways of dealing with evil, which we call witchcraft. Some traditional ways can bring healing but can also be destructive. Our challenge in proclaiming the gospel is to filter out what is evil while keeping what is life-giving. The tendency has been to throw out everything from African culture.

In African culture having children is integral to being an African. So, I have to show, by my presence and the way I accompany the people, that I am really with them and for them. Priests are called 'Father,' but we have to act fatherly.

Both Eble and Larmore commented that AIDS was present in the Mabatini area but that people didn't want to talk about it. At the parish level the chief means of combating AIDS was education. They had seminars on AIDS twice a year and made a target of preaching about it at Sunday Mass three times a year. The youth group also prepared and performed a skit about AIDS in church one Sunday in 2005. Larmore said that in Mabatini they followed the diocesan proposal of having an AIDS representative in each Small Christian Community, who would facilitate a caring response by the local community towards someone with AIDS. Much of the trauma of AIDS was alleviated when the ARTs became available for free to the people with HIV.

Visiting the sick in the parish was part of pastoral practice, but Larmore said that one never knew who had AIDS and who had merely a normal tropical disease.

People with AIDS come to Mwanza to be taken care of by their family, by their relatives. When it becomes really bad they go back to the village to die. So, it's still a hidden killer in the sense that it's not really identified. People aren't tested to know who has AIDS. (Larmore said this in 2005. By 2017 there was more compliance with testing, but it was still insufficient.) We in the parishes need a specific program of how to address this issue, but we are all doing something different.

Having a collaborative working arrangement with priests and Religious of other Religious Orders, as well as with diocesan priests, was a beneficial aspect of being stationed in the city of Mwanza, according to Larmore, who had said the same thing about his two years in Dar es Salaam. Parishes that neighbored Mabatini were staffed by Jesuits, Claretians from Kerala in India, SMA priests and diocesan priests. And, of course, the White Fathers still had several parishes in the city and in the diocese. Larmore said, "You've got all kinds of different religious groups here. That to me is the exciting thing about the city."

Eble expected that after he oversaw construction of a rectory and extension of the church the parish would be turned over to the Archdiocese and staffed by a diocesan priest. Although he had access to Maryknoll funding for construction, augmented by his

own personal mission funds, he wanted to carry out the construction at a slow pace, consistent with how an African priest would be forced to do it, not having the same access to outside funding. Thus, the rectory was not completed until 2011 and the church extension, which was about three times the size of the original church, was not finished until late in 2012.

The rectory is a huge, eight-bedroom building with a large living room, dining room, kitchen and chapel. Eble explained his reasoning for constructing such a large building.

> There was a diocesan synod with the vision that diocesan priests would live together and go out to different parishes. Each would be a pastor of a parish, but living in one place and supporting one another. There have been problems caused by priests living alone, such as drinking.
>
> This could also be a rest house for priests from rural parishes who can stay here rather than in a hotel. Right now they come to Mwanza, stay in hotels and get problems. Bishop Mayala actually issued a directive once, "Don't go to hotels." Not merely don't stay in a hotel, but don't even go to hotels.
>
> So, this big rectory could be like a hotel. It even has a chapel.

Hotels, of course, are not in and of themselves places of danger for celibate priests, even though the best tourist-class hotels in Mwanza usually had a few prostitutes sitting in public places in the evening. There were many aid workers in western Tanzania, such as in the refugee camps, and they frequently came to Mwanza for meetings, conferences, or just for a break. It is possible that some paid sex workers on occasion. Tourists from overseas also stopped in Mwanza, usually as part of a trip to the national parks. However, one would have to question the common sense of anyone seeking sex with a prostitute in the era of AIDS, when probably over half the prostitutes in Mwanza were already infected with HIV. In any event, having a few church-connected guest houses in Mwanza for priests had merits to it on several fronts.

In 2012 Eble was interviewed and said there were about 80,000 people living in the territory covered by Mabatini, about four square miles, and he estimated that 25% to 30% were Catholic – so around 20,000 to 25,000 Catholics. About 95% of the people were squatters, living in a variety of shanty-houses going up the rocky hillsides that surround Mwanza. There were twenty-two Small Christian Communities in the parish and visiting them was an integral part of pastoral work. Ethnically, about sixty percent were of the Sukuma tribe, but there were many people from ethnic groups located in Mara Region (i.e. from Musoma Diocese), such as Kuria, Luo, Bajita and others. The Kuria and Luo were well represented in Mabatini Parish, because they had a higher percentage of their population who were Catholic than the Sukuma. There were also many Wakerewe people, who also tended to have a relatively high percentage of Catholics. Larmore said that one characteristic of the Sukuma in Mwanza, also referred to as Washashi, was that few Catholics had canonical marriages. He thought that predicament would inhibit a Sukuma priest from doing effective pastoral work in Mabatini.

Eble described the pastoral work as follows:

> It is much more intensive and stressful here. There is constant noise. It is much more compact, with people piling up on top of one another. My vision was to create an ecology of Transformation in Christ, a physical environment that allows people space to be formed in Christ.
>
> We have a literacy program here. We also provide liturgical space, so that people can have that African joy and confidence, when praising the Lord. The city is densely populated, there are regular riots and there are political conflicts. It is not a war or refugee situation, but like a low-grade stress here. There is poverty here. Witchcraft is really big. And there are religious conflicts, between Christianity and Islam. So, part of our pastoral program is to provide people with a place to deal with the stresses.

When he was interviewed in 2012 Eble said that he was so immersed in the parish that he was not fully conversant with what was happening at the broader level, but he reported that there was an intensification of conflict with Muslims. He said that twice the Archdiocese had warned each parish that some radical Muslims had threatened to burn down churches, although nothing like that ever happened. But he thought that just a warning like that was indicative of changes taking place in Tanzania, the build-up of stress that made people more aggressive.

Larmore added that Bishops were placing their primary emphasis on staffing urban parishes, such as in Dar es Salaam and Mwanza – to the detriment of rural parishes, which were going unstaffed – because of fear of Islam. (Cf Larmore's comments on the conflict with Islam in the section on Mtoni Parish in Dar es Salaam.) As Catholic parishes had a strict two-year catechumenate, this gave an advantage to Islam, which did not have such a requirement to become a Muslim, according to Larmore. He also noted that Muslims would use marriage, i.e. a marriage between a Muslim man and a Christian woman, obligating her to join Islam, to reduce the number of Christians in Tanzania.

Eble said that he was glad that their rectory was a quiet, restful place, "like a cloister. This gives us a good space to be healthy, to pray, to reflect, to work on a good homily, to work on good teachings." When there was a large enough community of Maryknollers they had community prayer after supper.

In 2007 Larmore returned to the United States, to his home diocese in Nebraska. He was not sure whether Maryknoll would keep Mabatini Parish permanently, after all the buildings were constructed and the parish solidly established, or if Maryknoll would want to keep the parish as a place to assign OTP seminarians and new priests, as well as being a quasi-center house for Maryknollers. Larmore pointed out in 2005 that later that year two OTP students were coming to Tanzania, first to study Swahili and then be assigned to Mabatini in January, 2006.

In January, 2006, the two OTP students arrived, Hung Minh Dinh and James Egan. Egan stayed only for a while and then did not continue in Maryknoll. Hung stayed for his two full years, up till June of 2007, and he described his ministry as follows:

> At first I didn't have any plan for what my ministry would be. One day I went with some local people of a jumuiya (Small Christian Community) in order

to visit the sick. My invitation was to visit only one but then they told me there were others. I visited four more, five in all that day. They were very happy because they hadn't received a visitor for years. After that day I decided that this was my ministry.

At that time Mabatini had 22 SCCs. I went out almost every morning to visit the sick, walking up and down the hills, accompanied by people from the SCC. I would pray with the sick and give them communion. By visiting I got to know them and they shared with me. Some had pastoral problems that I as a seminarian could not solve. I brought back the information to Jim (Fr. Jim Eble), so he could provide the service needed.

When I visited the community we went from house to house. I found that my visits gave the people energy. A number of them had stayed at home for a long time, but after my visit some became better and came back to church. So, I found that to be a very powerful ministry.

Hung returned to the U.S. in 2007 and was ordained in 2008. After ordination he originally tried to work in the Nuba Hills of Sudan, but the war situation made this untenable. In 2009 he transferred back to Tanzania and was assigned to Ndoleleji Parish in Shinyanga Diocese.

With both Larmore and Hung gone, Jim Eble carried on alone for over a year and a half. Unsure if another priest would be assigned, he put out a request for a Brother to come to do special work in the parish. Fortunately, Brother Mark Huntington was available and had exactly the skills and training that Eble was looking for. Eble put out a job description about a place on the edge of the city, a community of poverty that had a real need for medical care. Huntington had a degree in Public Health and found it appealing to be able to use his knowledge back in Africa.

Huntington had been a Maryknoll Lay Missioner in Bura-Tana Parish of Kenya's Garissa Diocese from 1993 to 1998. Before joining the Lay Missioner program he had already obtained an Associate Degree in Laboratory Medicine and a Bachelors Degree in Clinical Microbiology. After concluding two terms with the Lay Missioners he joined the Maryknoll Brothers' Formation Program in January, 1999 and did formation up till 2001. He had not intended to do academic study at this time, because formation is full-time on its own, but after one year in formation he took a course in Health Care in Developing Countries, which led to him gaining sufficient credits for a Masters Degree in Public Health from Boston University. After two years of Brothers' formation, he did OTP training in Metangula Parish in Mozambique. In 2003 he returned to the formation program in Chicago for one year and then did further ministry in Metangula up till 2006.

From 2006 to 2009 he helped set up the Assisted Living Program at Maryknoll, NY, beginning with fourteen retired Maryknollers who agreed to join this community living at the headquarters. In 2009 he was ready to return to Africa and was pleased at the invitation extended by Eble. Huntington described his health work as follows:

In the beginning it was just to get to know the community and what their health needs were. We started a parish health committee consisting of nurses and lab technicians, which had two focuses. One was to guide and assist me in doing

research, to see what was available, what was needed, what the top ten diseases were in the clinics, and where we can refer people. Through workshops in the parish we also leaned what the community perceived as their health needs.

Secondly, while doing the research, we also began with some programs. We set up eye clinics, sent two people to Sengerema Hospital to learn physical therapy, worked with the physical and occupational therapy departments at Bugando Hospital, and referred people with children with disabilities to get places for their children in school.

The research that was done produced no major surprises for me. This led to establishment of another committee that included people from the community, which identified major health problems. These included environmental health, particularly sanitation, health education, poverty, mental health problems including abuse of alcohol and drugs, and divorce or the breakdown of marriage.

Once they identified these five priorities, the leaders decided to set up another committee, a combination of people from the parish and those who work in community health. The committee had two functions: one, to mobilize people when we had clinics, such as the eye clinic; and two, to address the public health priorities identified by the community at large.

When talking of the community, Huntington meant the government administrative Division, which was coterminous with the parish with the exception of one neighborhood that was in another parish but included in Mabatini's public health outreach.

Huntington was surprised when the committee established to implement the action priorities chose education about divorce and other family problems as their number one priority. He thought that environmental problems and tropical diseases were the more important public health issues, but after reflection he commented:

> As I got to thinking about it, and this is why we seek to know what the community sees as their needs, what they were basically saying was: "If we don't have peace at home we are not going to be able to change our environment and we are not going to have the money to get the medical care we need." So, we have had a number of workshops just for our committee looking at the subject of divorce, domestic violence and problems within families. And now we believe we can put together a workshop that we can do in the communities. (Huntington said this in February, 2012.)

As the government division was somewhat larger than the parish, the area covered by Huntington's public health program encompassed slightly over 100,000 people. They estimated that there were on average seven people per family. The program had one person hired full-time to work with the handicapped. She also helped with the workshops. In addition there were fifteen volunteers from the committee who helped organize the clinics and participate in the workshops.

There were several other fascinating innovations started as components of the public health program. One was the garden in back of the rectory that had a variety of trees. The leaves of one tree produced lemon-grass tea, good for treatment. Other trees were papaya, orange, lemon, and mango; the leaves of all these trees can be used for

various kinds of natural remedies. Huntington said that one purpose of the trees and garden was for shade and to make the property around the rectory look presentable. But the trees had another purpose: to be a demonstration garden that people in Mabatini could copy at their homes. Huntington collaborated with an organization called ANAMED, an acronym that stands for action in natural medicines.

Another development was to teach local women how to make yogurt from locally produced milk. The women, acting as a group, rented a small store and sold the yogurt daily, with apparently good results. Yogurt, of course, is basically soured milk, which is a basic food for all the subsistence farming families in East Africa, so a ready market existed in the city for this product. The Maryknollers at Mabatini were also regular customers at the women's store.

In response to a question, Huntington said that there were many clinics around the city but very little public health outreach. The public health program in Mabatini was unique in the Archdiocese. He explained that there were other growing health issues that needed more concerted educational actions.

> There are many people who have blood pressure and diabetes problems. Clinics at the hospitals treat diabetes and hypertension, but there is no screening going on in the communities. Unless people have gone to the hospital these diseases go undiagnosed, and we believe there are many cases that are not diagnosed. So, just as we have done with the eye clinics we hope to soon open some hypertension clinics. In our Ward there is a clinic that treats these diseases and we intend to schedule specific days when we can bring people in for screening.
>
> I think the biggest role is to educate people about the services that are available and to do the screening in order to uncover the extent of these diseases.

Huntington stayed on at Mabatini up to 2014, when he returned to the United States to do further work with the Assisted Living facility at Maryknoll, NY.

In 2011 two other Maryknollers were assigned to Mabatini, Brother Loren Beaudry, who arrived at the end of January, 2011, and OTP seminarian Lam Hua, who came in September, 2011. As a result, for close to a year the four residential rooms at Mabatini were occupied, but this left four other rooms for guests.

Beaudry had previously worked in Kenya for over sixteen years and knew Swahili fairly well. After leaving Kenya (Mombasa) in 2003 he worked in the Maryknoll Formation Department in Chicago for three years. He then accepted an assignment to Namibia, where he worked in Nyangana Parish of Rundu Vicariate, in the northern most part of Namibia around 450 miles north of the capital, Windhoek. In 2010 he concluded his ministry in Nyangana, returned to the U.S. for furlough and took a course in New Mexico in the fall of 2010. He came back to East Africa in January, 2011, and was informed his assignment would be in Mabatini. However, the rectory was not quite finished and he was requested to wait until the end of January to go to Mwanza. This gave him an opportunity to visit Mombasa where he had previously worked.

On arrival in Mabatini Beaudry did not have a specific type of work assigned to him. In fact, the Africa Region was not even sure that he would continue permanently in

Mwanza and asked him to delay opening a bank account. He was cordially received by Eble and Huntington and shown around the parish. Beaudry's first involvements were to visit the Small Christian Communities and to start teaching literacy to adults two days a week, on Tuesdays and Thursdays. This latter ministry has persisted right up to the year 2017, when this history is being written. Beaudry elaborated on the ministries that he eventually settled on.

> In the adult literacy course I first had 25 students, aged from their mid-twenties to even over eighty years old, but some were not able to keep up. The other teacher taught the regular class and I worked with about five to seven on a personal basis. The course had thirty lessons and it was good, because it was a real pleasure to see someone who can start reading.
>
> There are a lot of people who don't know how to read and write and even more who are ashamed to admit it. It's a real problem. You look over at the primary school and there are about 100 students in a class, outside talking, not serious, not getting anything done. There are private schools and it seems if you want a good education you have to pay for it. With high unemployment, not many can pay.

By 2016 Beaudry was teaching a different class on Tuesdays and Thursdays for people with learning disabilities. This class was later named '*Tunaweza*,' Swahili meaning 'We are able.' In 2016 he had seventeen students, whom he taught writing and reading in Swahili and math. They were also trained in washing dishes and clothes, sewing, agriculture, craft work and in interpersonal relationships.

Another group that Beaudry worked with were elderly people whom Eble had started bringing in to the mission on Wednesday afternoons. Beaudry took over this ministry and introduced bingo, which turned out to be a very popular game. By 2016 the group was still playing bingo, but Beaudry also arranged for speakers to come talk with them and he also organized bus tours. He also showed them videos; Beaudry added with amazement, since they lived so near Serengeti Park, that "one of their first requests was to see a video on wildlife!"

In 2011 Beaudry was informed of a facility, called the Bukumbi Rehabilitation Village for the Mentally Ill that accommodated about twenty residents with mental illnesses on the far outskirts of Mwanza, so distant that few people ever visited. A woman asked him to consider visiting, which Beaudry agreed to. Since then he has been visiting this facility two days a week, on Fridays and Saturdays. When he first arrives at the place they begin with a prayer and singing, and then he asks the people to draw something. The people do not have learning disabilities, but their psychological illnesses are so severe that many can not write nor even draw something identifiable. In contrast, some draw beautiful pictures. Other activities offered by Beaudry are basic education and bingo. In order to get the people off their chairs, so they would not be just sitting around, Beaudry bought musical instruments, such as drums and rattles, and encouraged them to get up and dance, which almost all African people enjoy doing.

To address apparent malnutrition at the center he introduced some simple farming, such as raising chickens, rabbits and goats, and planting a small garden.

Beaudry also tried to find a way to work with youth. He visited the diocesan youth office but it seemed that youth work meant merely having Mass for the youth. Eventually, though he was able to get involved with some youth at Mabatini. In 2016 he wrote that he does youth ministry on Sundays. He collaborates with Marygoreth Gervase, a Tanzanian woman who is an advisor to the youth of the parish.

For recreation, Beaudry plays tennis. He takes Mondays off and on Wednesday mornings he goes into the city to do shopping. As has been noted, Mwanza is a pleasant city in which to live and Beaudry affirmed that the Tanzanian people are warm, friendly and hospitable. The downside of the city, according to Beaudry, is the number of street children, people begging and physically handicapped people lined up along the streets of Mwanza when he drives to the city. Beaudry was trying to find ways to mobilize the affluent sectors of Mwanza to address the root causes of the homeless population, estimated to be about 1,500 children and young people, and find solutions to this crisis. In 2017 he wrote a short statement on the vocation of the Brother.

> The best example of a Brother would be Jesus himself. Jesus was a man of great compassion for all people, especially the poor, the sick, sinners and the outcasts of society. To be a Brother is to grow in compassion for all people, especially the poor and outcasts of society.
>
> Just as Jesus fasted in the desert for forty days and nights, to be a Brother one must strive to be a person of prayer.
>
> Jesus began his ministry by gathering disciples to form a community. To be a Brother in the Catholic Church today is to work in collaboration with the people around him. He does not do his ministry alone.
>
> Jesus said to take up one's cross. There will be times of trial and error, but a Brother must not give up doing God's will and bringing about the Kingdom of God.

Lam Hua had first arrived in East Africa in July, 2010, when he took a three-week course in African culture at the MIAS institute in Nairobi. He then went to Musoma to study Swahili, after which he was assigned to Buza Parish in Dar es Salaam, in December, 2010. After nine months he moved to Mabatini, arriving in September, 2011. After that nine-month period in Dar es Salaam he was gaining fluency in Swahili and was able to start working immediately when he arrived at Mabatini.

His first assignment was to visit two Small Christian Communities, rotating from one to another each week, as at that time all SCCs met on Saturday afternoons. Lam said that one SCC was very strong, with as many as seventy coming for the weekly meetings, whereas the other was struggling and often had fewer than ten in attendance. As there were 22 SCCs in the parish, Lam would have preferred to try to visit them all over a year, but he stayed with his assignment of visiting only two. He not only attended the meetings, as he explained:

> Before each jumuiya (i.e. SCC) meeting I visit three or four homes along with one or two of the leaders, who set up these visits in advance. I try to visit as many as I can, especially those who do not come to the meetings. I try to get to

know them and invite them to participate in the SCC. I tell them that they are part of the SCC and are not forgotten.

Members of the stronger jumuiya are very active in the parish and visit the sick of their SCC twice a week without me.

People of other SCCs have invited me to their meetings, which I would like to do, but as all meetings are on Saturday at the same time, I can not go to other SCCs.

Another apostolate that Lam engaged in was teaching religion in the catechumenate class for school children at the parish and in the religious education class at two local schools, one a primary school and the other a secondary school. Although English is used for most subjects in secondary schools, religion was taught in Swahili. Lam found this a difficult challenge, as he was still learning Swahili and he never considered himself a teacher. He commented: "They are forgiving of my Swahili; they laugh and enjoy it."

Another challenge he discovered in the schools, particularly the primary school, was class size. "The children fill the classroom. A lot of them sit on the floor. There's no space; I have no room in which to move around. I just stand next to the blackboard. The class lasts an hour and a half, but after fifteen minutes I have lost their attention. So, I do the best I can for that first fifteen minutes."

Lam had already begun preaching at Sunday Mass in Buza Parish and he continued doing it at Mabatini, although not as frequently for the adults. Eble had started a Children's Mass once a month on Sunday afternoon, a Mass that was as crowded as the two Sunday morning Masses, and Lam was asked to lead a Service without a priest on the other three Sundays of the month. He preached at this service and distributed communion. The children who came were primary school children, mainly under thirteen years old and as young as four years old. Lam said: "This has been going great. They have their own choir, a loud, active choir. They are dedicated and come and practice many times each week."

On some weeks Lam also presided at a communion service on Monday morning if Eble was unable to say the daily Mass. The parish had Adoration every Thursday afternoon and Lam was asked to lead this service outside of the seasons of Advent and Lent, when Eble presided. The Adoration service was not merely a liturgical devotion; the priest, or in Lam's case the seminarian, was expected to do some teaching during the Adoration Liturgy.

The catechist did a lot of the sacramental recording in the office as well as counting the Sunday collections. Lam sat in the office to help with these chores and to learn the administrative aspects of parochial work.

When he was interviewed in early 2012, Lam had been using Swahili for a year and a half and he said that he had become much more proficient in the language. The only continuing struggle was learning vocabulary.

Lam returned to the United States in June, 2012, to resume his final year of study at Catholic Theological Union (CTU) in Chicago. He commented on his time on OTP:

This has been a very good experience for me. I have learned what it is to be a missioner, not only from my own ministry but from the people I live with. I

> have met all the other Maryknollers who work in Africa and they have shared with me their experiences and mission work. I also know the difficulties of being in mission, the difficulties of living and working in another culture. I have found the faith of the people here inspiring, which has fortified my desire to be in mission.

This would not be the final time for Lam to work in Mabatini. After ordination in 2013 he returned to Tanzania and was again assigned to Mabatini. For one year he assisted in the parish as parochial vicar, under a diocesan priest who was the Administrator of Mabatini, and then in July, 2014, Lam was named pastor of the parish.

Mabatini was one of only two parishes in the Archdiocese that did not have an outstation, since the furthest distance a parishioner had to walk to the church was only two miles. But as of 2012 there was discussion whether or not to start an outstation over the hills going toward the lake. As noted above, in 2012 there were two crowded Masses on Sunday morning and Mass with a priest for the children once a month in the afternoon. If the parish could have two priests assigned Eble said that they would probably make the children's Mass a permanent third Mass every Sunday. After the extension of the church was completed there was much more room for people at Mass. With the small church there were about 1,500 coming to the three Masses on Sunday but after the church was enlarged (and the completed church is very large) it is likely that 2,500 to even 3,000 are coming to the Masses.

In addition to the large church and rectory, the parish compound also had a large administration block, with several offices and a social hall. The basement floor of the rectory also had several large rooms that could be used for meetings and catechetical classes.

One issue that concerned Eble was "how can we be in solidarity with the poor. With all these hotels going up, commercial development, and expatriates coming in, there is money here. So, that is part of our vision: to have a good building for the poor."

Eble obtained a formula from the Jesuits in their parish in Mwanza: "The local people should give ten to fifteen percent of whatever building project or parish program we have." So, he pushed the people of Mabatini to contribute that amount for the church extension. In addition, parish income paid for the salaries of a secretary, two full-time catechists, a cook and a housekeeper. The Maryknollers paid for the food and household supplies from their viatique money. The secretary for several years was Natalia Kadio, who had taken the CPE program with Eble at Bugando. She was a former nun who had visited the United States at least once. The parish also scheduled seminars, retreats and other educational events for parishioners; at some of these events the parish provided lunch but at others no food was offered.

Although the priests pushed the people to increase their giving to the parish, in 2012 there was a drop in giving. Eble wondered if the diocesan rule that the Archdiocese should receive ten percent of each Sunday's collection was one factor in the drop in income. In 2012 the Small Christian Communities were also being taxed by the diocese: to contribute to the seminary, to diocesan programs, and to hold a celebration for a newly ordained priest. The Maryknollers had fears that turning the SCCs into fund-raising

organs was scaring away Catholics from joining their local SCC and diverting the purpose from faith-sharing and enrichment into purely discussions about money.

[Editor note: in the 2010s Maryknollers in various parts of East Africa had begun reflecting on and discussing the change in the purpose of Small Christian Communities to one of fund-raising – primarily for diocesan expenses – versus the original purposes of interpersonal community-building, growth in faith, and outreach to those in need. By the 2010s many dioceses in East Africa were already up to their third or even fourth native African Bishop. It seems that these Bishops wanted to model their dioceses after what they saw in Europe and the United States, with large modern houses for the Bishops, huge beautiful cathedrals, and multi-story diocesan centers with a number of pastoral departments, each staffed by several salaried employees. The Vatican probably still provided some funding. However, to establish diocesan facilities equal to Europe or America required much more money, which the Bishops have insisted come from the African Catholics. Wealthy East Africans support the Bishops' summons to increase local contributions; for the wealthy this is a source of honor, endowing their diocese and ethnic community visible status in society and the Church. The African poor, over fifty percent of the population, can not support institutions mimicking western models, however. As poverty does not seem to be going away, one wonders for how long East African church officials will be able to pursue their quixotic dreams.]

Eble added a comment about the future, when Maryknoll can no longer staff the parish. He said that a diocesan priest would push the people for local funding much more strongly than he had done – and at times Eble actually did harangue the parishioners about the need for increasing their offerings to the church.

Eble continued on as pastor up to December, 2013, and then went to the U.S. for courses in spiritual direction, with the intention of returning to Mwanza to start a Center for Spirituality. He noted that his original goal for Mabatini was to turn it over to the Archdiocese, to be staffed by diocesan priests. In the meantime, Maryknoll needed a place for OTP students and as a place to assign returning priests. Thus, Maryknoll made Mabatini one of the Regional priorities; in fact, the number one priority.

Lam Hua was ordained in May, 2014, and assigned back to Tanzania. He went back to Mabatini, with the provision that he would be assistant to an African diocesan priest from Bugando Parish, who would be Administrator of Mabatini beginning in January, 2014, after Eble left. In 2014 Fr. Tom Tiscornia was also assigned to Mabatini. Then in July, 2015, Lam was appointed pastor. Tiscornia remained in Mabatini for only one year and transitioned to the U.S. either at the end of 2014 or in 2015 to work on Development in Chicago.

At that point, there was only one priest assigned to Mabatini, but Fr. Jim Eble had returned to Mwanza either at the end of 2014 or beginning of 2015 to establish a Center for Spirituality, and he assisted with Masses in Mabatini.

As was noted above, Brother Mark Huntington finished his work in Mabatini in late 2014 and returned to the United States. But in July, 2015, another Maryknoll priest, Fr. John Eybel, was assigned to Mabatini to be assistant to Fr. Lam Hua.

Beginning in 2015 three OTP students were assigned to Mabatini: in August, 2015, seminarian Jonathan Hill and Brother candidate Thomas Fagan went to the language school and after the Swahili course they went to Mabatini in December of 2015.

Fagan left after a year. Hill remained in Mabatini until August, 2017. Then in September, 2016, seminarian Greg McPhee studied Swahili at the language school and joined the Maryknoll team in Mabatini in December, 2016.

Thus, as of May, 2017, there were five Maryknollers living at Mabatini: Frs. Lam Hua and John Eybel, Brother Loren Beaudry, and OTP seminarians Jonathan Hill and Greg McPhee, although Hill was scheduled to return to CTU in Chicago several months later.

In 2017, Maryknoll decided that for the foreseeable future no further OTP students would be assigned to Tanzania, as all would go to Cochabamba, Bolivia. Despite this, the Maryknoll Africa Region has decided to keep Mabatini as a Maryknoll staffed parish for an indefinite period into the future.

As there have been no further interviews since 2012, we have no further documentation on other developments in the parish since then – except that the church extension was completed by the end of 2012.

FR. JIM EBLE, CENTER FOR SPIRITUALITY:

At the end of 2014 or beginning of 2015 Fr. Jim Eble returned to Mwanza and set about establishing a Center for Spirituality in Mwanza. He constructed a building for this, as a place for people to come for spiritual direction and personal meditation, and for individuals or groups to come for days of reflection directed by Eble. We have no other documentation on this, except that the Center is doing well and draws many people to its services.

MARYKNOLL LAY MISSIONERS IN MWANZA:

Beginning with Bill and Eileen Velicky, who arrived in Mwanza in 1993, there have been many Maryknoll Lay Missioners who have worked in Mwanza. Hopefully, at some time a history of the many varied ministries engaged in by Lay Missioners in East Africa will be written.

SENGEREMA HOSPITAL:

Dr. Bill Fryda had been a Maryknoll Lay Missioner managing the diocesan medical program for Shinyanga Diocese from 1981 to 1983, after which he decided to join the seminary. He spent one year at the novitiate in Massachusetts and the other years at Maryknoll, NY, studying theology. In the spring and summer of 1987 he did a short stint on OTP in Bunda Parish with Associate Maryknoll priest Fr. Bill Vos.

While in the novitiate in Massachusetts and at Maryknoll he engaged in prison ministry, particularly at Sing Sing Prison in Ossining, where he helped set up the prison's chemotherapy treatment for AIDS, not only for the prison but also for New York State. He was ordained a Maryknoll priest in June, 1988.

On return to Tanzania later in 1988 he chose to go to Sengerema Hospital, a large government district hospital across the bay from Mwanza and about ten miles inland from Lake Victoria. The hospital was situated in the recently established Geita Diocese (made a diocese on November 8, 1984), and the Bishop was Aloys Balina, originally a

priest from Shinyanga Diocese whom Fryda knew well. In fact, Balina wrote to Fryda while he was in the seminary at Maryknoll, NY, inviting him to come to the diocese and to the hospital in Sengerema.

Geita Diocese is a relatively small diocese territory-wise but densely populated relative to other rural parts of Tanzania, with a total population of over one and a half million, of whom over a third are Catholic (once again if the statistics of 2014 are reliable). The majority of the population are Sukuma. A local ethnic group living close to the lake has been assimilated into the Sukuma language and customs and by 2017 it is difficult to distinguish to which ethnic group they belong. Geita is also where several gold mines are located, providing work (low paying, unhealthy work) for rural Tanzanians, good profits for the companies managing the mines, and a sizable amount of revenue for the government. In 2014, Geita Diocese had 27 diocesan and six Religious priests serving in fifteen parishes, with an average of over 35,000 Catholics per parish. In 1997 Balina was made the Bishop of Shinyanga Diocese.

When Fryda arrived at the hospital he was appointed the Medical Officer in charge. He later elaborated about the hospital and work there.

> The hospital was built by Dutch missionary Brothers and was originally a part of the Diocese of Mwanza. It has 250 beds with a nursing school, nurse midwifery school, and a medical assistant training center. When I arrived there were many Religious Orders assisting in the hospital, as many as twenty-four at one time.
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> I did not have pastoral duties per se, but I think whenever a priest is working with people it is pastoral. I said the evening Mass each day, with a core group of about thirty people attending on a regular basis. A real rapport was built up among us over the years.
>
> Bishop Balina believed in integrating the different religious orders into the one setting, so that no one group would dominate. For me, it was a very good experience for community life. We had community get-togethers, support groups, and shared our experiences together, to see where God's hand was active in our daily life experiences.

In December, 1989, two Maryknoll Brothers with medical backgrounds came to East Africa for OTP training, along with other Maryknoll Brothers and Lay Missioners, and started Swahili classes at the language school in January, 1990. These two were John Mullen and Tony Ferro. When they finished their Swahili studies in June, 1990, they were assigned to Sengerema by the Tanzania Region. They stayed at Sengerema for only six months but Fryda and the two Brothers all thought it was a good experience. Mullen said:

> I was able to observe the medical practices of a third world country without having to immediately jump in and work. I observed, practiced the language, got to see the much lower standards of medical practice in Tanzania compared to the U.S., and learned to adjust to these differences in standards.
>
> For instance, there was a room where forty or fifty people came each day to have their dressing changed. In the U.S. we have clean gloves for each patient,

but in Sengerema the latex gloves were washed after each day, dried on clotheslines and re-used.

People lived far away and could not come every day to have their dressings changed. The wounds would fester and give out a pungent odor. To change the dressings we used forceps, which was never done in the U.S.

But the big thing was that they didn't have money to buy supplies and bandages. So the standards were much lower than in the U.S.

AIDS had also peaked at that time in Tanzania. I had worked with people with AIDS in New York, at Sing Sing Prison, so I was familiar with it. At Sing Sing they were given AZT, but they still died. In Tanzania it was learning about the magnitude of the problem. You can read about it, but there you were seeing it, seeing people losing massive amounts of weight, and seeing the numbers of people who were dying. It was the beginning of my education to the reality of AIDS in Africa.

Mullen thought that the Tanzania Region would have preferred that he and Ferro be split up and go to Kowak and Mugumu Hospitals respectively, but Fryda exerted pressure that they go to Sengerema, which was a much bigger hospital that gave them much more medical experience. At Sengerema the two OTP students lived with an elderly Dutch Brother, while Fryda continued to live alone in the house of the Medical Director.

After six months Mullen and Ferro went to Nairobi, Kenya, in January, 1991, as per the original program, but they both thought the time in Sengerema was well spent.

In May, 1991, Fryda also transferred to Nairobi, to Nazareth Hospital on the outskirts of the northwestern part of the city. He had found the economic realities of Tanzania difficult to deal with, especially the low salaries paid to doctors, forcing them to seek alternative means to earn a decent monthly income. He considered the experience at Sengerema worthwhile, but was looking for a more stable situation.

When he left, this ended Maryknoll's presence in Geita Diocese.

To sum up in conclusion: some of the youngest members of Maryknoll are stationed in Mwanza. This fact, plus the African Region's decision to retain Mabatini Parish as the Region's foremost priority, means that Maryknoll will remain in Mwanza for the foreseeable future. In ten years at most, all of the Maryknollers stationed in Musoma and Shinyanga Dioceses as of mid-2017 will most likely have departed from these dioceses, unless Fr. Hung M. Dinh decides to continue serving in Shinyanga Diocese. But Maryknoll will still be in western Tanzania at least through the 2020s and if one or two young Maryknoll priests are assigned to Mwanza, this could be one place in Africa that Maryknoll retains well into the future.