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"Come away to some lonely place all by yourselves and rest for a while"

(Mk 6:31)

Greetings from His Holiness Pope John Paul II

His Holiness John Paul II cordially greets the participants
from various countries summoned by
the Pontifical Council for Health Pastoral Care to study
the questions and issues connected with the scourge of HIV-AIDS.
In this circumstance the Holy Father encourages everybody
to work together, beginning with the resources of their own skills
and responsibilities, in taking care of those who suffer from this disease,
employing the resources of science to alleviate their suffering.
These people are accompanied by the solidarity of the Church
and the fraternal generosity of very many men and women of good will
who are moved by the example of the Good Samaritan
to come to the help, with suitable instruments, of these sick people,
being responsible for them until their complete cure or a serene death.
With these keenly-felt feelings he asks the Almighty,
through the maternal intercession of the Virgin of pain and hope,
to enlighten, and concede abundant fruit to, those who work
in this specific field of human pain, while he imparts with affection
to those present the requested Apostolic Blessing.

Cardinal Angelo Sodano, Secretary of State of His Holiness

The Catholic Church and the Challenge of HIV-AIDS

9-10-11 December 1999
Nova Domus
Sanctae Marthae
the Vatican city

Greeting and Introduction

I greet with affection the participants at this conference on AIDS organised by the Pontifical Council for Health Pastoral Care. I greet and thank all the speakers for their presence. They are really making a great contribution to the cause of health and health care in the world and to an intensification of the health care ministry.

This conference wants to achieve three principal objectives. They are as follows: 1. the promotion of help to those who are afflicted with HIV-AIDS; 2. guidance of the questions and issues associated with HIV-AIDS in line with the Magisterium of the Church; and 3. the co-ordination of the movements and groups belonging to the Catholic Church which work in the field of HIV-AIDS.

We will begin by examining the contemporary situation of the world as regards HIV-AIDS and what this situation is likely to lead to. This subject will be dealt with by UN-AIDS, the organisation of the United Nations which is responsible within that body for the question of HIV-AIDS.

We will then present the research which has been carried out by our Pontifical Council on the reality, the problems and the proposals of the local Churches with regard to the situation of HIV-AIDS in the world. Thereafter our studies will be concerned with three main areas of interest: prevention, accompanying, and enlightenment.

In discussing the question of prevention we will discuss life as a fundamental value, education in values, the place of education in values, the family, schools, the mass media, the experiences and the future prospects for action and initiatives and for programmes involving prevention based upon education in values. These experiences will be presented by the following countries: Italy, India, Spain, Senegal, as well as by "Caritatis Internationalis".

With regard to accompanying we will study caring for, and looking after, people afflicted by HIV-AIDS by paying attention to the health care-medical, psychological, moral-ethical, and spiritual aspects of the question. We will then deal with access to programmes of care and treatment in this field. This will be followed by the pastoral experiences of a number of local Churches of the five continents: for Asia we will consider the experiences of Thailand; for Africa those of the Democratic Republic of the Congo; for America those of Brazil, Haiti, and the United States of America; for Europe the experiences of Poland; and lastly, for Oceania, we will study the experiences of Australia.

With regard to the enlightening of these realities with reference to the Word of God, we will reflect upon pastoral theology and HIV-AIDS. We will conclude with an examination of the necessary guidelines for future, and better, pastoral action and care.

During our conference it is our intention to motivate and encourage the ground-level Churches to exercise greater influence on national health care policies in relation to HIV-AIDS. We expect a more significant presence of workers connected with the health care ministry within public and private health care structures – a presence which should be marked by a clear orientation with regard to the health care ministry and HIV-AIDS. It is our hope that this conference will help in particular to promote policies involving the protection of life by challenging the contemporary policies of prevention now operating which are based, often exclusively, on promoting the widespread use of the condom.

We want to promote the creation of a credible network of selfless groups of bodies and non-governmental organisations involved in the struggle against this illness. We want to support the actions of national governments in this area; lend our weight to the initiatives of Catholic and non-Catholic non-governmental organisations; help in the acquisition of funds and financial means for projects which envisage facilitating access to anti-retroviral drugs and treatment for opportunistic infections; we hope that there will be initiatives directed towards the promotion

of the socio-economic growth and development of those countries which are more afflicted by HIV-AIDS; and, lastly, we want to learn how to use the social mass media in a more mature and appropriate way – in particular the press, television, and Internet. It has been said that the Church has not made her voice heard with regard to the question of AIDS and that her silence is proof of her powerlessness in the practical field of a reality which is one of the most wounding that presently exists. Nothing could be more false! As is evident from the research which we will present at this conference, 9.4% of the bodies who look after people afflicted with HIV-AIDS are Church entities and 15.1% are Catholic non-governmental organisations. The financial means at their disposal, compared with such means considered as a whole, amount to 20.6%, and in great part these bodies are not public but private in character. To all these data it is obvious that we should add the clear positions enunciated by the Pope, to which reference will be made below, and the very large number of pastoral communications and declarations made by the bishops of the whole world which were recently published together in different forms.

We hope that during this conference there will be clarity with regard to goals and thus with regard to the direction of pastoral work as well. All this can be found in the doctrine of the Holy Father on the question of HIV-AIDS which has already been expounded – indeed at the previous conference organised by our Ministry on this subject. We would like to draw attention in particular to the action of prevention and to something in this area which is specifically Christian and which has been emphasised by the Pope in a clear fashion – we must bring out the force which the virtue of chastity must have nowadays. There can be no doubt that in the secularised context of our world this answer can appear to be an illusion, and in certain cases it can appear to be a matter of bigotry, of mere prejudice, when considered in relation to a terrible reality which overflows the confines of morality. However, there can be no doubt at all that for the pastoral action of the Catholic Church the virtue of chastity is at the present time the most urgent appeal which can be made in this field. It must be intensified both at the level of suitable espousal and at the level of practical implementation.

The virtue of chastity seems, it is true, something which goes against the tide in a pansexualistic society such as that which exists today. But it is the real solution to sexual contagion. It brings with it an anthropological vision of love and sex, and must be understood in all its social, familial, individual and personal range. It is to be understood in terms of the need for marital chastity and it is to be lived out in another form in celibacy. Without the acceptance of this vision accepted through faith one can well understand how for many people the use of the condom is a practical thing. Without faith, one can also understand why for many people it is absurd for the Catholic Church not to accept the practice of prevention through the use of condoms.

With regard to the treatment of people who are seropositive, at this conference importance will be given to the action of the governments of various countries – actions which we must recognise and encourage. We need to intensify the action of all those who are concerned with these sick people. In all people we need to intensify the solidarity-inspired conscience of the Good Samaritan so that in these sick people we can see our poor and least protected brethren who have fallen prey to this terrible evil, and in relation to whom special action by everyone (and in particular the professionals of the world of health and health care) is required.

Faced with the frightening drama experienced in particular by the two million children of Sub-Saharan Africa, the orphans of parents who died because they were infected by HIV-AIDS and most of whom were in turn infected by this disease, we urgently need to make the whole world aware of, and sensitive to, the fact that it must immediately come to their aid. A recent initiative has taken place which we believe it would be right to encourage: the official creation throughout the world of a day dedicated to children infected by HIV-AIDS. This day is to take place on 28 December, the day when the Catholic Church celebrates the feast of the Holy Innocents.

This Ministry has adopted this initiative and has sent an appeal to this effect to the bishops who chair the episcopal conferences of the world. In this appeal we ask them to present, if they so wish, this initiative to the people of God who are in their local Churches and to send as a Christian present to those who are most afflicted by this infection in the six countries of Sub-Saharan Africa their prayers and economic offerings for food and medicines for these children. The help given can be of many kinds. A help which is often forgotten about, as is more than evident in this secularised world, is that of prayer, and upon this we place great insistence. This will be a very special instrument with which to combat this plague – a plague with which we have been inundated at the end of the second millennium and the beginning of the third. You will be able to find the relevant documents in the material which has been given to you, and we hope that you will be able to be the spokesmen for this initiative in your local Churches.

May the most Holy Virgin, *salus infirmorum,* come to the aid of the very many children who are constantly dying as a result of this terrible evil, and bear in her heart in motherly fashion all those who are afflicted by HIV-AIDS!

H.E.Mons. JAVIER LOZANO BARRAGÁN,
Archbishop-Bishop Emeritus of Zacatecas,
President of the Pontifical Council for Health Pastoral Care.
The Holy See

AIDS in the World Today: the Current Situation and Challenges for the Future

Let me begin by thanking His Excellency, Monsignor Lozano, for a much inspiring presentation.

On behalf of the Joint United Nations Programme on HIV-AIDS (UNAIDS), I would like to thank you for giving me the opportunity to address this important Congress on AIDS, which I hope will further contribute towards closer co-operation between UNAIDS and all levels of the Catholic Church.

I would like to begin by outlining the extent of the HIV-AIDS epidemic as it affects the world today, and looking at the prospects for the near future.

Overview of the global AIDS situation

The spread of HIV-AIDS has by far exceeded our worst fears. There are over 33 million men women and children who are *currently living* with HIV-AIDS – a number equivalent to nearly the whole population of Poland. And half of these are young people under the age of 25. Over 1 million *children* are infected with HIV, most of them perinatally, and most of them in Africa.

Let me say from the outset that we are not helpless against this epidemic. I can point to countries and communities from every region of the world where infection rates have been stabilized or even reversed.

However, overall, the epidemic continues to grow relentlessly. Approximately 16,000 people are newly infected each day. Most of the new infections occur in those between 15 and 24 years old and increasingly the epidemic is affecting women. The overwhelming majority (some 95 per cent) of the men, women and children infected with HIV live in the *developing world*. Yet 9 out of 10 people in the world living with HIV do not know that they are infected.

Over 16 million adults and children have already lost their lives to this devastating disease, and the death toll rises each year. This year saw the highest number of deaths from HIV-AIDS since the beginning of the epidemic – 2.6 million. AIDS now kills far more people world-wide than any other infectious disease.

In Asia, the most densely populated part of the world, there is cause for serious concern. For example there has been rapid progression of the virus in some countries such as Myanmar and Cambodia, where the epidemic is well established in the general population with almost 4.5% of male blood donors infected. Perhaps the biggest worry is how the epidemic will evolve in the two largest countries of the region and the world – China and India. Already, it is estimated that in India alone, there are over 4 million people living with HIV, not only in urban centres but many of them in rural areas. In China, almost half a million people are estimated to be HIV positive, particularly among drug users, and the potential for HIV to spread beyond the injecting drug use population to other vulnerable populations is great. On the other hand, Thailand has shown evidence of a fall in new infections, largely due to sustained prevention efforts that addressed factors affecting both HIV risk and vulnerability.

The *Caribbean* is the second most affected region in the world, with countries such as Haiti reaching levels of HIV infection parallel to those in Sub-Saharan African countries, and rising infection rates in the Dominican Republic, Guyana and Barbados. In Brazil and Mexico, AIDS has been listed as the second cause of death, after violence, among men under 45, surpassing traffic accidents. In *Central America* increasingly high levels of infection are being found at surveillance sites among pregnant women, men having sex with men, and migrant populations. While in the Southern Cone, infection rates are increasing among those most vulnerable, particularly drug users and their partners.

The world's steepest HIV curve in 1999 was recorded in the *newly independent*

states of the former Soviet Union, where the proportion of the population living with HIV doubled between 1997 and 1999. In the larger region comprising these nations and the remainder of *Central and Eastern Europe,* the number of HIV infected persons rose by more than a third in 1999 alone, to reach an estimated 360,000.

In *developed countries*, great progress was made in the early years of the epidemic. However, prevention has stagnated for a decade. This year, as in earlier years, 75,000 people were newly infected and there is worrying evidence that unsafe behaviour is again on the rise. But, nowhere has the impact of HIV-AIDS been more devastating than in *sub-Saharan Africa*, where today it poses the foremost threat to development.

At the regional level, nearly 14 million Africans have already died – over 2 million this year alone. Nearly 4 million Africans were newly infected with the virus in 1999, bringing the total number of infections in Africa to over 23 million. In no fewer than 13 African countries, more than a tenth of the entire adult population is living with HIV-AIDS. And in some countries, such as Botswana, Namibia, South Africa, Zambia and Zimbabwe, one of every five adults is infected. Life expectancy at birth in countries such as Botswana is anticipated to fall below the levels seen in the 1960s (from 61 years in the late 1980s to 47 years today, and it is expected to plunge to 38 years by 2005 to 2010). The glimmers of hope in Africa are seen in Uganda and Senegal. Both countries have demonstrated that early and comprehensive prevention efforts in combination with the provision of essential services have kept HIV infection rates low. This success was driven by proactive political leadership that, from the outset, engaged civil society groups around actions to curb the spread of the epidemic.

But the millions of people

living with HIV-AIDS and those dying from the disease are only the tip of the iceberg: a much larger number of people are affected by the epidemic and are having to cope daily with its consequences. One of the hardest hit groups are orphans. As adults get sick and die, the number of orphans has increased tremendously. By the end of 2000, over 13 million children will have been orphaned by AIDS, most of them in Africa, and over 10 million will still be under the age of 15. In the past, the traditional family and community structures would step in to care for orphans – but that was before AIDS. Their grandparents are often old and poor and cannot take on their care. They are part of a new and growing phenomenon: the child-headed household. These are children who have seen their parents die; they are children without hope, with none to teach them how to fend for themselves, to become responsible adults and parents in turn.

AIDS is one of the greatest development crises of our time. Clearly, AIDS is more than an epidemic; it is a massive development catastrophe affecting many countries. While most infectious diseases kill off the weak – the very young and the very old – HIV targets people in the prime of their working and parenting lives. This age factor profoundly disrupts the economic and social bases of families.

More than this, AIDS threatens whole communities and economies. As President Nelson Mandela warned at the 1997 Economic Forum in Davos: "AIDS kills those on whom society relies to grow the crops, work in the mines and the factories, run the schools and govern nations and countries." Today, in many African countries, AIDS has already wiped out major gains in development registered over the past decades. Economists at the World Bank conservatively estimate that countries with high HIV rates will lose one per cent of GDP growth annually.

AIDS affects almost every aspect of social and economic life.

– *Health care systems* are stretched beyond their limits as they deal with a growing number of AIDS patients and the loss of health personnel due to death and illness. They also have to cope with rising cases of tuberculosis, the most common infection associated with AIDS. In Côte d'Ivoire, Zambia and Zimbabwe, HIV-infected patients occupy 50 to 80 per cent of all beds in urban hospitals. On average, treating an AIDS patient for one year is about as expensive as educating 10 primary school students for one year.

– *The education sector* is also highly affected. A World Bank study in Tanzania estimated that AIDS would kill almost 15,000 teachers by the year 2010 and 27,000 by 2020. The cost of training replacement teachers would be nearly $40 million. In Côte d'Ivoire, around one schoolteacher dies of AIDS every school day. The quality of the education provided is also suffering as less experienced personnel are pushed to replace those who fall sick and die.

– The HIV-AIDS epidemic is stretching the capacity of *social safety nets* to the limit. The impact on households begins as soon as a member of the household starts to suffer from HIV-related illness. This results in loss of income of the patient, a substantial increase in expenditures for

medical expenses, and other members of the household, usually daughters and wives, missing school or work to care for the sick person. Death results not only in additional expenses for funeral and mourning costs, but in a permanent loss of income from less labour on the farm or from lower remittances. In Côte d'Ivoire, in urban families where a member has AIDS the average income drops by 50-65 per cent, family spending on education is halved, and food consumption drops by 41 per cent, while individual expenditures on health care more than quadruples. Other consequences include the dissolution, or part dissolution, of families: children are sent away to live with relatives; a spouse or a child migrates to earn an income; and sometimes, on the death of her husband, the widow and her children are forced to move to a brother's house relinquishing any rights to property or inheritance .

– *Economic productivity* falls. AIDS primarily affects people who are at the most productive stage of their lives, often those from higher socio-economic brackets and those who have benefited from many years of investment in their training. As skilled workers and managers of sectors such as mining, petroleum and agriculture, become sick and die, the disruptive effects on production may even exceed the more easily measurable costs in medical benefits, sick days and training of replacements. In the private sector, AIDS-related costs are eating up as much as one-fifth of all profits in some countries.

What must we do to respond to the challenges ahead?

Much is already being done throughout the world to meet the challenges posed by this devastating epidemic, and the Roman Catholic Church is a key partner in efforts to stem its progress. But all of us must do much more. We are not only united by our common desire to do more, but also by the painful dilemmas that this disease brings. We experience anguish and pain when we lose members of our community or when we are unable to respond to the needs of those infected and affected by AIDS.

One of the key areas where the Church makes a big difference is *care* of those living with and affected by HIV-AIDS. The Catholic Church has played an exemplary role in supporting people living with HIV-AIDS and their families. A particular strength has been the spiritual and emotional support the Church has offered to people faced with the immense suffering brought by this illness, particularly to those who have been rejected by their families and communities as a result of their HIV infection. In the future, with the increasing number of people infected and affected by the epidemic, the services provided through the Church, which already constitute approximately 25% of the care given to AIDS patients in most countries, will be facing new challenges in trying to keep up with increasing demands.

The reduction of HIV transmission from mother to child is a breakthrough in the epidemic. Recent research has shown that an effective and affordable antiretroviral intervention can reduce by half the transmission of HIV infection from mother to child when combined with avoidance of breast-feeding. Many governments are now looking into the feasibility of providing this intervention to HIV-infected pregnant women. While it is not yet a perfect solution, working on the prevention of mother-to-child transmission will also help build the infrastructure needed for care and treatment, as well as strengthen access and quality of the voluntary counselling and testing services which are required for the intervention to work.

Discrimination and stigma associated with HIV-AIDS remains a major obstacle, increasing vulnerability to the spread of HIV. In a setting where stigma and prejudice are present, people are less likely to accept the presence of HIV in their community and to be open to prevention initiatives. The Catholic Church's belief in the dignity of all persons and her promotion of a just society are most relevant in reducing the shame and alienation experienced by people with HIV-AIDS, their families, and those considered to be at risk of infection, such as sex workers and injecting drug users.

In many countries, the Church was the first to open its arms to people with HIV-AIDS who were rejected by their communities – regardless of their past history, their sexual orientation, or their mode of infection. The challenge was expressed by Pope John Paul II: "God loves you all without distinction, without limits… He loves those of

you who are sick, those who are suffering from AIDS. He loves the relatives and friends of the sick and those who care for them."

By creating a safe environment for dialogue – without judgement, without prejudice – the Church community can make it more acceptable to all. By talking about HIV more openly and in more accepting terms, the Church can reduce the terrible need to hide the illness and reduce the stigma and injury of rejection. In this regard, we can all work together with other partners to influence national policies on human rights, on gender issues, culture, ethics and the law.

An essential partner in meeting this challenge is achieved through the *Greater Involvement of People living with HIV-AIDS* in all aspects of prevention, care and community life. People who live with HIV-AIDS or are directly affected by the disease bring personal experience to planning and carrying out a response to the epidemic. Those who are open about their own HIV status can help others to appreciate the need for solidarity between those living with HIV and those fortunate enough to have escaped infection so far.

How can UNAIDS work with the Church?

Collaboration with the Catholic Church and its organizations has been ongoing at the global, regional and country levels. In 1998 a formal partnership was established between the UNAIDS Secretariat and Caritas Internationalis committing us to work together to:

– promote HIV-AIDS awareness, responsible behaviour and care and dignity for those affected by the epidemic;

– address the wider development issues highlighted by the epidemic while always keeping the human being at the centre of development and

– to promote advocacy work around the issue of HIV-AIDS.

Each organization will do this from its own perspective – CARITAS Internationalis from the spiritual, moral and social teaching of the Roman Catholic Church and UNAIDS from its pluralistic standpoint as an organ of the United Nations.

In Latin America, in March 1998, the Episcopal Conference of Argentina held a regional Symposium on HIV-AIDS prevention, where representatives of the Catholic Church from several Latin American countries, a senior Vatican official, the UNAIDS Secretariat, and the World Bank participated. A follow-up conference was held in March 1999 to build on the momentum of the symposium, which has contributed further towards a more open and continuing dialogue on AIDS issues in the region. In Argentina, this collaboration resulted in support from UNAIDS for the inclusion of HIV-AIDS awareness messages in church publications that reach some 150,000 parishioners every week, as well as the broadcasting of messages concerning HIV-AIDS by some 35 Catholic radio stations.

UNAIDS is also actively collaborating with other denominations to support their efforts to increase awareness of HIV-AIDS and expand prevention, care and support services in their various communities. A few examples of such collaboration include assistance to the World Council of Churches (WCC) to build the capacities of their member churches to carry out values-based HIV-AIDS prevention, care and support – a programme to build a core of national and community trainers on HIV-AIDS within the WCC membership on HIV-AIDS is being piloted in India and Zimbabwe.

An inter-faith alliance in Africa to act as a focal point for information exchange, resource sharing, and capacity building is also being established. Case studies on the HIV-AIDS activities of religious communities in Africa and a survey and analysis of involvement of Buddhist, Christian and Hindu religious communities in Asia have been produced. UNAIDS also helped support the First International Symposium on AIDS and Religion in Dakar, Senegal. At this conference, participants from a variety of religious backgrounds including Islam, Christianity and Buddhism, exchanged practical experience in AIDS care and support and discussed prevention through abstinence, mutual fidelity within marriage, and responsible condom use.

Let me say in conclusion that we are very much in this together. All faith traditions are struggling with how to address the issue of AIDS and particularly how to reach young people with some of the messages I have earlier referred to. Sometimes we have identical approaches, sometimes complementary approaches. We must continue to seek mutual understanding and reinforce the dialogue between church and secular authorities, and not hinder each other's efforts. Our ability to find ways of working together may constitute our truest hope of reducing the tragic consequences of the AIDS epidemic. The next generation of young people, and the next generation of our leaders, depend on us to find the way. We must not fail.

Dr PETER PIOT
Executive Director, UNAIDS

Presentation of the Work of the Research Group

1. The appearance of AIDS provoked a strong reaction within society, a reaction which was made up of aggression, panic, and fear.

2. Immediately afterwards there was an explosion of services and concern both on the part of professionals and of institutions, and a bursting forth of witness, solidarity and professional commitment. We could say that AIDS has become a disease of the world. Certainly we have begun to give value to life, which we see as being so fragile and mortal, as indeed this disease has shown us that it is.

3. A fact I would like to emphasise is the care and concern demonstrated by the Church which in such circumstances has become a pioneer both through its *word* and through the *number of institutions and people* who have dedicated themselves to the service of those who have been afflicted by AIDS. Such an approach reflects a historically constant attitude.

4. In the meeting which took place in Geneva in May 1988 on the subject of AIDS, stress was placed upon the importance of the Church with regard to the definition of its point of view on the ethical questions and issues connected with, and raised by, this disease.

It was said that the drawing up and diffusion of documents which could clarify the position of the Church, and its response at a social, health care, and spiritual level, for a heterogeneous public – in terms of denomination and culture – was something which could be useful.

We can say that the Pope has on a large number of occasions enlightened us with his Magisterium when talking about this subject.

There are a large number of documents which the episcopal conferences and numerous local bishops have written for the faithful so that they could be present – as Christ himself was – amongst the weak, the sick, and those in need, and so that they could be 'protagonists' with a welcoming, healing and salvific presence.

The Church calls upon people to 'evangelise illness', to place it within its true whole, to give it meaning, to 'celebrate the sacraments, the source of grace, and to bear witness to service (*diaconia*) and communion (*koinonia*), the therapeutic strength of charity'.

5. The Pontifical Council for Health Pastoral Care – the right hand man of the Holy Father in the field of pastoral care in health – could not remain at the margins of this broad set of questions and issues. I would like to observe here in this assembly that there have been two important stages in the work and initiatives carried out by our Ministry in relation to the subject of AIDS.

The First Stage

– The international conference which was held in November 1989 was dedicated to this subject and had the title: 'Why live?: AIDS'. The readers of our journal *Dolentium Hominum* will find in number 13 – which has been sold out – the acts of this important congress.

– During this first stage we visited many institutions in the United States of America, in India, and in Italy, in addition to hospitals and special centres for these sick people.

– We also took part in other meetings dedicated to this subject.

The Second Stage

During this stage we began the planning of the work of our Ministry whose programmes are indicated in the book entitled 'Work Plan'. AIDS is examined under the heading of 'emergency illnesses'.

With the goal of engaging in thought about the subject we established within the Pontifical Council a work group whose work, indeed, forms the basis of this Symposium. The path followed by the work group began with the meeting of 25 June 1997. This first meeting was followed by meetings held on the following dates:

– 14.7.1997
– 2.3.1998
– 24.3.1998
– 21.4.1998
– 14.5.1998
– 20.5.1998
– 29.5.1998
– 16.6.1998

– July 1998. Questionnaires were sent to all the episcopal conferences and nine of them were asked to send a representative to belong to an enlarged study group.

– 18-19 December 1998. A meeting took place with the whole of the study group and the nine new appointed members.

In 1999 a number of meetings were held:

– 23.4.1999
– 13.7.1999
– 26.10.1999

Their goal was to prepare for the Symposium which we are now celebrating and to follow from close at hand – to study and to assess – the answers which we received from this questionnaire. The result of this path taken is this Symposium.

In the name of the Pontifical Council I would like to thank the work group and the secretariat. Everybody, at each level, has made this meeting possible, which we hope will be a trampoline for the continuation of our work on this subject.

H.E.Mons. JOSÉ L.REDRADO
Secretary of the Pontifical Council for Health Pastoral Care, the Holy See

Results of the Inquiry into: "The Realities, Problems and Proposals of the Local Churches in Relation to Socio-Health Care Services and Pastoral Action for People with HIV-AIDS in the World"

The Framework of the Project

HIV-AIDS has become a global epidemic which is no longer associated with the stereotype of homosexual behaviour (as was believed for a long time after its emergence in 1981) because it is now prevalently spread by heterosexual channels. A large number of international research institutes and international organisations, together with the ministries of health of many countries, are involved in the arduous task of trying to monitor this phenomenon both in order to achieve a more exact idea of its diffusion and to contain that diffusion, and in order to study suitable strategies for action for the purposes of prevention and assistance.

In this context the Church has asked questions about the nature of her action, both from the point of view of care and treatment and in terms of prevention, education, and pastoral accompanying. The Church has also dwelt upon what is known about the greatest difficulties which afflict the local Churches in the very sensitive area of pastoral care for those afflicted by this disease and upon the future prospects for action and intervention.

Definition of Objectives at the Level of Knowledge

This inquiry, which had an exploratory and descriptive character, sought to:

A) learn about the present-day situation concerning:

– programmes of social and health care assistance for seropositive people and those suffering from AIDS;

– pastoral action;

with special reference to action aimed at prevention, education, informing the population (and in a special way young people), and the training of workers in this area.

B) The identification of the issues and difficulties which have emerged in the implementation of these initiatives and programmes;

C) The listing of the proposals and suggestions of the local Churches subject to the inquiry in order to proceed to the application of new strategies in the approach to these issues and difficulties.

The inquiry was conducted through 112 episcopal conferences of the same number of countries (these conferences were contacted through the local apostolic nunciatures) in order to reach the bishops within those conferences who are specially responsible for the health care ministry. These are people who have a profound, but at the same time broad, knowledge of the subject of research.

In order to guarantee a high qualitative level in the reliability of the answers it was proposed to use small groups of experts placed within each local area of the inquiry where the project of research was organised. The role of those whom we interviewed should not therefore be undervalued. This is because the 'subjects' interviewed have a role and a representative character within the local Churches or international bodies which means that they have a reliable, qualified and trustworthy knowledge of the information which was necessary to this research.

In order to carry out this inquiry we drew up a questionnaire organised in paper form with questions requiring a closed standardised answer or multiple open answers. From July onwards of this year this questionnaire was sent through the apostolic nunciatures to the 112 episcopal conferences to be given to the bishops responsible for the health care ministry so that it could be filled up by them.

The questionnaire was organised into seven areas based upon different subjects: social fabric, ethical-moral aspects, pastoral action, social and health care services, projects and experiments, emerging issues and difficulties, and proposals and suggestions. 31 August 1999 was fixed as the final date for the return of this questionnaire.

By 31 August 1999 this Ministry had received 56 duly filled up questionnaires from episcopal conferences from countries belonging to the five continental areas. Thirteen episcopal conferences, instead, sent summary reports on the subjects of the questionnaire but which primarily contained information on the specific nature of the political situations and socio-cultural contexts of their countries. Six episcopal conferences said that they were not able to provide answers because the question was of marginal importance to their social reality. Thirty-seven episcopal conferences failed to reply. In analysing the distribution in terms of major geographical areas of the countries which filled up the questionnaire it is possible to observe that with the exception of the Middle East and North Africa the answers which were sent in were sufficiently representative of the countries of the areas which had been identified by the inquiry.

It is important to emphasise that the results of this inquiry are results which cannot be extended to all countries because this was an inquiry based not upon a probability sample but upon a reasoned sample. However, these results nonetheless remain valid and useful for the Churches which were questioned and for the launching of future action and the drawing up of more general guidelines.

The Social Fabric

In the first part of the questionnaire an attempt was made to throw light upon:

– the most urgent problems perceived by the local Churches (illiteracy, poverty, unemployment, immigration, the loosening of family ties, etc.);

– the most evident failings (in the political, economic, cultural etc. arenas);

– the kinds of bad conditions most widespread amongst the sections of the population most associated with forms of behaviour at risk in terms of infection by the HIV-AIDS virus (prostitution, drug-addiction, alcoholism, juvenile delinquency, etc.);

– the institutions or the bodies which are most involved in the social or medical-health care problems of the country (whether of a public or private character, ecclesial bodies and associations, and Catholic and non-Catholic non-governmental organisations);

– and finally the direction in which the social and medical-health care situation is going (improvement, deterioration, or stasis).

Some descriptive statistics

Those interviewed were asked to refer to the questions and difficulties of their social context which they thought were most urgent and prevalent in their countries. Of the categories referred to, poverty together with the inadequacy of social policies constituted those most cited – each being indicated in 82.1% of cases. This association of poverty and the inadequacy of social policies invites us to reflect upon the situation to be found in all those developing countries where poverty is still not seen as a problem of society which should be tackled by all of its members.

Unemployment followed with 80.4%, the loosening of family ties with 76.8%, and the process of urbanisation with 64.3% – a phenomenon correlated with a progressive emptying of the rural areas, in particular in the areas of the countries of Sub-Saharan Africa. It should be noted that illiteracy, indicated in 53.6% of the returned forms, was not seen as being of primary importance given the general trend in favour of an increase in the proportion of the population which receives schooling.

Those interviewed were also asked to place these questions and difficulties in a decreasing order of importance. The result was the following. Poverty was the modal category of both the first and second positions and has the highest frequency at these two positions. It was placed in the first or second positions with a frequency respectively of 33.9% and 28.6% and a total of 62.5%. The view that poverty was the prevalent problem was also widespread in most of the Churches which were interviewed and this was to be found throughout the countries of the various geographical areas which are very different from each other in terms of growth and development.

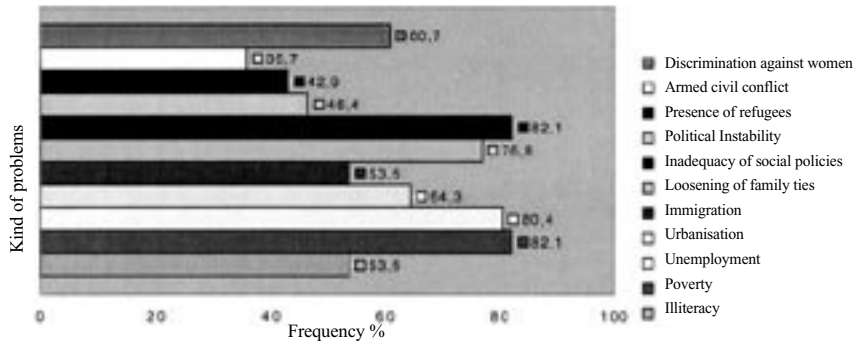
Unemployment and the loosening of family ties were placed in third position with a percentage of 26.8% and in fourth position with a percentage of 16.1%. The perception of both problems is clearly very high but emphasis is prevalently placed on unemployment, a phenomenon which is linked to the more practical and thus more visible difficulties of daily life. However, the phenomenon of the loosening of family ties constitutes a serious alarm bell because of its consequences for the social fabric as a whole (see Graph 1).

These data are to a great extent matched by the answers to the second question we asked in the questionnaire which sought to identify the areas where the greatest failings are to be encountered. From the graph it is evident that the greatest failings are connected to the lack of social policies and initiatives (85.7% of cases) and economic policies and initiatives (74.9%), followed by failings in educational and cultural policies and initiatives (73.2%).

In this case as well the people who were interviewed were asked to establish a decreasing order of importance for these areas of failure. The highest percentage frequency in this hierarchy was achieved by the lack of social policies and initiatives (32.1%), a fact which confirms what was brought out by the previous question where major criticism was felt in relation to social policies.

As regards the second position, on the other hand, the highest percentage score – 21.4% – was obtained by economic failings which, although in this graph are to be found at a lower level, are seen as constituting very serious problems indeed. This fact also confirms what was previously revealed with reference to the problems of poverty and unemployment (see Graph 2).

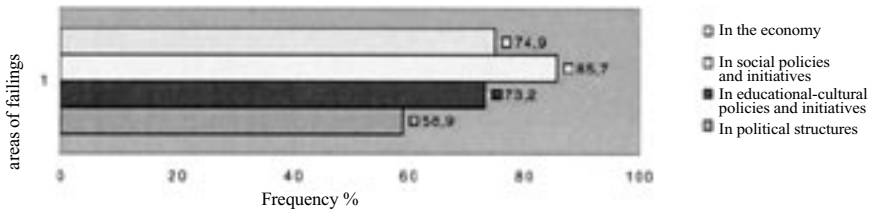
Graph 1 - Social Problems



Problems	% present
Illiteracy	53,6
Poverty	82,1
Unemployment	80,1
Urbanisation	64,3
Immigration	53,6
Loosening of family ties	76,8
Inadequacy of social policies	82,1
Political Instability	46,4
Presence of refugees	42,9
Armed civil conflict	35,7
Discrimination against women	60,7

Areas of Greatest Failings	%
In political structures	58,9
In educational-cultural policies and initiatives	73,2
In social policies and initiatives	85,7
In the economy	74,9

Graph 2 - Areas of Greatest Failings



In the next question those interviewed were asked to indicate the kinds of social evil associated with forms of behaviour at risk in terms of infection by the HIV-AIDS virus. As could well be expected, drug-addiction and prostitution obtained the highest percentages – 89.3% and 85.7% respectively – followed at a short distance by juvenile delinquency with 83.9% and by alcoholism with 82.1%. Although they did not achieve similarly high scores, marginalisation and the exploitation of minors were social evils which are seen to be deeply rooted in a large number of countries.

When those interviewed were then asked, as with the previous questions, to place these social evils in a decreasing order of importance a very interesting fact emerged upon which the replies of the Churches which had been interviewed notably converged. The highest percentage frequency placed in the number one position was alcoholism which had 23.2% of preferences. This brings out how much this factor influences sexual behaviour, especially amongst young people, and this is something which exposes them more easily to the risk of becoming infected by the virus (see Graph 3).

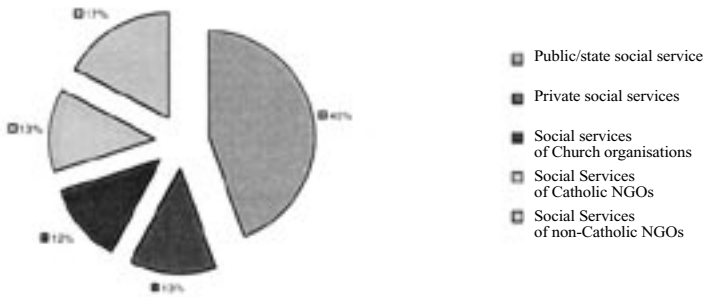
Drug-addiction is the modal category with regard to the second position with a percentage level of 28.6%, which was matched by prostitution which achieved the third position with a percentage figure of 21.4% in terms of the order of general preferences, as can be observed in the graph.

These data are confirmed by the subsequent question which asked which groups display the highest number of people with HIV-AIDS. Indeed, the modal levels corresponding to the first and second positions correspond to the categories of drug-addiction and prostitution, with percentage figures of 26.8% and 19.6% respectively. Of no lesser importance, in third position, is juvenile delinquency and the exploitation of minors, factors which have a strong impact on the models of behaviour of the young.

Concentrating on the initiatives of a social character which had been promoted in order to deal with the social difficulties encountered by people who live with HIV-AIDS, the people who were interviewed were asked to indicate the percentage contribution made by certain public/state, private, Church, or international bodies. As can be observed from the graph, 45% of the average percentage contributions for social interventions is sustained by the public/state sector, followed by the non-Catholic NGOs with 17%. However, if one takes an overall view of the average contributions made by Church bodies (12%) and by Catholic NGOs (13%), a total of 25% is reached, something which makes the Church the first partner of the state in the social field (see Graph 4).

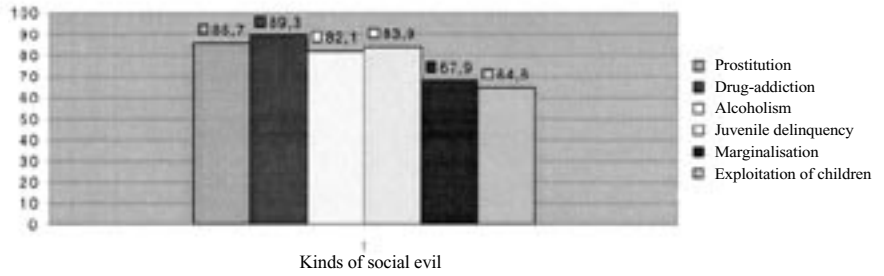
	%
Public/state social service	44,5
Private social services	13,2
Social services of Church organisations	12,3
Catholic NGOs social service	12,7
Non-Catholic social service	17,3

Graph 4: Average Percentage Contributions as Part of Overall Social Services



Kinds of Social Evils which Involve Exposure to Forms of Behaviour at Risk in Relation to Infection by HIV-AIDS	%
Prostitution	85,7
Drug-addiction	89,3
Alcoholism	82,1
Juvenile Delinquency	83,9
Marginalisation	67,9
Exploitation of minors	64,6

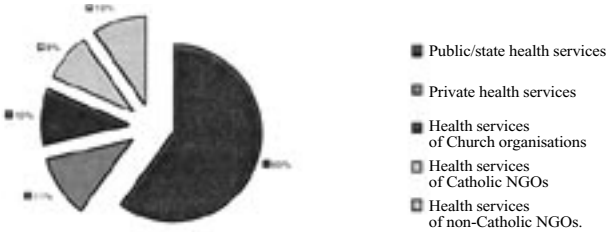
Graph 3: Kinds of Social Evils which Involve Exposure to Forms of Behaviour at Risk in Relation to Infection by HIV-AIDS



If we then use the same criteria to consider health care provision it is to be observed that in this specific area the role of the state is much greater with 60% of the average contributions, and once again we find that the Church is the first source of back-up with 19% – a figure which represents a third of the state contributions and double the contribution of the non-Catholic NGOs (10%) and private individuals or bodies (11%) (see Graph 5).

	%
Public/state health service	59,9
Private health services	11,3
Health services of Church organisations	10,4
Health Services of Catholic NGOs	8,7
Health Services of non-Catholic NGOs	9,7

Graph 5: Average Percentage Contributions as Part of Overall Health Services



With regard to the social situation taken as a whole, the perception of the phenomenon by those who answered the questionnaire is distributed rather equally between the three available options: 37.5% answered that it is continually increasing, 28.6% that it is worsening, and a substantial 32.1% noticed no change. The improvement in the social situation is more evident in the countries of Eastern Europe, in the Middle East and North Africa, and a marked improvement is also to be found in Sub-Saharan Africa.

The picture is very different in relation to the medical-health care situation whose distribution is very much concentrated on the modality which expresses the perception of an improvement (66.1%),which in turn is much more marked in the countries of Eastern and Western Europe, in the countries of Eastern African and the Pacific, whilst it is deteriorating in the countries of Sub-Saharan Africa and those of Central and Northern America.

The inequalities in health are due in large part to the inadequacy of social policies as well as of health care policies and are thus to be found in poor countries in addition to those which are rich and developed.

It is important to emphasise that these results express the perceptions of bishops or their collaborators concerning these questions and because they describe a picture of the social fabric which is well known to everybody they offer an empirical demonstration that the local Churches have a perception of the widespread questions and difficulties of the social context which is very near to actual facts. It means that the Church is integrated into the connective fabric of society despite and in the face of all the objective difficulties which in some cases it comes up against (as reported for example by the Churches of Lesotho and Cuba). The work of the Church is not, therefore, based upon theoretical assumptions but takes place within the living fabric of society, and in perceiving its difficulties the Church acts in consequence.

The Ethical-Moral Dimension

Certain descriptive statistics:

In this part of the questionnaire the phenomenon of social discrimination is examined, to which people afflicted by HIV-AIDS are often subjected, in particular in the family, school and health care environments.

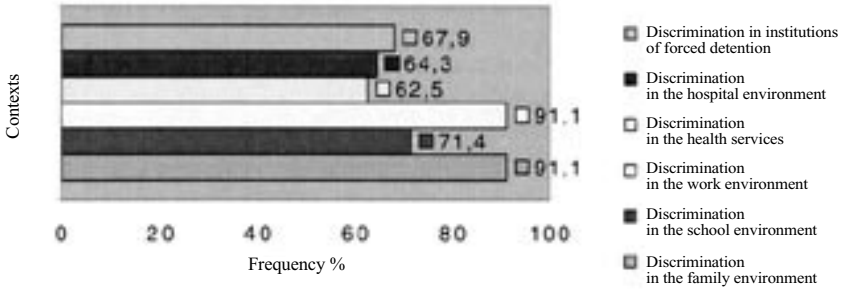
From the graph it can be observed that the spheres in which such forms of discrimination most take place are primarily the family and the work environment, both at 91.1%. These are followed by the school environment with a percentage of 71.4%, a figure which brings out the difficulties involved. The Churches were asked to establish an order of decreasing importance in relation to these spheres where forms of discrimination towards people with HIV-AIDS are manifested. The modal category of the first position was the work environment with 41.1%, with the school environment occupying the second position (25%), followed by the family environment in the third position (32.1%). It is important to emphasise that we are dealing here with social contexts within which the most important processes of socialisation take place, namely the family, schools and peer groups, and work.

The worry which is most frequently encountered is that of becoming infected (85.7%), something which is linked,

above all in the countries of the Asian area and Sub-Saharan Africa, to a low level of information about the ways in which this disease is transmitted and to phenomena which are of a more specifically cultural character. A fact which should lead us to reflect is that in 24.1% of cases this fear is present in the countries of Western Europe correlated in an almost mathematical correspondence with an equally high level of prejudice (21.4%) towards those people who are afflicted with this disease (see Graph 6).

	%
Discrimination in the family environment	91,1
Discrimination in the school environment	71,4
Discrimination in the work environment	91,1
Discrimination in the health care services	62,5
Discrimination in the hospital environment	64,3
Discrimination in institutions of forced detention	67,9

Graph 6: Contexts in which Forms of Discrimination are Encountered



a. The family

Family discrimination does not seem in the least to be something characteristic of one culture or another. It is a phenomenon which is present in all countries and all cultures, as is the case, as we have seen, with poverty. However, it is a good idea to ask ourselves at what level of familial relations this phenomenon most manifests itself.

Within the nuclear family the ties between parents and children and between marriage partners seem to hold up in the face of the manifestation of this disease whilst in 64.3% of cases it is the so-called wider family, that is to say the realm of second or third degree ties of kinship, which expresses forms of discrimination and marginalisation towards a sieropositive member of the family.

The reasons behind these forms of discrimination are to be found first and foremost in the allocation of blame (71.4%) and in the fear of contagion (69.6%) (see Graph 7).

In all the great geographical areas and in particular in Asia (16%), in South America (21.4%) and in Sub-Saharan Africa (17.9%) in order to deal with and tackle the problem of HIV-AIDS initiatives dealing with information and training have been activated which are largely directed towards preventive health care (67.9%), together with educational concern with the emotional ties of the couple (21.4%) and the overcoming of the barriers of discrimination.

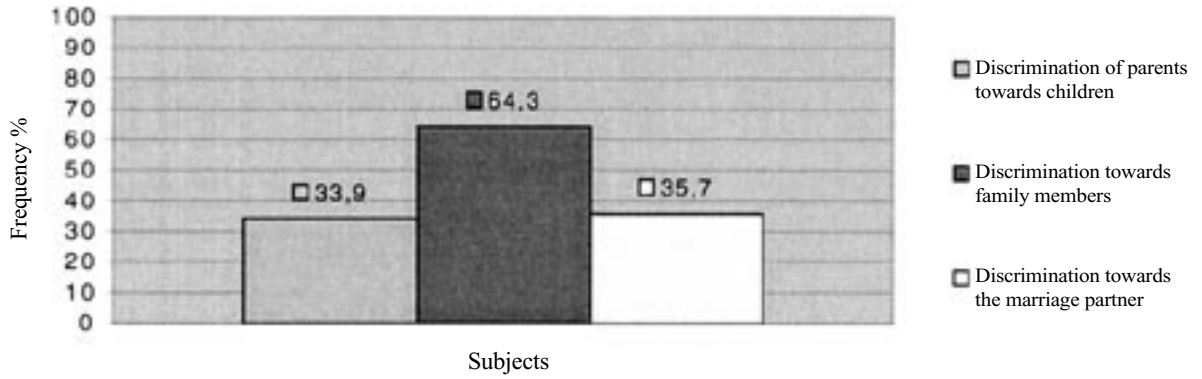
The entities which have promoted these initiatives are government agencies (60.7% of cases), followed by very active voluntary associations (44.6%).

b. Schools

With regard to the phenomenon of discrimination in the school environment, the other important context of socialisation, there is to be observed – differently from the family environment – a greater oscillation between the different geographical areas, not least because of the varying impact of the social policies which have been adopted. It is to be seen that in the Asian area – with regard to the school environment – this phenomenon is on average less widespread than in other countries. Indeed, it is to be observed that in India, for example, the Church is intensely committed in the sphere of schooling and is engaged in the promotion of correct informa-

	%
Discrimination of parents towards children	33,9
Discrimination towards family members	64,3
Discrimination towards the marriage partner	35,7

Graph 7: Discrimination Towards Individuals within the Family Environment

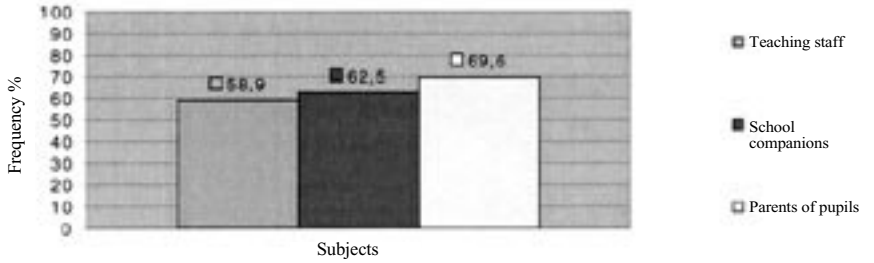


tion not only in relation to students but also as regards the teaching staff in matters connected to the disease and its forms of transmission.

In the sphere of schooling the individuals who most often display a discriminatory attitude towards people with HIV-AIDS (69.9% of cases) but are also to be found in the first position in the decreasing order of capacity for discrimination are the parents of children (% of the modal category: 39.3%). This is particularly marked in the countries of the Western area (see Graph 8).

Individuals	%
Teaching staff	58,9
School companions	62,5
Parents of pupils	69,6

Graph 8: Individuals by Whom Discrimination is Expressed in the School Environment



The teaching staff constitute the category which is most open to understanding and to the welcoming of seropositive pupils. However, the activity of information and training in the state schools in relation to AIDS is only occasional in 51.8% of cases, a percentage which decreases in the countries of the Western area and in Latin America. These initiatives are principally directed towards the diffusion of health care education of a preventive character (42.9%) and the training of teaching staff with regard to forms of prevention (33.9%). This fact could explain the particularly welcoming attitude of the teaching staff of schools, to whose training especial attention is given. The elements which are the promoters of these initiatives in the state schools are many in number: from government agencies to voluntary associations, the teachers themselves and the Church organisations – where this is allowed.

b.1. Initiatives of the Catholic schools

Catholic schools, especially in such countries as Mexico, India, Colombia, and the Lebanon, are very committed on this front despite the objective difficulties which exist which are largely due to the lack of financial, and even more human, resources. The activity of Catholic schools in these countries is principally directed towards the provision of information and the raising of the awareness of students so as to achieve a more careful and detailed knowledge of this disease and the ways in which it is transmitted. This is accompanied by an intense educational and formative initiative with regard to respect for life, loyalty to marital love, the emotional ties of the couple, responsible parenthood, and all this to achieve a lifestyle marked by Christian moral values.

Health care education constitutes a large part of preventive action in the Catholic schools and this is entrusted to well and suitably trained teachers capable of transmitting these important ideas to young pupils.

Naturally enough, there are certainly countries where the Catholic Church suffers unjust forms of exclusion from social life. In Cuba, for example, Catholic schools do not exist; and in Lesotho the AIDS units of the Catholic Church are not accepted in 75% of schools. Teachers and the parents of the pupils need suitable education and training in this area but there is a lack of funds.

The initiatives which were most commonly recorded are the following:

– the organisation of meetings between parents, students, Catholic movements and external experts for the purposes of education and information;

– listening to the testimony of people who live with AIDS-HIV;

– educational conversations with debates, theatre, videos, forums, and the testimony of those afflicted with the disease and voluntary workers;

– the publication of consciousness-raising material: pamphlets, leaflets, posters, multimedial packages for schools, brochures on prevention etc.;

– education in self-promotion, in the search for and positive view of individual capacities and skills;

– the organisation of teaching staff for education in the prevention of HIV-AIDS and the training of young people belonging to anti-AIDS clubs and peer support groups;

– education in emotional ties within the couple, in responsible procreation, the promotion of changed sexual behaviour, and education in life and love (the EVA Programme of the Cameroons);

– health care education, meetings with workers in the health care field, with representatives of the medical and scientific world, and with representatives of the political world.

c. Health care structures

In the health care structures and in particular in the hospital field forms of discrimination towards people afflicted by HIV-AIDS can be encountered. However, these are less frequent than in the sphere which

has just been referred to, being drawn attention to in 64.3% of those interviewed.

In particular it can be observed that in Western countries where professionalism in work is accompanied by an increasing culture of the safety of work the phenomenon is felt much more keenly than in the so-called developing countries where even minimum safety conditions at work do not exist. Thus it is that in areas such as the Asian area where hitherto low average levels in the presence of this phenomenon have been recorded there is a marked and significant increase .

The recurrence of rejection by health care workers in the hospital structures and in social-health care services of people with HIV-AIDS is only observed 'at times' (on average 41.1% of cases) and this datum is supported by the fact that in 50% of cases there takes place within health care structures regular activities of training and/or information provision in relation to the health care personnel in order to achieve a policy of prevention. In 80.4% of cases seropositive health care workers are known about and in the majority of cases the health care structures, although they consider this fact a problem, face up to it together with the health care worker and keep him or her in his or her job (64.3%). However, these individuals become the objects of a subterranean ostracism by the working group or team around them despite the attempts made to curb this practice by the administrative structure.

The duty to respect secrecy is always observed in 37.5% of cases and often in 30.4%. For this reason there are good grounds for believing that respect for this important right of the individual is rather widespread. With regard to the effective upholding of that right it comes as no surprise that in the United States of America where an individualistic culture prevails this duty is rigidly observed, irrespective of any concomitant event. In other countries, on the other hand, which have a predominant religious dimension – such as for example in Latin America and Eastern Europe – the rigid application of this principle can diminish in the presence of contingent factors. A space is left for the assessment of the person who has to deal with each case as it arises.

To tackle such situations, which raise problems of no minor ethical and moral importance, initiatives to protect the marital partner or partner have been engaged in. The most widespread of these – in 76.8% of cases – is counselling flanked by psychological support which is provided to the marriage partner or partner who is unaware of the seropositivity of the other member of the couple. In public structures, in 51.8% of cases, priority emphasis is placed upon the use of condoms as a preventive measure.

To the sensitive question of knowing about the experimental and non-controlled use of new drugs and medicines, 76.8% of the local Churches which were interviewed replied negatively and 23.2% replied positively. This 23.2% principally concerned the use of children (14.7%) and the terminally ill (8.8%) in such experiments. These were followed by women, prisoners, and the mentally ill.

Both public services and services rooted in the Catholic Faith were involved in supporting and sustaining pregnant seropositive women:

Public Services

– information and psychological support for such women are reasonably present and are chiefly directed towards the well-being of the mother (55.4%) and the child (35.7%). However, the public service seems orientated towards accompanying the mother until the end of her pregnancy (26.8%) rather than encouraging its interruption (19.6%). This fact is confirmed by the information provided by many local Churches which in recent years have observed an inversion of the trend – even though small – on the part of many national governments which display a greater sensitivity towards, and respect for, life.

Services rooted in the Catholic faith

– in this field the Catholic

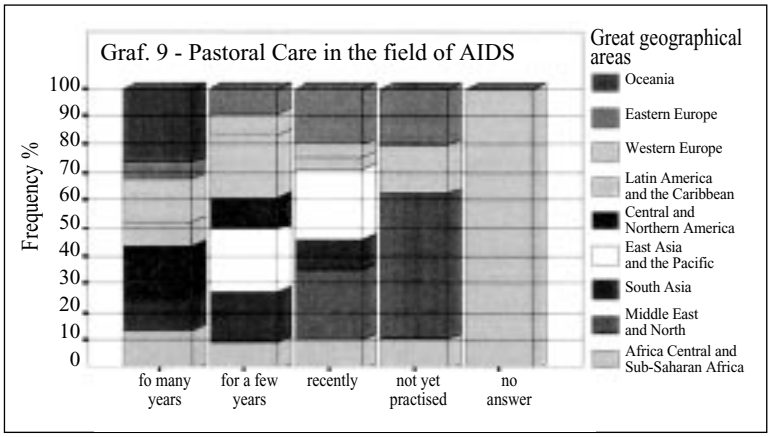
Church is still not very present. However, where the Church does work attention is primarily paid to the well-being of the child (46.4%) followed by the mother (42.9%), naturally enough with the aim of accompanying the pregnancy until its natural end.

Pastoral Action

Some descriptive statistics

The health care ministry of the local Churches which were interviewed began to concern itself with the question and difficulties of HIV-AIDS in 42.9% of cases many years ago, albeit not always in a systematic and planned way. The graph illustrates the distribution by great geographical areas of when the Church began to be concerned with the pastoral care of accompanying those suffering from HIV-AIDS. Naturally enough, the Churches which first began such pastoral care were those in the countries which first experienced the outbreak of this virus – the United States of America and Western Europe. Moving to more recent years we can find Africa first, where the spread of the virus has reached such high levels that the Churches have been led to take immediate responsibility for the problem and activate a series of initiatives – above all of an educational and cultural character – in order to spread the idea that AIDS is a disease and not a punishment. We then find a number of countries of the Middle East and North Africa where full awareness of the problem encounters diffi-

culties in taking off but where the Church also comes up against many problems of co-existence with Islamic governments (see Graph 9).



About 80% of the Churches which were interviewed did not refer to an official body in their local Church responsible for pastoral work in the field of AIDS. 50% of options were placed under the heading of 'health commission' to which specific pastoral care for the field of AIDS was referred.

66.1% of the Churches which were interviewed declared that they had established a programme for action to deal with the AIDS emergency. In some cases (for example in the Ivory Coast) the local Church acts as the national co-ordinator for all the services and initiatives in the field of HIV-AIDS, acting as a point of contact between the dioceses, the parishes, the health care structures, and the movements and the associations of the territory. This commitment seems to be concentrated, naturally enough, in the areas where the epidemic is tending to spread with greatest speed (Sub-Saharan Africa 17.9%, Asia 16%). The essential points of the action of the local Churches can be summarised in the following way:

A. Training
B. Prevention
C. Health care and assistance
D. Taking care of and the pastoral accompanying of those afflicted by HIV-AIDS,

even though the taking care of, and spiritual accompanying of, these sick people and their families is of especial importance. Taking care of people goes beyond those with the disease to those who have been orphaned because of it, and they are increasingly great in number – from current estimates their numbers are on an upward curve. This is a question which we will hear talked about for a very long time to come and which requires the drawing up of suitable programmes of action.

A. Training

– the training of health care workers (medical doctors, paramedics etc.) and voluntary workers;
– information/training and male and female religious and pastoral agents (religious and lay);
– the training of educators for natural family planning, animators;
– the training of young people leading to the creation of groups of educators amongst peers.

B. Prevention

– education in prevention and the raising of the awareness of the members of society;
– preventive health care education;
– the education of young people and adults in responsible love and respect for the human body;
– official documents, brochures about sexuality and the family, information booklets for schools;
– information for male and female religious;
– national and international symposiums with the participation of representatives of institutions of the state, of non-governmental organisations, and of the population as a whole;
– education in family life, in marital faithfulness, and in responsible motherhood and fatherhood;
– seminars for health care workers;
– the development of awareness.

C. Health care and assistance

– the involvement of chaplains and voluntary workers, and of Catholic medical personnel;
– counselling services pre and post test and basic home support;
– the identification and diagnosis of seropositivity;
– participation in projects with other co-operation agencies;
– support for national projects in the fight against AIDS-MST-TUB;
– support for charitable associations (Caritas);
– promotion and support for mutual aid groups;
– the establishment of rest homes for those suffering from AIDS;
– rehabilitation centres;
– projects of assistance for AIDS victims and their family relatives from a health care, human, psychological and spiritual point of view (the Good Samaritan Project in Mexico).

D. Caring and pastoral accompanying

– psycho-social and health care assistance for people suffering from AIDS;
– caring for orphans, widows and widowers;
– the accompanying of people with AIDS in institutions of forced detention;
– support for activities directed towards the social reintegration of HIV positive people;

– homes for children and their HIV positive mothers (Argentina);
– homes for HIV positive men and women who are in a condition of destitution;
– community homes.

In order to carry out such programmed initiatives economic contributions have been requested in 48.2% of cases from bodies such as:
– MISEREOR
– CRS (Catholic Relief Service)
– MEMISA
– CARITAS INTERNATIONALIS (CAFOD)
– FOREIGN CHURCHES
– WHO
– THE WORLD BANK
– UNICEF
– UNESCO
– UNDP (United Nations Development Programme)
– FOREIGN DONOR AGENCIES
– NATIONAL BODIES
– GOVERNMENTS AND HEALTH MINISTRIES

These requests has been made with prevalently positive results (42.9%).

At a diocesan level planned and systematic pastoral action is underway according to 57.1% of the respondents to the questionnaire. However, this figure is only slightly higher than the number of Churches who declared that such action had not yet been set in motion. The essential points of such planned action are as follows:

A. Prevention
B. Training
C. Assistance

Pastoral action at a diocesan level follows the model defined by the local Churches, even though with greater attention being paid to the practical needs of the local territory and population.

Different initiatives exist with regard to health care and psycho-social care for people with HIV-AIDS and orphans, a category which is becoming increasingly numerous. However, notwithstanding the fact that the progressive increase in the number of orphans is an urgent problem there are as yet very few initiatives in this direction. Attention is prevalently paid to caring for people with AIDS/HIV and to prevention. There are important forms of activity promoted

and supported by the local Churches which are producing reassuring results – the Providence Outpatient Clinic of Rio de Janiero, the EVA Programme in the Cameroons, the pastoral programme of the Good Samaritan in Mexico, and the Open Hearth House in Ireland. All these initiatives cover the whole of the social-health care context and adopt multidimensional strategies towards the problems of people who live with HIV-AIDS.

The objective which the dioceses currently hold to be of primary importance in relation to the question of AIDS is education in love and in chastity amongst young people (67.9%), help for sick people and their families (66.1%), and sexual education (58.9%).

The Training of Candidates for the Priesthood and Pastoral Care of Sick People with HIV-AIDS

The teaching of this particular pastoral approach is slowly being inserted into courses for special morality or courses for education in life, or into the units for pastoral counselling during pastoral theology studies, or into courses for pastoral medicine, courses for pastoral education, courses for the training of chaplains, or into the training of young candidates for the priesthood.

Such forms of teaching and training utilise audio-video cassettes which, after being seen, are followed by individual commentaries, by testimonies from people who have experience of this approach, by illustrative and explanatory sessions about MST and HIV-AIDS, by conferences, and by direct experience in the provision of social pastoral care.

There is then an attempt to develop a capacity to engage in counselling, to encourage contact with patients, and to stimulate contacts and links between seminarists and health care workers in this sector.

Socio-Health Care Services and Initiatives

It should be made clear that it is not possible to offer reliable and significant data on the number of Catholic hospitals which have sections specially dedicated to AIDS and the number of non-hospital Catholic centres which care for and treat AIDS victims. This is because of the small number of countries where it is possible to carry out such an inquiry.

It is, however, possible to observe that there is a rather homogenous distribution of the different kinds of non-hospital Catholic centres, with the medical health care centres, social-aid, socio-educational and social support centres hovering around 35%. However, it is the social-aid centres which are most frequently encountered (42.9%), something which confirms the prevalent concern of the Church in relation to the question and reality of AIDS. Such aid is, however, accompanied by an intense educational and training action directed towards the person in an overall sense. Education and aid are the two pillars of the response of the Church to AIDS at the level of action and practical initiative.

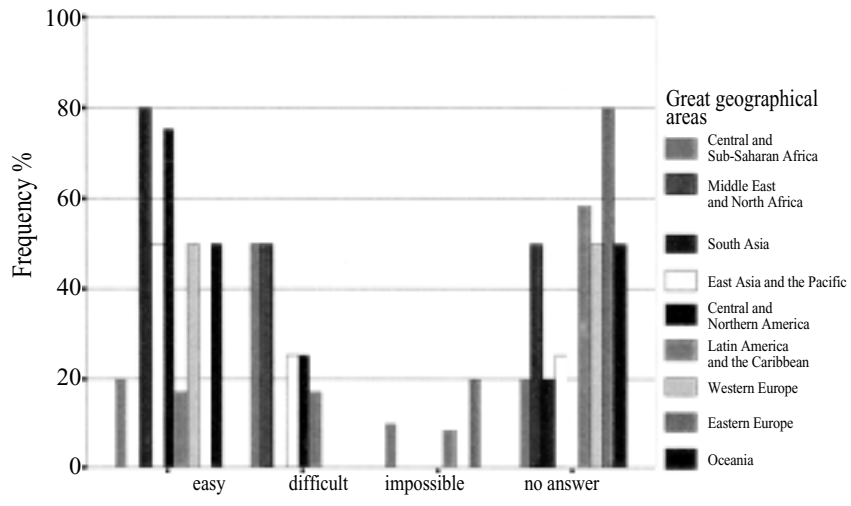
Both the Catholic hospital centres and the Catholic non-hospital centres are concentrated in the urban areas, even though they are also present in many rural areas or hinterlands – areas which are often very dangerous and where the Church is the only reference point or possible support for a population abandoned to itself.

With regard to the assessment of the ability to meet the needs of the patients, either the respondents were not able to reply (32.1%) or they defined it

as being reasonable, and indeed the access of patients and the terminally ill to such hospital centres or non-hospital centres is rather easy (39.3%-37.5%). However, the access of the terminally ill to structures for admission and specific forms of care is clearly much more difficult.

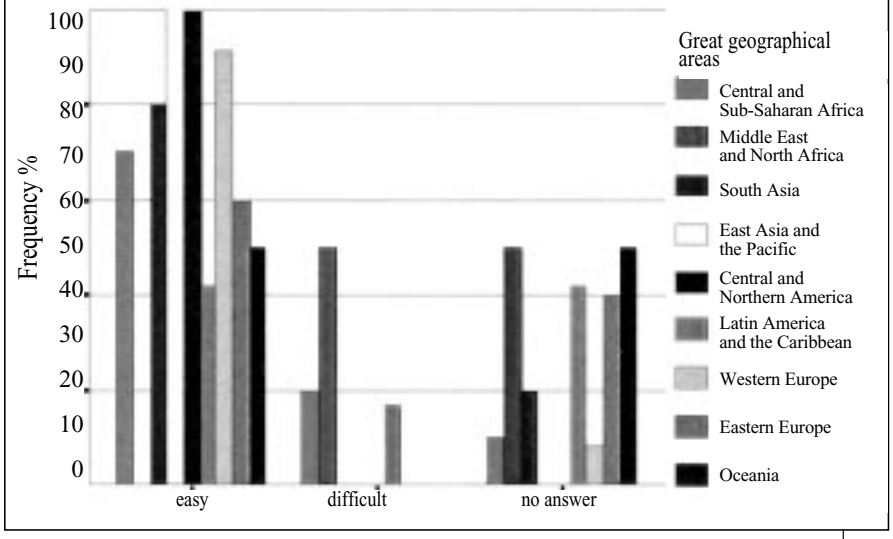
With regard to services of a medical-health care character, an attempt was made to register the level of accessibility to some of the tests which are most present in the systems of health service available in the countries of the people who were asked to fill in this questionnaire. It should be pointed out that many 'no answers' were recorded under these headings, probably because of the special nature of the question being discussed. However, an examination of the distribution by great geographical areas of the opinions expressed on levels of accessibility to the anti-HIV test reveals that by now access to this kind of test for the identification of seropositivity is rather widespread and available even in the poorer countries, such as those in Asia. However, in Africa, where it could prove to be an effective means for the monitoring of this phenomenon, access is still rather difficult (see Graph 10).

Graf. 10 - Access to the anti HIV test



As regards pastoral care, the opinions expressed seem to converge in full agreement concerning the high level of accessibility to this kind of support which, however, in the countries of Latin America and the Caribbean is still not yet sufficiently planned and organised (see Graph 11).

Graf. 11 - Access to Pastoral Care for the Sick



When it comes to immunological tests there is a certain difficulty at the level of access, above all else in developing countries in Asia and Africa.

With regard to protease inhibitors, side by side with a general access in the richer countries, such as the United States of America, there is an inability to obtain access to such forms of treatment in the poorest countries which do not have the economic resources to meet the costs of buying this pharmacological package.

Lastly, with regard to pharmacological prevention at the level of the maternal foetus it is to be observed that this is widely adopted in the United States of America but something which is even more impossible and unobtainable for developing countries.

This picture demonstrates that the level of services in 55.4% of cases is still inadequate, in particular in Sub-Saharan Africa and Asia, and this despite the employment of professional figures such as medical doctors, nurses, social workers, spiritual assistants, voluntary workers, and the members of religious orders. Professional figures such as psychologists, laboratory technicians and legal advisers are less numerous and less present on the ground.

In 64.3% of cases it is to be observed that the up-dating of health care workers takes place at least every twelve months. This is something which ensures an average level of professional skill and competence which in 50% of cases is defined as being 'good'.

Projects and Experimental Initiatives

In order to improve the response to the needs of people suffering from HIV-AIDS, there are presently underway in the sectors of intervention identified by this research in 76% of countries projects and experiments of a largely national character (64.3%), which are increasingly supported by international forces and agencies (32.1%).

The following are the most important:

– the creation of institutes of

social hygiene and contagious diseases, medical-social centres, and programmes to strengthen diagnostic capacities;

– in Germany, Belgium, the United States of America: pharmacological studies, studies on mutations in the virus with a view to creating a vaccine;

– ecumenical programmes to promote the fight against AIDS; units for reflection about AIDS; the training of voluntary workers to provide home-based care for those people suffering from AIDS/HIV;

– in Argentina: the opening of homes for seropositive mothers and their babies;

– in Peru: the 'Casa Hogar' project for the children of sieropositive parents;

– in Burundi: the 'New Experiences' project of Brijumbura, the establishment of the Nyamugari Centre in Citega, the 'Families for the Defeat of AIDS' national project, the creation of the Association of Seropositive People and AIDS Victims, and the national programme of aid for orphans.

– in Uganda: CRS-CAFOD-CARITAS for a project of medical-health care assistance and support for orphans; UNAIDS for the prevention of transmission through the maternal womb; and funds supplied by the World Bank;

– in Guinea: the project for the creation of three medical-health care and social support centres in the dioceses of the country: the project for the creation of a unit for the thought and action of the Catholic Church in its fight against AIDS;

– the Ivory Coast: the national AIDS plan of the Catholic Church for the years 1995-1997 and the three year AIDS plan of the Catholic Church for the years 1998-2001;

– in India: conferences and workshops on the subjects; co-operation with Catholic institutes, non-governmental organisations, and dioceses; the publication of three books on the subject; text books for schools on AIDS, and a book on pastoral assistance;

– in Poland: projects of co-operation with the Ministry of Health and large NGOs, the establishment of a free telephone line on AIDS run by the voluntary associations engaged in the struggle against AIDS; support for family life; and the production of information materials for priests.

– in Brazil: projects for the fight against poverty and destitution; projects in favour of children, adolescents and young people at risk; projects for homosexuals; projects dedicated to the improvement of the quality of life of people suffering from HIV-AIDS; and the Providence Clinic of Rio de Janiero.

At the present time there is increasing co-operation between public/state bodies and Catholic non-governmental organisations (71.4%), even though this is not always of a sufficient level (only in 30.4% of cases). Some of the most important forms of such co-operation are directed towards the financing by government/state bodies of training projects for voluntary workers providing a grounding in counselling, the acquisition of drugs and medicines for opportunistic infections, food aid, the monitoring of the HIV infection in pregnant women, the establishment of ethical and scientific committees, and seminars for the study of AIDS and the launching of ecumenical action against this disease.

Co-operation between government/state bodies and non-Catholic non-governmental organisations is even more intense (78.6%), but in this case as well it is not always satisfactory (33.9%). The most important experiences in this area regard the creation of micro-projects, the organisation of information seminars and debates, food aid and other forms of aid, aid at the level of drugs and medicines against opportunistic infections, the free distribution of condoms, programmes for the administration of methadone and against the exchange of syringes, programmes against social marginalisation and exclusion; and the diffusion of material for the defence of sexuality.

The Emerging Questions and Difficulties

a. The social fabric

Poverty is without doubt the problem which most afflicts the countries whose Churches received our questionnaire. It is connected with serious forms of marginalisation of people in relation not only to social life but the health care system as well.

Poverty is also connected with unemployment because there is a lack of work and where work is available the wages are very low. As a result there is a veritable exodus of young people from the rural to the urban areas and the abandonment of elderly people in the villages. We should also take into account the low levels of education which are to be encountered, especially in certain countries.

These problems, which are rooted in the social fabric, result in the exposure of large segments of the population to forms of behaviour at risk in relation to the transmission of the HIV virus:

– prostitution: women, often very young women, engage in prostitution, enter the world of sexual tourism and have homes where such encounters are organised;

– drug-addiction: the use of drugs of various kinds, the exchange of syringes.

b. Ethical-moral aspects

Today the way in which HIV is most transmitted is through heterosexual contact. This fact raises serious ethical and moral problems, amongst which:

– the protection of the non-infected spouse/partner;

– social discrimination towards seropositive people (including children) or those suffering from AIDS at work, in the services, and in the family environment;

– the recovery of moral and spiritual values;

– greater respect for cultural traditions;

– greater solidarity towards various groups which have different lifestyles;

– the promotion of human life;

– education in love and sexuality.

c. Initiatives in the field of the health care ministry

The answers to the questionnaire brought out a recurrent request for greater support for the action of parishes and priests from the local Churches and an urgent request for guidelines for pastoral care in this field directed towards establishing certain directives about the prevention and control of HIV-AIDS in line with the ethical and moral parameters of the Church of Rome.

There is also an evident need for a specific training of the male and female members of religious orders in this area of action, for greater co-ordination of the various experiences in relation to this subject, and for a more rigorous planned and organised approach to pastoral action.

d. Social-health care services and intervention

The answers to this questionnaire bring out the need for greater financial, (professionally trained) human, and material resources in order to respond in an effective way to the needs of AIDS patients.

There also emerges a need for:

– psycho-social and medical-health care assistance which is more capillary in nature;

– the use of modern medical equipment;

– easier access to anti-retroviral drugs and medicines and specific forms of health care;

– the prevention of opportunistic pathologies;

– a greater number of hospital and social centres belonging to the Catholic tradition.

Proposals and Suggestions

The international community should intervene in the field of AIDS by fostering the allocation

of funds and financial resources in order to create projects which involve making access to anti-retroviral and anti-opportunistic drugs and medicines easier; initiatives directed towards the promotion of socio-economic development; the creation of a 'credible' network of partnerships between non-governmental bodies and associations involved in the fight against MST and HIV-AIDS which could support activities already underway and reproduce those which have had most success elsewhere; support for the action of individual national governments; and support for the initiatives of Catholic and non-Catholic NGOs.

The local Churches should be able to influence national health care policies, first and foremost by establishing closer ties and forms of co-operation with public authorities, thereby becoming an indispensable partner of the state. There is a need for a more significant presence of male and female religious within health care structures; a joint struggle against poverty and illiteracy; and the creation of a clear orientation with regard to the health care ministry and AIDS.

We need to find substantial economic and financial means with which to promote the activity of Church organisations involved in advancing policies in favour of the protection of life and which challenge contemporary preventive policies based – often solely – on the widespread use of the condom.

We need to learn how to use the press and the mass media in a mature and suitable way.

58% of the Churches which were interviewed asserted that the national legislation of their countries offer a suitable response to AIDS.

The areas which can be improved are:

– the strengthening of the right to health and to suitable care and treatment for everybody;

– the protection of the rights of people who suffer from HIV-AIDS;

– the reduction of the costs of care and treatment and making access easier;

– the obligation to engage in counselling both before and after the test;

– blood tests;

– the drawing up and implementation of norms against social discrimination;

– the study of effective systems of prevention;

– making sure that seropositive people and those suffering from AIDS can keep their jobs;

– support for groups at risk.

Contemporary legislation meets the questions and difficulties generated by this disease only in part (58.8%) and often the major problem is the actual implementation of such legislation. The public sector very often does not permit the provision to Catholic centres of public funds and this is yet another problem brought out by this inquiry.

I believe that through this broadly-based inquiry the Pontifical Council for Health Pastoral Care has become the spokesman of the courage and commitment with which the Church continues to face up to the question and difficulties of AIDS at a moment when little is said about it – a demonstration of how the Church never forgets about the least of our brethren and the most alone. This work seeks to be only a modest point of departure, a launching pad for suggestions and observations from which this prestigious assembly can draw information in order to set in motion a work which helps to establish the bases for those guidelines which most of the local Churches are calling for in order to achieve greater uniformity and incisiveness at the level of action and in terms of the message which is conveyed.

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Social Researcher, Italy

Section I
PREVENTION

Life as a Founding Value

One of the greatest Italian poets, Giacomo Leopardi, asks the moon about the meaning of human life in a tender poem that he wrote: "Tell me, moon: what is the value to the shepherd of his life, of your life to him? Tell me, where do my brief wandering and your immortal course lead?" In a dramatic crescendo Leopardi observes that after so much suffered running man has before him a "horrid, immense abyss – where everything falls into complete oblivion". And that "man is born with difficulty, his birth runs the risk of death; trial, pain and torment to begin with; and in his very beginning, his mother and parent consoles herself at being created". The conclusion is without hope: "perhaps in that form, whatever state it may be, in his lair O moon, it is fatal to be born on that day of birth". In another verse the poet refers to himself when he concludes with the statement: "life for me is evil". The contrast with *Evangelium Vitae* of John Paul II could not be more radical. In section 34 the Holy Father writes: "Life is always a good".

Because I have allowed the contrary to be said by a poet, to confirm the positive view of life there come to mind the verses of another poet. Full of amazement – and like Leopardi looking at the sky – this poet wrote psalms 138 and 8: "I praise thee for thou art fearful and wonderful. Wonderful are thy works" (Psalm 138). "When I look at thy heavens, the work of thy fingers, the moon and the stars which thou hast established; what is man that thou art mindful of him, and the son of man that thou dost care for him? Yet thou has made him little less than God and dost crown him with glory and honour. Thou hast given him dominion over the works of thy hands; thou hast put all things under his feet"(Psalm 8).

Who is right and who is wrong? "Why is life a good?" (*Ev. Vit.*, 34). John Paul II answers that the good of life is an "instinctive perception and a fact of experience, and man is called to grasp the profound meaning why this is so" (*Ev. Vit.*, 34). This definitive reason could be expressed by employing the words of St Ireneus: "Living man is the glory of God". The roots of the value of human life are in the Trinitarian heart of God. We can say this with the simple words of Mother Teresa of Calcutta uttered when she was contemplating the beginning of human life: "that still unborn child was created for a great thing: to love and be loved". I know this deep reason but because for almost a quarter of a century I have been called upon to explain it to those who, like Leopardi, do not want to ask God but want to limit themselves to talking to matter (the moon), I will try to relate my experiences as the experiences of one who is compelled for the most part to explain the reasons for life without reference to the Faith. This is a hard task, especially when human life encounters suffering, and it is even harder when – as has been observed in this seminar – suffering and death come forth during the flower of years and often, although not always, are the consequence of a desperate search for joy, for encounter, for meaning, for escape, and for the future, as takes place in the practice of sexuality, that is to say of our humanity, which in the distinction between masculinity and femininity is the image of the inner self of God and a condition of the very meaning of the creation.

Following the exhortation of section 34 of *Evangelium Vitae*, I will seek to demonstrate within a merely human horizon – that is to say of "instinctive perception" and "experience" – that life is a value. Then I will try to go beyond this and to follow the title of this conversation by demonstrating that this value is at the base of every other value and of the essential structures of society itself. Finally, I will ask myself if the horizon which I have termed "merely human" is sufficient or whether, instead, human experience and intuition do not touch upon the threshold of religiosity and the Faith and do not constitute a very human and very rational appeal.

For many years I have transformed myself into a biologist in order to proclaim the value of life: the life of the embryo, of the foetus, of the newly-born child, of the person with a handicap, and of the elderly person has great value because the qualification of being noble which lies in existence depends exclusively upon membership of the human species. This is something which unfailingly requires a scientific demonstration – that is to say that which can be supplied by the disci-

plines of biology and genetics.

For some time, however, my attention has been directed in large measure towards the question of meaning. Present-day experts in bioethics, such as Singer and Engleharth, do not deny the human identity of weak individuals, such as the foetus or handicapped people or the dying, but they judge them as being of less value than a badly trained dog or a computer because of their alleged inability to be useful.

In *Practical Ethics* (pp. 100 and 126) Singer writes that "there are many non-human animals whose rationality, self-awareness, knowledge, ability to see and so forth are superior to those of a week-old or even a year-old human child". For this reason, "it seems that the life of a newly-born child has less value than that of a pig, of a dog, or a chimpanzee". "Whatever the case may be, the principal point is clear: the killing of a newly-born child who has malformations is not morally equivalent to killing a person. And very often it is not in the least wrong".

Faced with such ideas the defence of the weakest individuals cannot be limited merely to demonstrating their human biological identity but must tackle the question of the specific meaning of being human.

The complexity of the argument and the nature of this paper only allow me to outline the subject, which, indeed, deserves far greater analysis.

The first instinctive perception is that if there is a meaning in the whole universe this is to be found in the life of man. According to what we know and we can experience, man – indeed every individual man – is the most complex and perfect part of the entire universe. And there is more: the modern theories of relativity proposed by Einstein and the ideas of Darwin all demonstrate in scientific terms that the entire energy of the universe is directed towards the appearance of man. Indeed, it is known that according to evolutionism life appeared on the earth first in elementary forms which later became more complex: from the single-cell living creatures to the fish, to the reptiles, to the birds, to the mammals, to *homo faber* and on to *homo sapiens*...and all this over very long periods of time. A great amount of time was needed, therefore, to obtain man. But according to the theory of relativity time and space are intrinsically linked. Vast space is needed for vast time. And if a vast amount of time was needed to obtain man, then the whole universe, with its innumerable stars, galaxies, and its extraordinary distances, is directed in the nature of its purpose to man.

Here the second instinctive perception is to be found and located. Every human being before being a son of a man and of a woman is a son of the Immense. Thus his life is marked by something which is incommensurable, extraordinary, and which deserves and requires contemplation and amazement. It must have a wonderful meaning if in order to bring it about a building site of enormous proportions was prepared and all the resources of an unimaginable intelligence were devoted to it. Human life is really a marvel. Such could have been the moon's answer to the poet Leopardi.

The third instinctive perception is that of a gap between man and the rest of the creation, of a mysterious transcendence which places him within an absolute diversity in relation to the matter of which he is composed. It is not only his power over things which is not equalled. What gives rise to amazement is his capacity for thought. In truth, the entire immensity of space and time would be non-existent if man were not capable of thinking about it. As Lombardi Vallauri has written on this point: "human life is that place of mature matter where there mysteriously burst forth awareness, thought, moral experience, expressions of contemplative and creative spirituality, nostalgia and dedication and tragedies in love, all things which make human life the largest part of the entire biological and physical universe which contains it, an effect that can transcend the immense cause in which it has its origins...the ontological majesty of man as living body and spirit renders valueless distinctions of social rank and roles; it makes every individual humanity a cosmic and indeed more than cosmic greatness...".

And thus it is that we come to the fourth instinctive perception. The "big bang", which according to many contemporary scholars gave rise to the universe ten or twenty thousand million years ago, was not the real creative big bang. The beginning of the life of every human being is the real creative act, in the full sense of purpose; it is the real step from non-being to being. Something which previously did not exist suddenly begins to exist and it is something which is extraordinarily different and superior to everything which exists merely to prepare its origins.

This series of instinctive perceptions and demonstrations does not yet tell us if the impress of positivity is to be found in human life, as the psalmist sang in his psalm, or instead whether we encounter the impress of negativity, as expressed in the lament of Leopardi. Does the "horrid immense abyss" which seems to finish that life prevail, or are we faced, rather, with the grandiose immensity of a building site which prepares for life and then gives rise to the real creative big bang in the tenderness of an encounter between a man and a woman who should together express a wish for love, an unusual self-giving, and voice an unheard cry towards the eternal? However the majesty of human life seems to be so great that it cannot be referred to a collective entity whatever that might be – class, race, nation or species – but appears, instead, as the quality of every human being as such and as something which does not allow of gradations: it is always the maximum. This idea is ex-

pressed in very secular modern thought – whether philosophical, legal or political – with the phrase "human dignity". This phrase is found in many constitutions of the second part of this century and especially in the Universal Declaration of Human Rights of 10 December 1948. In the preamble to this document we can read that "the basis of freedom, justice and peace in the world is the recognition of the dignity of every being who belongs to the human family and his equal and inalienable rights". The phrases "human dignity" and "value of human existence" are the same in meaning. For this reason, the link established between dignity and equality should be underlined. The long historical process which led to the rejection, at least at a conceptual level, of the past divisions between men into slaves and freemen, foreigners and citizens, blacks and whites, women and men, reached its point of arrival in the upholding of equal human dignity. This dignity is so great that it does not allow of a distinction between lives which are more valuable and lives which are less valuable, and at the same time if such a discrimination in relation to dignity was allowed this would be a denial of the principle of equality which has been achieved in such a difficult way.

But the word "dignity" is enveloped in mystery. It has a religious connotation. Some people have spoken about the declaration of human rights as a secular prophecy. In this word is to be found the amazement of man in the perception of his grandeur, but there is no demonstration of why this should be. However the history of amazement adds an indirect proof: the painful experience of mankind demonstrates that each time that the equal human dignity of everybody and of each individual is denied, humanity is invaded by anxiety and pain. Because of this historical experience, as a postulate of hope, the charter of 1948 affirms the faith of the peoples of the earth in the rights of man. One should observe the entrance of the word "faith" in a civil juridical act and remember the symbolic meaning of the year 1948: it is in the middle of our formidable century, after the Second World War has recently finished and shortly after the supreme risk of an atomic conflict capable of making the whole of human history fall into the absurd has arisen. A few years previously the German constitutional court, the highest court of the state which had caused the holocaust, had written: "faced with the omnipotence of the totalitarian state which sought dominion in all the areas of social life and for which respect for the life of the individual meant nothing, the constitution has built a system of values which places the individual man at the centre of all its norms. At the basis of this approach is the idea that man, in the order of the creation, has an autonomous and specific value which requires constant unconditional respect for the life of every individual, including the life of those who may seem socially valueless".

In this way the apparently valueless person becomes the parameter of dignity, which in turn is the guarantee of hope. Human thought arrives to this point. And such thought is certainly not without contradictions. The confrontation between utilitarianism and personalism is at its sharpest when judgement concerns the most marginal stages of human life – unborn life and life near to its end. In this area utilitarianism, which values only what is useful and is the decadent son of materialism, seems still to have the better of personalism which instinctively perceives the mystery within and outside man, and which places its bet on such a mystery of existence.

And yet personalism has already won when it manages to place the same question which was formulated by the Pope in *Evangelium Vitae*: "can there be a human individual who is not a person?"(n.58), that is to say a bearer of a ministry which makes him different from every other part of the creation – always a subject and never an object, always an end and never a means, and never to be reduced to thing?

A word should be added about the fundamental character of the value of life.

This affirmation can already be found in the Universal Declaration of Human Rights: human

dignity is the foundation of freedom, of justice and of peace. In the encyclical *Evangelium Vitae*, in a most apt neologism, the value of life is termed "fontal", that is to say a source, a generator of every other value. The demonstration, furthermore, is very detailed. One cannot but cite the "pressing appeal" addressed to "each and every person": "respect, protect, love and serve life, every human life! Only in this direction will you find justice, development, true freedom, peace and happiness!" "Upon the recognition of the right to life", John Paul II writes a little earlier in the encyclical, "every human community and the political community itself are founded" (n.2) The theory of the rights of man (n.18), solidarity (n.18), democracy itself (nn.19, 70, 90), the rule of law (n.20), and the moral sense which knows how to distinguish between good and evil (nn.4, 20) become endangered if the value of every human life is not recognised and respected.

Here it is of course not possible to examine all the aspects of the question. I will make a simple reference to the subject which concerns me particularly because of my profession as a judge, that is to say the whole area of man and the law. The question posed by St. Augustine has always perturbed me a great deal: "what distinguishes the state from a well-organised criminal organisation?" And I have also always been disturbed by another question which from Socrates onwards until the Nuremberg trials of the Nazi war criminals marked the history of human thought: "what distinguishes law from the rule of the strongest?" A secular answer to what Christian thought had

always seen came in the middle of our formidable century from the Universal Declaration of Human Rights: the distinction lies in human dignity, that is to say in the equal value of the life of each person. The reason why we live together in an organised society is because there is a kind of implicit pact according to which we are ready to pay a high price to ensure that our individual lives are defended. The rule of law is required by ethical reasons even when its dictates are mistaken because the legal system as a whole, because it is a guarantee of order, is an instrument "for life". But if, and in the extent to which, law goes against life, it ceases to be law.

There are other aspects through which the value of life displays its fundamental or "fontal" character, and these are aspects to which we should dedicate special attention given the concerns of this seminar. I am referring here to the degradation of sexuality and of the family, something which reduces the capacity to see and respect human life. Yet from the conceptual point of view it is precisely the contemplation of the wonder of human life which can reconstruct the meaning of sexuality and the family. In a materialistic vision of things the search for meaning of life comes close to the banality of pleasure, of which sexual pleasure is a specially intense expression, and to the anxiety of loneliness in an absurd universe where individual self-assertion is the only thing that matters, that is to say the power of the individual. The life of another person is thus seen as a limit which is not be crossed solely when to do so would provoke pain or a diminution of pleasure. When this is possible – as indeed takes place when the life of the other person is especially weak – the other person is even censured or mentally cancelled out. Thus pan-sexualism becomes almost the meaning itself of a life which is banal because it is without greatness and mystery, and the family, which is the structure of gift and victory over transience, becomes an unacceptable bond. Thus to restore meaning to sexuality and the family these two realities must be pervaded to the utmost by the mystery that envelops human life itself. The sexual action cannot be banal if by its very nature it is the way in which the grandiose mystery of the creation comes to be implemented. The family cannot be listed amongst the structures of repression and alienation but rather should begin its existence by promoting the gospel (= good news) of love.

It is clear that this reflection has on more than one occasion touched upon the religious dimension of things. The culture of death and the culture of life confront each other exactly on the religious terrain in the sense that the first sees nothing beyond death (because man, seen only as an especially well organised part of matter and as something which remains matter, is reduced to a thing and as such is destined to finish), while the second (perceiving instinctively that man is "mysteriously high" in relation to matter and that as such cannot have the same destiny as things) hopes, bets, hypothesises, and believes in a human mystery beyond the tomb.

But there is something which reason is not able to understand on its own, and which leads it to fall into natural "amazement" when considering human life: this is suffering, the pain of the innocent.

I have often discussed abortion and euthanasia with other people. Even when I have not introduced God into the argument I have always perceived the objectively victorious superiority of my arguments in defence of the unborn child. But I confess that I have never had the same sensation when I have debated the issue of euthanasia. In the European Parliament I was able to impede the approval of documents in favour of the killing of human beings in pain who were near to death by employing human arguments. I said that the freedom to end life does not exist because without life freedom, too, ceases to be. I demonstrated that nobody accuses a person who impedes the suicide of a healthy young person of violence since the subject of euthanasia is not one which concerns freedom but rather a negative judgement on quality of life which, indeed, distinguishes between lives which are more worthy and less worthy of being lived. I added that the euthanasia argument has an expanding force and can endanger the lives of all suffering people, the least capable, the least useful, the social burdens. But when faced with suffering life, in order to be victorious, needs God. And furthermore it needs Christ. And again: it needs the crucified Christ. And thus it is that I have often thought of what St. Paul wrote, even though I have never given voice to these words during parliamentary debates: "*Nihil aliud inter vos cupivi scire, nisi Christum et hunc crifixum*".

The full value of human life finds its compete truth in the mystery of the measureless Love of God. What makes every human life "mysteriously high" is the origin of love and the destination of love. For this reason, the Holy Father in *Evangelium Vitae* sees in the "eclipse of the sense of God" the loss of "the sense of man" (*Ev. Vit.*, 21). In the end in order to believe in human life you need to believe in Love. "*Credidimus Charitati*".

It seems to me a source of great hope that the second millennium of the Christian era is closing not only with the tragedy of the twentieth century but also with the entrusting to the new millennium by all the peoples of the earth of words which place their hope (for freedom, for justice and for peace) in an unarmed word: human dignity.

I am convinced that for this word the dominant word of modernity – to think and to act "*etsi Deus non esset*", as if God did not exist – will sooner or later be abandoned. "If God does not exist, everything is possible". Even the idea that human life has no meaning. But then it would simply become impossible to live. For this reason I believe I can conclude with the observation that the value of human life during the third millennium will no longer be a wall or a dividing ditch but a bridge and a territory of reconciliation between the resources of reason and the resources of the Faith.

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Education in Values?

In technical civilisation, which today permeates the thought and wishes of man, it is not easy to speak about education. In this civilisation people are trained to produce objects of every kind and for everyone, and thus man is encouraged to forget about his own being and that of others. Blocked in this way in this "produttura" (production) – if one could use a neologism in Italian which is neither linguistically nor phonetically elegant – which is quite wrongly today called "culture", the perception of man becomes debilitated to such an extent that he comes to mistake the surrogates of the real, things which are the productively dreamed objects of his own *cogito*, for what is actually real.

In the world of surrogates, which function as though they were reality itself, man is not so much educated as drilled to know how to function in order to make him able to survive in an increasingly comfortable and pleasant way. The education of man gives way to the training of the functionary who is efficient and effective from the point of view of doing something. The utility of the function, which is itself produced by man, takes the place within man of the very meaning of life. He does not change himself but changes, rather, his functions and those of other people.

Modern Sophists, who follow after their predecessors the Athenian Sophists, realise that the *cogitor ergo sum* is translated into *fungor ergo vivere possum* and sell to their fellow citizens various forms of knowledge connected with producing things which help them not only to survive but also to dominate each other. Indeed, the working of the surrogates of the real immerses society in the "slave-master" dialectic. In the final analysis rather than having before us society we encounter the need to address ourselves to those collectivities which are composed of the functionaries of the economy, of politics, of sex, of marriage, of the family, of sciences, of philanthropy and so forth. The former produce "bread" which is used for their greater or lesser pleasurable survival, whilst the latter produce "entertainments" (Pascal) which work towards forgetting the real. In surviving in a comfortable way in forgetting the real, they free themselves from the moral obligation to live in a decent way.

The *cogito-fungor* of both categories, in drawing them away from being, leads them to that surrogate for wished-for salvation which is one or another form of *u-topian* Function, that is to say a function erected into an ideal. For the *cogitor-fungor* it is of no importance whether the ideal is real or not – it is sufficient for it to function as though it were. The *cogit-fungor* does not even think about the devastating consequences of its own actions which, deprived of the wish to know the truth and to love good, leads man to *u-topian* non-being and, as a result, to a non-suitability to living with this flower, with this wood, and with this man. The otherness of every being frightens him and disturbs him.

The functionaries of the utopias, by way of example, mention only the Communist utopia or the utopia of prosperity, and condemn everybody to compelled behaviour which is education *à rebours*. They treat man as though he were a computer to be programmed. Computers function better than men do in terms of the efficiency and the speed of their operations, but so far nobody has spoken about the education of these machines. Indeed, the brainwashing which precedes the "programming" of men provokes in men mental disturbance and insanity.

Not even the Church is immune to the risk of Sophistic education. This education fragments the unity of the spiritual life of believers and corrupts their faith because many of them, rather than struggling for the salvific meaning of life, dress themselves up as functionaries and fight for those things which allow them to feel at ease in the world of functions. For salvific faith they substitute today tomorrow's set of elements which place them at the mercy of the *cogitor-fungor*. People who are thus educated in a Sophistic way enter into dialogue with no one at all. Indeed, objects do not engage in dialogue – they struggle to have a higher price.

The spiritual life of man is carried out and realised in dialogue. In engaging in dialogue he unites with the sacred identity of the other which is sacred because it does not depend upon any man. The identity of every being is a gift which is continually made by the creative thought of God. The gift is to be worshipped. In worshipping "in spirit and truth" (cf Jn 4:23-24) man worships the origin of every gift, that it to say God. He worships it when in the light of God he contemplates a mountain, a flower, a lake, but he worships it above all else when he contemplates another man who, in turn, in giving of himself also enters into dialogue with him and in contemplating him worships God.

The person who worships his own *cogita* is compelled to construct so-called consensus. Otherwise his worship loses its sig-

nificance. The functionary who does not manage to construct consensus does not function, and this is something which for him means that he does not live. In the final analysis the "spiritual" life of functionaries, which lies specifically in the construction of consensus, is only a struggle to reach ever higher functions because it is these functions which decrease or increase the value-price of life. Never be pushed to one side, indeed never be overtaken by others! This is the basis and the ideal of the morality and the education of functionaries, and such morality and education, in essential terms, can be reduced to a low quality form of politics.

For those functionaries who no longer feel important in the world they live in, freedom, which is revealed in the selfless union of man with good – something which does not work to increase their having and their power – is a source of scandal. They ridicule it and marginalise it and depict those who aspire to such freedom as anachronistic. For functionaries, the person who loves useless things which do not increase having and power are touched by madness because they impede technical progress. Directed towards realities which are found beyond such progress, that person is concerned with the direction of progress itself and in this way disturbs the peace of the functionaries who bring it about. For functionaries, such a person is irritating because in not concealing the fact that he has obligations because of, and towards, invisible realities, he forces them to think. Socrates was killed by men who were "very talented in educating both the young and old, men and women, and turning them into what they wanted".[1] For this thinker, however, freedom involved choosing not what one wanted but what one should want. Today, when so many forces act together against man in order to force him to accept his own condition as a "useful slave" and to produce visible things from the beginning to the end of his life, the words of Socrates still have a prophetic ring: "it should be recognised that in a political constitution along contemporary lines the person who saves himself and becomes what he should be, if you say that he is saved by a divine favour you can be certain that you are not telling a lie".[2]

The situation becomes even more dangerous when the mere exteriority of the state, which is made up of administrative functions, in a totalitarian way strives to make the citizens administrable. The exteriority of the state cannot tolerate the "person being" of men because ecstasy – that is to say the person – transcends all functions and their ability to be administered. The functionaries who are chained to the exteriority of administration devastate within this being of man the ecstatic love of truth and good which are greater than utility and effectiveness and close the door in the face of freedom. Lost in time and detached from each other because there is no element which can unite them, freedom becomes reduced to so-called free choices, that is to say to reactions to contemporary and visible forms of stimulus.

The functionaries of the visible are not directed towards the invisible Transcendence from which the freedom of man takes its origins and thus do not know how to govern free men. In not understanding their being love for things which are greater than the visible world, they fall into an inability to engage in communion with other people. They are with others only when they need them for something. When the product has been manufactured they separate from others. In their world betrayal and loyalty are unknown categories. Indeed, loyalty and betrayal take place only in a world built in a knowledge and love of being, and never in the world of functions. Indeed, only the man who knows and loves the being of other people and identifies with it to the point of becoming it really knows what it means to betray or to be loyal.

In the Church the mentality of functionaries corrupts love and thus corrupts the work of evangelisation. This is a corruption of love, of knowledge, and of work. This corruption is expressed by Christians and their pastors in being actively concerned with many things and in neglecting this "single thing" without which all other things pass and disappear into nothing. When amongst Christians and their pastors there is no shining forth of the Word which "leads out" men from the darkness and from the non-understanding of their immanence and leads them to freedom-love which renders them understanding and saved, the Church gives the impression of being an association established to carry out some or other kind of social activity. Vocations are obstructed or stopped because young people perceive a contradiction between evangelisation and the administration of functionaries. The mechanism of the pure exteriority of administration sooner or later is substituted by the computer. However, the fact remains that man does not feel called to become a computer.

The pastor leads out and guides his flock. He is an educator. And this is a difficult undertaking. What, then, is education?

In etymological terms the word "education" refers to a particular action – that of leading out ("*edurre*") a man from a state of ignorance in order to lead him to a state in which he encounters new evidence. The educator awakes. The person who is awakened, who is so to speak "led out" of sleep, enters into the real world where he sees how things really are. In this state he feels free from the things which are dreamed and to which he surrendered his reason and his will, immersed as they were in sleep.

A man is educated in proportion to the extent to which he allows the truth of beings to defend him from the chaos of the unreal world. The real world resists the feelings and calculations of man. It wants him to adapt himself to other people, and this is something which means the abandonment of the comforts he previously enjoyed in his dream world. The truth of beings calls man to convert himself to them, and this is something which is the very essence of education. Indeed, the person who converts himself is led out of dreaming opinions and led to live together with others. This is a paschal journey which is never easy.

The liberation of man which takes place in conversion begins in his becoming a question: “where do I come from and where am I going?”. This question, which seeks the Invisible whose imperative presence in all the realities of life means that every ending is nothing but a beginning, frees man from the visible things, which, indeed, are transient. The man who is led out and guided by this question to the Other touches upon the meaning of life.

In the question “where do I come from and where am I going?”, which is brought about by the experience of time which man is from his birth to his death, to a certain extent there is expressed the Memory of the Other which is eternity. In this question there vibrates the hope that the end of life does not deny its beginning but confirms it and gives it significance and meaning. The question “where do I come from and where am I going?” is the beginning of education in the deepest sense of the term. The educator is a person who helps man to become this question. In order to do this he himself must know how to unite the beginning and the end of life in asking with his whole being: “where do I come from and where am I going?”. The person who knows how to unite them knows how to live because only he knows how to die and to be born again. He dies and is born again asking the question: “where do I come from and where am I going?” He dies and is born again looking for “one thing only”, which is something he does not have (cf Mk 10:21). He searches, that is to say, for that Other who is the beginning, from which he comes, and the End, to which the “new pilgrim of love...directs his face”.[3] Any other form of education stops man in things which are detached from the unity of the end and the beginning of life because of the non-presence of the question: “where do I come from and where am I going?”, and which reflect only his being closed up within the human. In seeing himself in others and things as though they were mirrors, man sees only this or that *hic et nunc* to which he is reduced and whose last word is pleasure. Tautologies, and not only homosexual tautologies, never have an educational character. They do not “lead out” man from himself.

The education of man begins with his body. It is his body which is the first reality to point out to man the exit door from himself. In the presence of a person who is sexually different man begins to see the direction in which he must direct his ecstatic being in search of the Beginning and the End. Life lived beyond sexual difference by-passes the question: “where do I come from and where am I going?” and means that man behaves in a mistaken way. He is “badly led out”, that is to say badly educated.

Sexual difference “leads out” the person from himself and leads him to another person. It frees both of them from the loneliness within which neither of them manages to understand themselves. Indeed, the man-male cannot understand his being without the light of the man-female, and the converse is also true. The truth of the being of each of them is revealed only when they reveal themselves to each other. Where sexual difference is forgotten the education of man has already failed. It has failed because of the impossibility of walking towards the truth and the good of man. I would venture to say that in not accepting this difference man closes the path which leads him to understand the Otherness of God even at the very point of asking: “where do I come from and where am I going?”

In other words, man, in proportion to how he neglects or forgets sexual difference does not direct himself towards the meaning of life, a meaning whose otherness begins to shine forth in the otherness of the other person. If the otherness of the meaning of life begins to express itself in sexual difference this meaning obliges man not to halt in that difference which is something which only opens up the path. The meaning itself, shining forth in the visible, remains invisible and calls us to go further. It is the Invisible which obliges man in the deepest sense of the word, not the visible. Thus it is the Invisible and not the visible which educates man.

We can, I think, leave to one side the explanations as to why the world made up of functions does not know loyalty or betrayal. Only the Invisible, which does not identify with any function, requires man, and calls on man, to engage in unconditional loyalty. And precisely in calling him to this it “leads him out”, it educates him. However, man cannot be loyal to the Invisible only because It shines forth in the visible. For this reason, the loyalty of man to the Invisible is fulfilled in loyalty to the visible in which the Invisible reveals itself to him and gives itself to him, and this because the man who abandons the visible betrays both. To love the Invisible as though one abandoned the visible and love the visible as though one abandoned the Invisible – here is the secret! Christ revealed this secret and only he amongst men knew how to realise it in a divinely perfect way.

At the same time, loyalty to the Invisible, brought about through loyalty to the visible, requires that man abandons the visible itself and increasingly moves upwards. Otherwise he will never be able to be loyal to the Invisible. Lacking loyalty to the Invisible, his loyalty to the visible has already failed because he does not seek to save it.

Loyalty and betrayal refer, of course evidently enough in different ways, to the meaning of the life of man. As a consequence, the man who is loyal to the Invisible which shines forth in the visible is loyal to himself. When he betrays this dual totality, he betrays his own being which is directed towards it.

The meaning of life, which is in some way present in the question "where do I come from and where am I going?" is expressed as the unity of the Beginning and the End. Man comes from the Beginning and goes towards the End in which he hopes to be able to find it again. Does this mean that he loses it? And if so, when? The answer to this question can only be the following: *in illo tempore*. For this reason, he lives this Beginning in the same way as he continues to lose it in every *hic et nunc*. In the light of what happens *in illo tempore* he understands the things which pass and how he should behave in order to do justice to them. His education should be directed towards what happens *in illo tempore* and from which comes the truth of everything that exists *hic et nunc*. Only the man directed towards the realities which constantly take place and never pass away knows how to behave in every situation. He is prepared for new things and nothing takes him by surprise or in a condition where he is unprepared.

This was how Abraham and his son Isaac were educated in the area of the mountain in the country of Moria. Both of them search for the meaning of life which is provided by God (cf Gen 22:7-8). The father searches for it in the otherness of the son and the son in the otherness of the father. They entrust themselves to the truth that they believe has a divine origin and hope that they will not be disappointed by it. For Abraham this truth shines forth in Isaac; for Isaac it shines forth in Abraham. One *auget*, enriches, the trust of the other, placing in him his own trust. Each for the other becomes *auctoritas*, that is to say a reality in which the "lost" Invisible shines forth and is wished and searched for by both together. Uniting themselves to each other they place themselves on the road of return. From where? From "exile". They go up, reaching the summit... In the entrusting of man to man the question "where do I come from and where am I going?" does not cease to be a question but grows deeper, one could say, in the direction of the Invisible. It becomes increasingly directed to what, although it takes place in the time which passes, it is not identified with. The man who is trusted is trustworthy. In not allowing himself to be devoured by the *saeculum* which, as Tacitus declared, *corrumpit et corrumpitur*, he does not allow himself to be corrupted and does not corrupt other people. Only the person who is not corrupted by the things which pass, only the person who is not that is to say secularised, is able to educate others. The transparency of his visible being allows them to perceive the Invisible from which like a sun everything and everybody is illuminated. This is exactly what being educated really means.

Man educates another man in relation to the extent that he reveals himself. The educator gives himself to the person who is being educated. In other words, the educator dies of his own accord. He dies in his own entrusting of himself to the other person. For this reason he is born again in him because the other person in his turn entrusts himself to him. Both of them, in educating each other, are educated. The uneducated do not rise again because they do not know how to die.

The uneducated fall into loneliness in which the non-education of man in relation to the reciprocity of giving and receiving expresses itself in surrender to the dialectic of "slave-master" where the "master" teaches the "slave" and the "slave" teaches the "master" according to their respective needs. Loneliness always has a polemical character which at times is even aggressive. Usefulness and comfort, indeed, lead the "slave" and the "master" far away from the Invisible which is "lost" *in illo tempore*, thereby giving them up as prey to things of any price.

The person who halts in useful and comfortable things to the point of identifying with them will always be secondary, in the same way that the instruments which serve to some end are always secondary. He will always be saleable and buyable. His price will increase or diminish in line with the rules and workings of the market.

The person who comes first is only that person who allows himself to be *led out* from himself and guided towards the invisible Other. The first are Abraham, Isaac and Jacob because in yearning for He who only *is* they have no price. They are not saleable and they are not buyable. They can only offer themselves. Each one of them is dignity and represents an ideal in itself. Each one of them lives in the world of visible things but does not belong to that world. They measure themselves in relation to the Otherness of the Divine which they wish for and which they search for. They measure themselves not in relation to their time but in terms of the the eternity that He is. The understanding of Abraham, Isaac and Jacob comes from the fire with which they burn and which enables them to present themselves with the words: "I am". In coming *from* and going *to* the Reality which takes place *in illo tempore*, the time of their earthly existence is lived out by them as a time of becoming and not as a time of corruption.

Dignity requires the heroism of *agere*, that is to say the heroism of knowing truth and loving good. Dignity is not something to be purchased. It *fit*. It takes place in dying of one's own accord and rising again in the loved and known person. The person who does not decide to think and exist in a heroic way is someone who is unable to say to another person: "I am you and you are me", and he will never be dignity. In his inability to engage in heroism he expresses his non-education. Only he who says to the other person "I am you and you are me" behaves in a worthy way. He is the dignity which educates the other person, calling him to be dignity as well, that is to say to reply: "I, too, am you".

The non-education of man is expressed in his inability to say: "I am you and you are me" in marriage, in the family, and in friendship. It expresses itself in his inability to engage in ponti-fical mediation between men and God, and in an especially painful way in the mediation of priesthood in the strictest sense of the term. Tragedies in marriages, in families, in friendships and the Church herself arise from the fact that many marriage part-

ners, many friends, and many priests are more "mere workers" (*homines fabri*) than "pontiffs". They do not build bridges which unite men and unite men with the Other. In other words, those who are not suitable to heroism do not convert themselves to others. As a result, they do not perceive the meaning and the greatness of life. This is the real tragedy itself of the non-education of man. The man who does not think and exist in a heroic way does not have before him that Future which is greater than time. And in not knowing where to go *in saeculo* he becomes easily corrupted. Secularised man does everything on his own because in not being led out from himself he does not reach others. Closed up in his own private world he becomes, as the Greeks would have said, "*idiotes*". The "idiot" does not unite himself with others, he does not even look for them, and it is precisely for this reason that he is an "idiot". In reducing everything and everybody, including himself, to an object with some price or other, he breaks the organic unity of love, of knowledge and of work. He transforms them into techniques by which to do and make things. He makes love but does not love because he does not reach the other person; he acquires knowledge but he does not know because he does not reach the other person; and he engages in work but he does not work because in not reaching the other person he merely produces objects to be sold in which he does not offer himself to others. His love, his knowledge and his work fall sick.

They lose their educating force because in the technical activity of loving, knowing and working the truth about man is not revealed, that truth which makes man free. Indeed, the truth about man is never given to "idiots" because "idiots" do not give themselves to each other.

The light of the Invisible, the Memory of which (*anamnesis*) the educator awakens within the innermost self of man, illuminates everything and everybody around it. It is precisely this light which frees man from "idiocy" and leads him to the wisdom of love, knowledge and work. One force alone is the educator of man – the Invisible. "Do not have yourselves be called masters because one alone is your master, and you are all brothers" (Mt 23:8).

The educator educates to the extent that he opens himself and invites the other to enter and live therein with him. "Master, where are you staying?" Andrew and Peter asked Christ. "Come and see" He answered them. "They came and saw where he was staying and they stayed with him that day" (Jn 1:38-39). The person who has nothing to reveal, indeed has many things to hide, will never be an educator. The home should be revealed; the hovel should be concealed.

It is only at home that man feels the "you" directed towards him by the person who has invited him to enter. This "you" awakens him because he enters a real world made up of his "I am" and the situation which he is given to exist and live in. In the real world, which is different from the dreamed world of his *cogito*, the "I am" of man is before him like a primordial gift and at the same time as a primordial task. The "I am" does not arise from the *cogito* of anybody and as a result is not to be identified with any *cogitatum*. It shines forth in man and evokes him. It is as though his "I am" were not his own property even though in reality it is his. In remembering it man enters into the work that the Other carries out *in illo tempore*. As a result, in ascending to his "I am" man transcends time. He does not allow himself to be secularised. He resists.

Man ascends to his "I am" by entrusting himself to the person who calls him with "you". In order to then become himself, that is to say "I am", it is necessary for him to die of his own accord. Only in this way can man rise again as "I am". Every person is the "I am" of the other. But this is not true of "idiots" because they do not reach such a stage of experience. Indeed, in being secularised, "idiots" allow themselves to be corrupted by time.

"I am" has a divine sound. It burns with the "I am He who is". To his "I am" man ascends in ascending to "I am He who is". He abandons himself in order to be really himself. It is precisely for this reason that man is sacred, in the same way as the burning bush is sacred. Faced with his own "I am" he feels called to "take the sandals off his feet" (Gen 3:5). The Light which is the "I am He who is", in illuminating him, frees him from "idiocy" and leads him to that freedom which takes only one form, namely divine freedom. It is not easy to be educated, which means to be free, because it is not easy to become similar to God.

The home in which each person is "I am" is based upon the relationship between the father and the son. Abraham and Isaac build this home on the slope of the mountain of the area of Moria. The father who runs to the prodigal son and the prodigal son who returns to the father build this home. The friends who are "journeying" towards some Emmaus or another (cf Lk 24:13) build it. All those who search for the truth and good entrusted to their knowledge, their love and their work all build this home. In the relationship between father and son there reawakens in men that self-awareness in which they remember that Other which the Gospel tells them to call "Father". In and thanks to this relationship men discover and "remember" that they are loved and known "before the creation of the world" (cf Eph 1:4). "And call no man your father on earth, for you have one Father, who is in heaven. Neither be called masters, for you have one master, the Christ"(Mt 23:9-10).

If things are of this character, education takes place in the *adaequatio filii cum Patre, per-*

sonae cum Persona, and it is in this *adaequatio* that there is revealed the truth pointed out by, and aimed for in, the question which man becomes, that is to say: "where do I come from and where am I going?". In other words, it is the question about the meaning of life which begins the spiritual generation of man.

When the uncontrolled activism of "idiots" destroys man, and as a result society and nature as well, the Sophist-physicians sell various remedies, which they call values, in order to salve the painful parts of man and nature. If they are theologians they speak about God as though He were one of these values – the greatest of them all it would appear.

I do not oppose values – quite the contrary! I am opposed only to the Sophists who make them objects to be sold. The Sophists killed Socrates because his questions about values (what is justice, what is peace? etc.) which they said they knew and practised, had placed them in difficulty.

The home in which we dwell is without doubt built upon various values. We will find there life, economic, political, aesthetic and moral values. Some of them we possess; others, on the other hand, call upon us to become them rather than to possess them. Those values which are possessed serve for our survival and for our comfort; without the others, however, we could not be dignity. The difference between values which are to be possessed, and values to be, emerges from the world in which we know them and realise them.

Things appear to man as values to be possessed and he sees their calculable utility in relation to what he can have and do. His reason (*ratio*, from *reor*, *ratum*, to calculate) calculates their value, or rather to put it more precisely their price, and his reason "knows" its own calculation, that is to say its own construction. This is without taking into account that beings are true, good and beautiful (*ens, bonum, verum et pulchrum convertuntur*).[4]

The values which man should become do not depend upon man. They offer themselves to him, touching and moving the whole of his being so that he identifies himself with them without becoming their master. These values are the objects of the compassion of man. Com-passion makes him a "neighbour" of the being that has touched and moved him in this way. The Good Samaritan passed opposite a man who had been attacked by evil: "he saw him and felt compassion for him" (Lk 10:33). There can be no doubt that the man attacked by evil was in himself a good, a truth, but for the priest and for the Levite he represented no value at all. They were probably concerned and moved by other goods which took primary place in the calculations of their reason.

It is no accident that immediately after narrating the parable of the Good Samaritan St. Luke refers to the visit made by Christ to Martha and Mary. Mary "sat at the Lord's feet and listened to his teaching. But Martha was distracted with much serving; and she went to him and said, 'Lord, do you not care that my sister has left me alone? Tell her then to help me'. But the Lord answered her, 'Martha, Martha, you are anxious and troubled about many things; one thing is needful. Mary has chosen the good portion, which shall not be taken away from her.'"(Lk 10:39-42).

To perceive that the being is "true" (*verum*) and "good" (*bonum*) still does not mean to live it as a value so as to become it. This being lights up in man from such a value when he allows himself to be touched by truth, by good, by the beautiful of the being that calls him to defend such things, if they are threatened, or to realise them if they are not carried out. The person who answers "no!" to this call commits an injustice, destroys peace, and the person who says "yes! effects justice, creates peace...Com-passion does not allow him to treat the being who calls him as an object which is useful in relation to what he does and to what he possesses. Compassion requires him to treat this being as a subject which can give himself (the person) or, *mutatis mutandis*, which has already been given to him (the thing). Between the man and the being which calls him to defend him or to help him, the value emerges as a reality which is still to be realised in knowledge and love in the profound meaning of these terms. In uniting himself to this value man unites himself with the being himself. After carrying out such a *con-summatum est* he can do anything that he wants. His *facere* will be transfigured by *agere* (to know and to love). And in his free choices he will express the freedom of love and the love of freedom.

These values, therefore, depend both upon the beings themselves which are "good" and "true", that is to say loved and known "before the creation of the world", and on man who in his compassion feels called to re-love them and to re-know them. In re-loving them and re-knowing them, that is to say by thinking and knowing in the metaphysical dimension, man grows together with such beings. Indeed, he ascends beyond the "good" and "truth" of the being because he ascends to their Beginning and their End, that is to say to God. God is He who in addressing himself to man with "you" through the "truth", the "good" and the "beautiful" of every being, leads man to Himself, that is to say to Holiness.

If education is not towards holiness it is reduced to teaching man to do this or that, whose value depends on the one side on the situations in hand, and on the other on the wish or the capacity to calculate. Education is connected, as has already been pointed out, with the home. Education which is not directed towards the holiness of man, the holiness which transcends all values, throws man into hovels.

All values, even those of having, disappear the moment man ceases to carry them out. They exist until man realises them, calculating them (values of having) or having com-passion for the other person (values of being). In both cases man identifies with what is valuable for him. In identifying with the values of having he becomes today the tomorrow of the calculated object, something which some people call "self-creation". This, in fact, is none other than a maltreatment of man, a maltreatment made possible by his forgetting about

himself. In carrying out the values of being, on the other hand, man exists as a sovereign subject, that is to say he is possessed by nothing and by nobody. Indeed, who can become the master of the man in whom there takes place the event of love, of faith, of hope, the event of truth, justice, peace and of many other values which cannot be grasped by possessive hands?

The subject being, realising in his actions the values whose validity derives from the holiness to which man is directed, will never be something which is purchased once and for ever. Man becomes a subject by working continually. It is in his work that he is led out "of the dust of the earth" (cf Gen 2:7) and guided to the Freedom of God the creator who *semper laborat* (cf Jn 5:17).

The subject being of man derives, on the one hand, from his constant filial work, and on the other hand from the constant work of the Father. The Father always generates and creates. When He says to man "you are my son, today I created you" he gives him Himself, and thus God makes a gift and does this in a divine way. He does not keep anything back. Not even Himself. The Father is absolutely poor. He alone is the Father, that is to say Love: "I am He who is" (Ex 3:14). "God is love, and he who abides in love abides in God, and God abides in him" (1 Jn 4:16). This is the truth of the divine Subject being and of the human subject being who becomes Him. To the paternal poverty of God, man must reply with the filial poverty which he has still to achieve.

All this means that the values of being, whose realisation is decided upon by man, reach him as gifts. Only on his decision to receive them diligently or otherwise depends whether he will exist as a subject or as an object. His ability to receive them diminishes when man worships his reason and his will and as a result when he reduces his freedom to so-called free choices. Free choices which do not emanate from freedom shipwreck man in the chaos in which he, in the best of cases, searches for salvation in *moralism* or in *aestheticism*, that is to say in the possession of moral values or values which are purely aesthetic in character.

Idiots can increases their possessions, including their moral (the possession of virtues) and aesthetic ones, but they cannot increase their being. In order for man to grow he himself should know how to reach the other. Despite the appearances, *idiots* – who do not reach *as far as*, and do not unite themselves *with* the other – do not know the real and do not really work. This is because they only love their own constructions. To be a holder of the Nobel prize does not mean to say that such a person is not an *idiot* – an *idiot* is somebody who does not reach the real different of his *cogito*.

The being of man grows only when he grows together with another being; he grows together with him con-templating his identity. The identity of every being represents a *templum*, a temple, and a temple is no longer a temple for the person who does everything he can to gain possession of it. Possession is divisible because what is possessed is itself divisible. The divided *templum* is no longer a temple. If the *verum, bonum, pulchrum* were each divided, the Other to which they refer would also be divided. Our knowledge of truth and our love for good, that is to say our person being, would also be divided. To be divided means to be calculable. But neither man nor God is calculable.

In not ascending, therefore, beyond having, or even beyond the possession of virtues, in not building that is to say his home with that Other who is absolutely poor and whom we call Father, man does not *contemplatur*, i.e. he himself does not become a *templum*. It is precisely this that I am talking about when I speak about growing in the growing together of the being of man. In not con-templating, in not, that is to say, becoming a *templum*, man himself should not be con-templated. He does not say to the other and the other does not say to him: I am you and you are me. He walks along gropingly, wasting his "inherited goods" (*verum, bonum, pulchrum*) in the same way as they are wasted by the prodigal son in the "far away country" through forgetting about his own being and that of his father, his brother, and the other inhabitants.[5]

Contemplation is absent and knowledge, love and work decay. Activism, even moral activism, corrupts man because it secularises him. Maria, seated at the feet of Christ, "chose the best portion, which will not be taken away from her", and that portion was: to say with all oneself to the other – I am you and you are me.

When the identity of man is forgotten about, man has no dwelling place. Home is a dwelling in which everything is oriented towards the "centre", from which the identity of what is found in the boundaries set out by this centre springs. Man bows in worship in front of the "centre". If the "centre" is not God but something else which apes him, worship degenerates into an idolatrous prostration along the lines of what happened with the "golden calf", whose possession depends upon reason and will. We should not, therefore, be amazed if those who worship the "golden calf" worship the so-called free choices of their own reason and their own will. In the men who are prostrated in front of such choices the values of being are no longer ignited. The prostrated people see only the ground, indeed they see only that piece of ground which is near their hands and under their feet. They calculate it in the spontaneity with which their free choices "respond" to the determined stimuli of situations. They are not able to go further, to the holiness of freedom which when it is not divine is not freedom. The idolatry of free choices represents the highest possible level

of non-education, that is to say of allowing oneself to be blocked by one thing or another. Idolatry is the beginning of the destruction of the home, that is to say the beginning of the destruction of the filial being of man and the beginning of the negation of the paternal being of God.

In a society which is prostrated in this way the "honest" person is he who knows how to achieve social balances out of individual interests which are treated in an idolatrous way. The person, instead, who has not thrown *honestas* amongst used objects, who in classical philosophy speaks about the union of man with truth and good which transcend usefulness and pleasure, is listed as being one of the mad.

The man who in the deepest sense of the term is "non-educated", that is to say who is dominated by doing and having, believes that he can be the "Lost One". At times he thinks he can do this with the help of ethics which are mixed up with science in which moral virtues are the instruments by which to construct and have the "celestial kingdom".

The young rich man asked Christ the question: what do I have to do to gain the kingdom of heaven? The answer given by Christ is suitable to this ethical question – "observe the commandments". The young man went on: I have obeyed them ever since I was a child. Then Christ looked at him with love and said: "only one thing you do not have: go and sell everything that you have and give it to the poor...and follow me"(Mk 10:17-21).

The man who is made uneducatable by possession does not receive with all of himself the call of Christ to exit from having, and even from having virtues. He does not understand that only men who are free from having manage to reach being and are joined by *verum, bonum, pulchrum*.

One ascends to being. At the summit of being, to which Abraham and Isaac climbed together, there is no longer having to which to connect oneself. Up there man can only decide to carry out a decisive step in favour of his liberation. Up there in front of man there is only the abyss of the Invisible in which to throw oneself like a question-challenge shaped only by hope: "where do I come from and where am I going? Please tell me!". Up there on the summit Abraham and Isaac, illuminated by the Invisible, carry out such a great act of trust in the Holiness of Divine Freedom that from that moment onwards, although they exist on the earth, they no longer belong to it. They love the earth and they abandon it.[6] They live as though they were flying. Up there, on the summit, the man who does not open his wings and does not throw himself into the abyss in the hope of being able to fly beyond himself in the Freedom of the invisible Other, collapses spiritually and hands himself over to the dreams of the functionaries.

The young rich man was too rich to be able to fly. "At that saying his countenance fell, and he went away sorrowful; for he had great possessions" (Mk 10:22). Having many virtues, he thought that as a result he could also have the kingdom of heaven. He was not able to sell everything and take that decisive step. Virtues can close man up in ethical *idiocy* and deform his spiritual life so that the man with wings, given to him to fly, as C.K.Norwid would say, ends up by sweeping the streets. "Blessed are the poor because the kingdom of heaven is theirs" (Mt 5:3). "Be perfect as your Father in heaven is perfect" (Mt 5:48).

In those axiologies which are detached from the metaphysics of the father-son relationship, values go mad and man, in trying to live them, becomes insane. Values which have gone mad do not help him to fly. They contradict themselves. Stopped in the present they cease to be an event of holiness. As a result, they are easily used in political struggles. What do the words "peace", "brotherhood", "love" and "hope" really say in the mouths of politicians and the crowds which are manipulated by them? The "kingdom of heaven", seen as an ideal object to make and to possess, is transformed into *u-topia*, to which the education of man is directed. Educated to *u-topia* man falls ill because of an unreal ascension. He is absent and is thus treated as such. The rich are absent. Their absence makes them clumsy. They forgive everything, even though they gain the "whole world" (Mk 8:6).

If the things of man are of this character, the only "textbook" for education to divine poverty of the "I am" is the speech made by Christ on the mountain (cf Mt 5 and 6). It is there that the Memory of man relights the question: "where do I come from and where am I going?". His wings spread out and explain themselves in the wish to fly beyond every having, in the Divine Poverty of Love "which moves the sun and the other stars".[7]

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Notes

[1] PLATO, *The Republic*, VI, 492b.

[2] *Ibidem*, 492e and 493a.

[3] DANTE ALIGHIERI, *La Divina Commedia. Purgatorio*, VIII, 1 and 4.

[4] I am referring here to the so-called transcendentals of classical metaphysics, namely: *ens, verum bonum et pulchrum convertuntur*.

[5] Obedience understood as this ascending in the contemplation of other people and in the worship of God does not alienate man because to obey another man by contemplating him and in the final analysis to obey God by worshipping Him, means to follow the truth of his own identity, whose realisation in God is reflected in the sacred identity of other people. With the alienation of man, instead, we are face to face with man obeying functions, by "con-templating them", and obeying functionaries, by "worshipping them".

[6] In the context of this throwing of oneself into the abyss of the Holiness of the Freedom of God I would like to cite the words of Christ: "He who loves father or mother more than me is not worthy of me; as he who loves son or daughter more than me is not worthy of me; and he who does not take up his cross and follow me is not worthy of me. He who finds his life will lose it, and he who loses his life for my sake will find it."(Mt 10:37-9). That love which does not abandon the loved one so that its bearer can climb to the summit devastates not only the loved one, halting him by himself far from the mountain (cf Gen 22:4) but also the person who loves. This, then, is not love. If Abraham had not abandoned his son Isaac, both men would have remained at the foot of the mountain together with their slaves, as their "masters" and at the same time as "slaves".

[7] DANTE ALGHIERI, *La Divina Commedia. Paradiso*, XXXIII, 145.

ROUND TABLE

“The Places of Education in Values”

I: The Family

Introduction:
The Link between the Epidemic of AIDS-HIV and the Crisis of the Family

In the years immediately after the discovery of this illness little attention was paid to the role of the family in the struggle against AIDS. Attention was paid above all else to the medical and epidemiological aspects of the illness and thus to its prevention in narrowly technical terms. Today this can no longer be the case. The alarm has been given by social workers and those who look after these sick people outside hospitals, that is to say by those who are the first to be in contact with the human reality of AIDS. In the front line we find the international humanitarian organisations, such as the World Health Organisation, which are drawing the attention of people to this polymorphous link between AIDS and the family, something which does not fit into the usual rules and schemata but which is increasingly central to the problem of this illness and its repercussions.

This is the case at four different levels:

1) there is first and foremost a relationship of cause and effect between the degradation of family structures and values and the appearance and spread of AIDS.

2) There is in addition the serious problem which AIDS raises for the family – it destroys families and family bonds, corrodes solidarity and the family spirit, brings about the death of parents, and makes children into orphans.

3) The family is the best place to take care of the person afflicted with AIDS, to help and accompany him day after day, and to help him in his journey towards death.

4) Lastly, the family should be the strong point in the struggle against AIDS, the place where the counter-attack should commence, and this in line with its ability to become once again an entity with an educational role and the place where it communicates its values to its children and opens them up to true love.

This paper will confine itself to this last point – that of the values of the family which enable it to prevent children from being contaminated by AIDS. These are the values which must be cared for, supported and promoted within the framework of the struggle against HIV-AIDS.

1. Infection by HIV: a Sign of the Crisis of Human Values

Despite the evident diversity to be encountered in the contexts and epidemiology of AIDS, the same observation is valid in relation to HIV-AIDS transmitted sexually as for HIV-AIDS transmitted within the sphere of drug-addiction. In both cases – that of contamination because of a heterosexual or homosexual relationship or that of contamination by means of an infected needle or syringe – we find the same context of mental weakness in the individual concerned. He is immature and rather irresponsible towards himself and others. This leads to an approach which is full of risks.

In this weakness of character of the child, which exposes him to contamination by HIV, is to be found, according to the phrase employed by Pope John Paul II, a ‘sort of immunodeficiency of existential values which cannot but be recognised as a real pathology of the spirit’.[1] This ‘worrying crisis of values’[2], which is ‘characteristic of the emergence and spread of AIDS’, continues the Holy Father, finds one of its principal roots in the crisis of the family. When the family is deficient, destroyed or not loyal to its own vocation it loses its ‘warmth’ and the ‘psychological and spiritual immunology’ of its own children begins to disappear, to employ the figurative phrase of John Paul II.[3]

2. The Family as a Place of Training of the Character of the Human Person

If this is a fact which has been empirically demonstrated, it is also true that the climate itself of the family means that young people find in it the necessary defences by which to overcome the challenge which brings with it attraction both towards a premature, immature and not very responsible form of sexual activity which is reduced to mere individual pleasure, and towards the use of, and attachment to, drugs. This

is because the family becomes the *fulcrum and key element in the training of the character* of the person and is thereby a decisive guide in forming attitudes towards other people and towards society as a whole.

a. The family, the first and fundamental school of life

If one can speak of human *ecology*, the *first and fundamental school* and structure in favour of such an ecology is the family itself. Indeed, in the heart of the family 'man receives his first and determining ideas about truth and good, learns what to love and to be loved means, and thus what *in practical terms being a person involves*. Of course here one is referring to the '*family based upon marriage*, in which mutual giving of oneself by a man and a woman creates a life environment in which the child can be born and develop his potentialities, become aware of his dignity and prepare himself to tackle his unique and never to be repeated destiny' (*CA*, 39).

And it is here that we touch upon the central feature of the family, both as a *place of the education* of men and women who are masters of themselves, and, in contrary fashion, as a lost opportunity for the acquisition of the above mentioned fundamental human values. Education within the family is above all else *life, lived out values*, and only in second place and later is it something of a conceptual character. Experienced life can then become a concept, an intellectual expression achieved through retrospective thought in order to establish a value which has previously been lived out, and which thereby becomes a conscious value.

Recognising and wishing for this value helps to incorporate it into one's life, but this is not something which is automatic or which can be taken for granted. The school and other media of information can help a person to look deeper into the values which already exist in that person at the level of disposition, but only with difficulty can they develop them if they are not already gained in the primary structure of training received within the context of the family.

b. Giving of oneself as a generating nucleus within family education

'One cannot forget that the most radical element in education, which defines the educational task of parents, is *paternal and maternal* love'. This is the love that brings to perfection the work of the child which was begun with procreation.

On the one hand there is the relationship of love between the married parents and the children which is the best school for their training and education. But on the other hand there is the child who like every man needs love and 'cannot live without love'. He 'remains for himself an incomprehensible being...if love is not revealed to him, if he does not experience it and makes it his own' (*RH*, 10). There is therefore on the one hand the need for love, and on the other hand the structure which is suited to provide for such a need in a full way. And thus in the family which works, people matter, are loved and are treated as people.

The *generating heart and nucleus* of the ability of the family to educate its children is the *giving of oneself* which takes place between the marriage partners. A self-giving that in addition to involving the marriage partners unites the persons of their children. Indeed, at the basis of their existence there is a concrete realisation of that initial self-giving which made them become *one flesh*. The children express at least in a physical sense the reality of this *one flesh*, which unfortunately would be poor in character if it were not an expression of the communion of their spirits. It is this *profound communion* of the persons of the parents which must inform and support the daily life of the family as a communication and participation of all its members. Precisely because it is a communion based upon the mutual self-giving of the marriage partners, all the relationships between the members of the family community are inspired and guided by welcoming, encounter and dialogue, disinterested *willingness to help*, generous service, and profound *solidarity* (cf *FC*, 43).

Indeed, the love of the parents as a *spring* must further become a '*soul* and thus a *rule* which inspires and guides all practical educational action and activity, enriching it with those values of sweetness, constancy, service, disinterestedness, and spirit of sacrifice which are the most valuable fruits of love' (*FC*, 36).

3. The Family, a Place of Education in Personal Values

In a well constituted family the children are seen as unique and never to be repeated persons, with their gifts and *their own specific vocation*. As a consequence, they also are led in parallel fashion to self-esteem, to the discovery of *their own capacities to discern moral values*. For this reason, the family must be the principal source for the transmission of moral values.

The parents in this way train the children in the *essential values* of human life. Some of these values, when they are not acquired within the sphere of the family, can only be acquired subsequently with great difficulty. Thus it is in the family that the right freedom in relation to material goods is assimilated, with a simple and austere lifestyle. In the family as well the children can be enriched by the meaning of real justice, by *respect for the personal dignity of others*, and by

real love as sincere concern and disinterested service in relation to other people.

It is precisely in the family that one learns the *real meaning of sexuality* and where each child is prepared for self-giving, as a beginning to a life of love as well. Sexual education here is based upon integrating sexuality into the richness of the whole of the person – body, feelings and soul – and manifests its meaning in the giving that the person engages in through love.

4. The Family, Place of Education in Social Values

The *giving of oneself*, which inspires the love of the marriage partners, presents itself as a *model* and guideline for that self-giving which must take place between brothers and sisters and between the various generations which live together within the family (cf *FC*, 27). Daily communion and participation, in moments of joy and familial difficulties, represent the *most practical and effective form of teaching* for the active, responsible and fecund insertion of children into the broader horizon of society (*ibid.*).

In the family 'the various generations encounter each other and help each other to achieve a more complete human wisdom and to match the rights of individuals with the *other needs of social life* (*GS*, 52). 'Faced with a society which runs the risk of being increasingly depersonalised and modelled along mass lines, with negative results of so many forms of *escape* – such as, for example, alcoholism, drug-taking and terrorism itself – the family still possesses and releases formidable energies which can tear man away from anonymity, ensure that he is aware of his personal dignity, enrich him with deep humanity, and actively integrate him with his uniqueness and never to be repeated nature into the tissue of society' (*FC*, 43). The family becomes, in relation to human relationships which go beyond its circle as well, a necessary and irreplaceable school for *personal and social values* such as respect for the person, commutive and social justice, solidarity, hard work, and so forth. The family cannot become itself without serving the life of its children: that is to say by generating and educating children in the virtues, and thus without serving the *good of society*. From the family, indeed, are born *good citizens* who have understood and try to live for those near to them and far from them through a *giving of self*. They have found the best school for human and social virtues in the sphere of the family. This is the reason why the family is seen as the *soul of society* (cf *FC*, 42). And thus 'the family is the native place and the most effective instrument for the *humanisation and the personalisation of society*' (*FC*, 43).

5. The Family in the Struggle Against Sexually Transmitted HIV-AIDS

Because the family is not only a transmitter of personal and social values but also an educator in these values, it has an essential role in the prevention of the infection of its children by HIV.

When one asks the question about the education to be given to young people in order to prevent sexually transmitted HIV-AIDS, that question is often posed in a negative way: *what must one do not to contract AIDS*? To this question there is no real possible answer which does not deceive and which is positive other than the following: adopt a chaste form of behaviour, that is to say prepare oneself for conjugal love so as to give oneself to one's real partner.

Prevention within the family environment of sexually transmitted HIV-AIDS is to be achieved through education in the essential, personal and social values of chastity, responsibility, and solidarity.

Today there is a great deal of talk about informing young people about HIV-AIDS and its transmission. But it is forgotten that information on its own is not sufficient, as indeed was pointed out by the Holy Father in his speech of 15 November 1989 to the fourth congress of the Pontifical Council for Pastoral Assistance to Health Care Workers held in Rome: 'as a consequence it is necessary in the first place to repeat with force that the work of prevention, in order to be *worthy of the human person* and really effective, must set itself two objectives: to *inform* adequately and to *educate* to responsible maturity' (n.5).

To inform young people about infection by HIV, about its forms of transmission, and about its development, is obviously important. But this information is not sufficient in itself to stop these young people from falling into an irresponsible attitude which provides HIV-AIDS with its opportunity. In order to bear fruit this information about HIV-AIDS must encounter a *rooted sense of responsibility from early childhood* in these young people. The education in values given by the family is thus a fundamental element in the prevention of HIV-AIDS. The Holy Father clearly indicated the condition for effective education in relation to the prevention of AIDS. John Paul II talked about helping young people to discover 'the fundamental meaning of existence, love which is self-giving' (speech of 15 November 1989, n.5). 'Only' with this kind of education 'is it possible for adolescents and young people to have the strength to overcome forms of behaviour at risk' (*ibid.*). This education, therefore, must be 'preparation for responsible and loyal love' (*ibid.*). The encyclical *Evangelium Vitae* (25.3.1995) con-

tinues on from *Familiaris Consortio* in insisting on the importance of this sexual education provided by the family. It must be a '*training in chastity* as a virtue which fosters personal maturity makes one capable of respecting the "spousal" meaning of the body' (*Evangelium Vitae*, n. 97).

6. The Family in the Prevention of HIV-AIDS Connected with Drug-Addiction

The problem of the prevention of transmission through drug-addiction seems distant from that discussed immediately above. Here one is no longer acting through education in responsible love but in terms of the struggle against drug-addiction. In this field we encounter the same importance of the values transmitted by the family. Where the family performs its educational role well there is no space for drugs. It is unfortunately true that the transmission of values is not easy today in many homes. The use of drugs takes place in many very good families. But it is useless to remember that the drug-addict often comes from a *weak family* which is weak or unstable because of a variety of motives, a family which cannot or does not know how to react by offering an overall education in order to deal with the common problems of life.

Drug-addicts are the personal victims of their own decisions, but in large part they are previously the *victims* of a society *without a soul* which produces its life models and makes its citizens become its admirers by shaping them in the image and likeness of these empty deformations.

Today these are on a worrying increase in society and give rise to *crises of marriages and families*: separations, divorces, and co-habitations which express the immaturity of many of those who, having to give of themselves in marriage, do not know how to live the needs of such a self-giving. The consequences for the marriage partners are the difficulties in their relationships in the family and an inability to fulfil themselves consistently with that self-giving. In the children who have lived in these distressing circumstances there appears a *void* and a *disorientation* in their spirits in relation to the meaning of life and the values which structure their relationships with other people.

In the realm of drugs those who are the parents, friends or those accompanying drug-addicts recognise the incontestable fact that the principal factor which encourages the use of drugs is the absolute or relative absence of family life. The *lack of family*, indeed, makes the person lacking in human values, with scarce resources by which to defend himself against dangerous forms of dependency on drugs. This is one of the causes, perhaps indeed the most important cause, but certainly it is not the only one.

Drug-addiction is above all else a symptom which manifests an interior situation of *profound emptiness*. An emptiness in relation to those moral values which help to direct and guide existence. This emptiness of values tries to find compensation artificially in escape or flight into the unreal imaginary worlds which drugs produce. The idea that 'drugs cannot be banished with drugs' is very true, or in other words that the problem is not medical or psychiatric in nature, at least to begin with, but existential, human, and to do with values.

Investigations into the phenomenon of drugs agree in demonstrating that there is a relationship between the family and drugs. When in the home deep values have not been inculcated in the children, these latter experience emptiness with anxiety. This can be a consequence of the break-up or fracturing of the family, or because of the weakness of the lack of an authority which must also be supported by example. Young people are forced to bear the heavy burden of an interminable adolescence in a permanent state of the immaturity of their personalities.

When the family is loyal to its vocation, when self-giving, generosity, solidarity and respect for the person and his freedom is lived out daily in the family, then such a family is an ideal environment for prevention, for recovery, and for integration into society.

Conclusion

Today the question of prevention dominates the ethical debate about HIV infection. The message which the Church addresses to all men of good will with regard to AIDS is much broader than the discussion about the use of a condom or the kind of information which should be given to young people: it is a 'yes' to life, a 'yes' to a life lived out nobly and humanly with respect for one's own body and the bodies of other people. To the question: 'a condom yes or no?', the Church answers 'chastity', self-control, education in real love, loyalty, and individual and social responsibility. This is not an anachronistic message; it is not an impossible message. But this message assumes that the family is strong, loyal to its vocation as an educator of man, because faithful to its vocation of love and self-giving, the spring of life and of authentic freedom.

H.E. Mons. F. GIL HELLIN,
Secretary of the Pontifical Council for the Family, the Holy See.

Notes

[1] JOHN PAUL II, 'Discorso ai Partecipanti alla Conferenza Internazionale Promossa dal Pontificio Consiglio per la Pastorale degli Operatori Sanitari (1989', in *Insegnamenti di Giovanni Paolo II*, XII, 2, p. 1270.
[2] *Ibid.*
[3] *Ibid.*, p. 1273.

II: Schools

Introduction

Luc Montaigner, who together with Robert Gallo discovered the virus responsible for AIDS, made clear that in order to counter the spread of this disease 'medical instruments are not enough: it is much more important that there should be campaigns which operate at a deep level, and in which the various actors of society participate, against sexual practices which are against the biological nature of man. And in particular we need to educate young people against the risk of sexual promiscuity and sexual vagabondage'. These words of the French scientist well introduce the theme which has been entrusted to me. Amongst the actors of society called to carry out these campaigns there should certainly be listed institutions dedicated to schooling. From many sides there is a call for schools to act as a place of prevention. Programmes are drawn up to explain what AIDS is, the ways in which the virus is transmitted, and to provide information about relationships at risk. Much more rarely does one hear people speak about values, about emotional maturation, and about the meaning of life. This should not surprise us in that it brings out to the full a difficult and complex reality which bears upon the identity of schools themselves and their educational role. For good reason, this paper of mine is given at a round table discussion whose subject is 'the places of education in values', but the question which is at the basis of everything is whether schools, at least in certain parts of the world, are really educational. This is not, unfortunately, a merely rhetorical question. On the ability of schools to be educational depends the possibility of drawing young people near to values and of developing 'authentic' prevention in relation to an illness, such as AIDS, which bears upon forms of behaviour, values, the meaning of life, sexuality, and so forth. My paper is organised around three principal points: the educational challenge today, education in values, and sexual and emotional education.

The Educational Challenge Today

It has often been said that the historical period in which we are living is not only an epoch of changes but a real change in epochs. Light and shadows, advances in civilisation and new challenges, poverty and wealth, and marginalisation and development, represent the brightness and darkness of the dawn of the new millennium. Paradoxically, we find ourselves faced with a reality where the mutations which are underway have increased the opportunities for each individual to gain access to information, to knowledge and to places, such as in certain areas of Africa and Asia but also in many city outskirts of Europe and North America where access to instruction is denied, where the school 'mortality' rate is very high, and where millions of people are illiterate. A developed and technological world and a world that suffers illiteracy and exclusion: unfortunately when it comes to education as well the world is divided into two. At the same time, in the so-called first world, the factors of scientific, technological and economic change require modifications in skills and notable adaptations, thereby giving rise in an increasingly large part of the population to a feeling of insecurity and situations of new marginalisation. We are immersed in an event that is not only partial but which has the characteristics of being world-wide and total.

In such a context education has rightly been declared to be the 'central question' of this change in epochs. The civil community is convinced of this fact; and the Church even more so. Civil society, indeed, is rediscovering the great value of education and sees it as one of the absolute priorities if we want to guarantee the future not only of individuals but also of humanity as a whole. In particular, schools have become a sensitive cross-roads of these changes and are called to meet the challenges raised by them and to overcome these challenges. Today two approaches prevail. On the one hand reference is made to the right to education for all, on the other hand there is an attempt to ensure that schools and education are of quality and adequate, and teach 'reading and arithmetic' in today's society.

Education and Values

I believe, however, that the educational challenge is principally another. There are, in fact, very many perplexities raised by the educational situation. I am referring in particular to values, to the person, to the concept of education and of schooling. I ask myself, indeed, if it is enough to educate young people to use techniques and

manage complex systems. Or whether we should place the student in a condition to acquire new work skills. Or whether education has achieved its objectives when it makes a student a manager or an established professional. The problem of AIDS is an eloquent answer to the inadequacy of such a methodological approach. These questions bring to mind an essay by Postmann, a United States pedagogist who spoke about the 'end of education'. In order for schools and education to retain a meaning we have to overcome the error of their reduction to mere instruction or a place of instruction. One is not dealing, in fact, with merely providing knowledge but with bringing the man out of the boy, of allowing the boy to become a man in the full maturity of all his being.

Man, the person, has a spiritual, ethical, emotional, religious and social dimension which cannot be forgotten in the educational process without running the risk of 'the end of education'. In a document published by the Congregation for Catholic Education over twenty years ago, dedicated to schooling, one reads the following: 'if one listens to the deepest needs of a society characterised by scientific and technological development which could lead to depersonalisation and a mass scale of existence, and if one wants to give suitable answers to these, there emerges the need for schools to be really educational and able to train strong and responsible personalities which are capable of making free and right decisions. This is a characteristic which can be even more deduced from thinking about schools as institutions in which young people are capable of progressively opening themselves to reality and of training themselves in a certain concept of life' (Congregation for Catholic Education, *La Scuola Cattolica*, n.31). We need, in a word, to recover the total meaning of man in the educational and schooling process.

Who is the complete man to whom the educational effort should be directed? Today great insistence is placed upon various aspects of training but the central core of the question is to be found elsewhere. Beyond the various forms of 'training', the educational *proprium* is another. It consists, that is to say, in enabling the student to be able to make free choices on the basis of freely taken on values. From a pedagogic and educational point of view, the essential thing is to teach the person, to use a term dear to Aristotle, the 'trade of being a man'. All this brings us to the fundamental discussion about education in values, the central concern of this round table debate.

During our century pedagogics has influenced in a determining way the way in which schools exist: they are more 'functional' in relation to the individual, his tastes, motivations and needs, than directed towards goals and values. We must recognise that still today the composition of these two poles has not been arrived at, even though the problem is beginning to be felt in many quarters, including authors and scholars from different cultural and ideological backgrounds who welcome a return to values in the various educational contexts and in particular in schools. It is right for a person to go to schools, to come into contact with learning, to be helped to overcome the various forms of conditioning (of a biological, psychological or social character) inherited from the past or present in the context in which he lives, but such 'freedom from' is not enough if it does not become 'freedom to'. We are dealing here, therefore, with giving young people the possibility to ask themselves about which values they wish to spend their lives with, which ideals they wish to invest their own human capital in. We need to reach the other shore of freedom - that of responsibility - without wandering in a state of emptiness, in non-commitment. That freedom which chooses something or someone without employing values becomes transformed into ballast, burden, 'hell'. Existence without essence and thus without values becomes a tragic and insoluble drama from the educational and pedagogic point of view as well. One must, therefore, be able to choose 'for'; that is to say choose in a positive sense. At a practical level schools must be able to train people for an essential thing, through that which is specific to them: the courage of real freedom. AIDS, unfortunately, is often the extreme symptom of freedom spent badly, of an existential emptiness which is filled with artificial paradises produced by drugs, by wandering about without a meaning and without a goal.

Emotional and Sexual Education

I spoke at the beginning of this paper about the totality of man, and his emotional life and sexuality form by no means a small part of this totality. An overall reflection on emotional maturation cannot neglect the existential personal and relational conditions of being, as well as the social and economic insecurity, the difficulties of social integration faced by young people, and the crisis of the values which characterise our society.

Emotional education, seen in the context of the unitary process of the maturation person, for which schools cannot but be responsible, is also a matter of a progressive opening up to moral values, the acquisition of the ability by the individual to live out his emotional, sentimental, psycho-sexual and friendship dimension in an autonomy of judgement and in the light of values which are fully taken on by his rationality as a man. The student brings to school the whole of his self. The complex dynamics and the

ways by which schools help in the training of young people and adolescents are the subject of study by experts, but the actual power of their influence is not something which is under discussion.

Relationships between people are bound up with variable values and elements over which the creators of school programmes (officials, headmaster etc.) have little or no control. The relationship between the teacher and the student takes place, in fact, in a personal psychology of values which only with difficulty can be referred to clear objective methods. This is because each person is a 'world unto himself'. The emotional relationship between people certainly follows strategies but the ways by which it unfolds are almost unknown. Childhood and early youth are stages when personality forms its basic affective structure, and these are stages which coincide with the school period. The responsibility of the school institution is great, therefore, called, as it is, to be a 'home' where the students can mature. Even greater is the responsibility of the educators, upon whom depends in essential terms the success of the school educational project.

The area of sexual education, to adopt a judgement of the philosopher Abbagnano, is the most difficult and unstable sector of the training of young people in which nobody feels at ease even though he may have behind him a long experience as a teacher and a consolidated *iter* of reflection.

Sexual education, in fact, given that it aims for the maturation of the female and male personality, cannot merely be seen as an initiation into hygiene and the physiological aspects of sexuality. Nor can it be carried out outside the total training of man.

The young people who prepare themselves for life need precise and scientifically drawn-up knowledge, but above all else they need to be directed with regard to the overall meaning of sexuality and affectivity and their objective ends. This reminds us that in the educational relationship educational transmission is never something which is removed from the attitudes of the educators, nor by its nature is it neutral, but it is strongly linked to the anthropological vision which underlies it. Within the framework of a permissive anthropology, for example, the growing individual feels that he has a right to sexual pleasure over and beyond any moral and cultural indication. The age of youth, in this approach, must lead onto the adult age in an atmosphere free of any constraint. Within the framework of a naturalistic anthropology man is seen as an object of nature and studied in relation to the external world. The consequences of these approaches are easy to predict. In our case they become translated into pseudo-educational and partial remedies such as the distribution of condoms and the use of sterile syringes. Very often in schools the line is drawn at minimal education which is limited to information which aspires to be 'scientific'. We need, however, to strive to 'fly high', above all in schools, by basing the educational journey on the concrete and real person. The person should be seen for what he is: a rational being endowed with freedom and thus with rationality, directed towards the transcendent and open to other people, not because of social contingencies but because of inner needs which are specific to the human being. Affective and sexual maturation is possible if within the individual there are motivations which justify it and match the individual in his totality. In this sense sexuality should never be seen as an absolute because it must be continually vivified by the spirit and find its fullness in the dignity of the spousal state. Human love, in an educational and school context which is both healthy and meaningful, must be placed within the perspective of responsible commitment so that life is lived out under the banner of seriousness and of being a project.

As can be seen, such an 'anthropology' centres educational attention not on instruction but upon education and the goal of growth. It also reaffirms the value of the ideal in the structuring of the person because he is seen as an individual who does not react almost mechanically to natural or external stimuli but as someone who is able to accept self-discipline and the sublimation of his own impulses without compromising his self-actualisation. In this context education in values finds its space and its meaning, and becomes 'prevention' in relation to diseases such as AIDS.

Schools are certainly a place for training in values but they are also part of a wider context. There are many environments in which values or anti-values are acquired. These contexts are sub-divided by scholars into two categories: those which are functional and those which are intentional. People of the same age, and society in terms of its instrumental aspects and the mass media, are functional. They place the individual face to face with sexual issues and questions, and not only these (for example they place him face to face with violence, drugs etc.), working for the most part in a traumatic way, and they are not concerned with the young person or his possible reactions. Here we need only refer to certain television programmes, or films, or think about the contexts in which young people pass their free time.

The intentional spheres, on the other hand, are made up of the family, schools, and youth groups. In these an attempt is made to enlighten young people who are engaged in a search, to respond to their interests and their needs, to bring about positive attitudes towards life, to entertainment, to sexuality, and to promote their maturation. Given the data produced by the research which has been carried out, the functional environments by a large measure prevail over the intentional. Only a percentage of about 20-25% of young people draw upon information gained from competent adults in matters relating to sexual education. Most young people learn facts and news from unqualified sources which make their personal equilibrium unstable and rather than solving their individual situations actually make them worse. This should make educators reflect a great deal, make them ever more

aware, and prepare them for their vital tasks.

Schools as an educational institution cannot, therefore, ignore the problems of the emotional development of their students and allow them to undergo the damaging impact of alternative models. Even in the ideal hypothesis that parents do their duty to the full, schools should broaden and deepen their activity. When this is totally absent, as unfortunately seems to occur in the majority of cases, the responsibilities of the schools increase out of all proportion, and this is something which complicates what they have to do. For this task, schools need a trained teaching staff with suitable equipment and the presence of specialists. Most concerns revolve around the involvement of the families, the definition of the contents which are most suitable to each age group, the methods to be used at a group level and with each individual, and the physiognomy of the class which has to be addressed. Despite these obstacles, schools must maintain a critical position, of research, and of experimentation, in order to carry out their function as a guide in the development of young people. The task is arduous and full of problems. This is aggravated by the dangers into which teachers can fall: thinking that everything can be resolved by biological information, wanting to do without the family, and inculcating certain ideas about life, affectivity and sexuality. The contents of sexual, affective and human education are multifaceted. Indeed, they involve information about the descriptive aspects of sexuality and questions about the meaning of life which worry young people, in addition to authentic and real education designed to make them understand their motivations in order to control their sexual instincts so as to subject these to reason and their will, in order to integrate the sexuality of the person in a harmonious way, into his affections, and within a life project. The first aspect, which is of a scientific nature, does not imply a moral purpose; the second, which is of a moral character, pre-supposes a basis of a scientific nature, and in this sense becomes education in values.

Conclusions

It seems to me that what I have tried to say can be summarised in a fundamental concept: schools must be educational and not merely the providers of information if they want to become ‘places of education in values’. The recovery of this educational dimension requires deep synergy between schools, the family, and society; in a word the creation of an authentic educating community. In this sense the Church offers her contribution and her ‘experience in humanity’, as Paul VI loved to say. In particular, Catholic school institutions, with their educational project which has in Christ and the Gospel its inspiration, can offer their valuable contribution to an ‘across the board’ education where values and responsibility have full ‘citizenship’. It is certainly the case that the problem of AIDS is not only of an educational nature, indeed in some areas of the world, such as, for example, Africa, its presence is so high as to even compromise the future of peoples and nations, but without doubt schools and education can do a great deal by training men and women who are able to turn their lives responsible self-giving.

H.Em. Cardinal PIO LAGHI,
Prefect Emeritus of the Congregation for Catholic Education, the Holy See.

III: The Communications Media

How can the communications media help to prevent the spread of AIDS?

I know that some would respond that the media should promote the notion of so called “safe-sex” – that is, the use of condoms in sexual activity.

It will come as no surprise that I do not share this view.

First, let me indicate why not.

For me, the promotion of condom use is an invitation to immature and irresponsible sexual activity and to sexual promiscuity. The promotion of the use of condoms is, in my view, also deceptive, because the method can certainly not be said to be infallibly effective in preventing desease.

Also, instead of treating sexual intercourse as an act of self-giving and unselfish love in the context of a permanent and exclusive loving union of a man and a woman in marriage, it would seem that the use of condoms is designed to avoid both responsibility and consequences in sexual activity, an activity which comes to be viewed as primarily recreational rather than as procreational.

I also think that such objectification or instrumentalization of sexual activity and of sexual partners leads to the objectification of antidotes to the spread of tragic disease. What I mean is this: sexual activity is viewed as a mere means of personal pleasure and the sexual partner is viewed as the object through which such pleasure is obtained; the antidote to unwanted consequences from such activity has become the sale of objects, and there is money to be made from the sale of objects. Nobody makes money from self-control and abstinence. Nobody makes money from respect for others, and respect for the sacredness of sexual activity is not promoted and this is why the sale of condoms is promoted.

When I was preparing these

remarks, I asked the members of our discussion group during the Special Assembly for Europe of the Synod of Bishops if they had any suggestion, and the Bishop of Gibraltar gave me a pen on which were printed the words: "Fight AIDS with a new lifestyle".

In an age in which preventive medicine is encouraged in order to avoid contracting disease which are both difficult and expensive to cure or to contain, it is amazing that few have the courage to say: "Fight AIDS with a new lifestyle".

So, let me address the question of what I think the media can do to prevent the transmission of AIDS.

First, let the media help make known the dangers of promiscuous sexual activity and let the media help make sexual abstinence outside of marriage the accepted norm. The media have done much in some societies to remind the public of the dangers of smoking and have made abstinence from tobacco the accepted norm. While the sexual urge is much stronger and more fundamental than the desire to smoke, the Judaeo-Christian norm has always been that sexual activity is to be expected and indeed encouraged within marriage and that sexual abstinence is to be expected outside of marriage. For centuries, the Judaeo-Christian norm was also the norm for society itself. Then came what has been called the sexual revolution, but it should be consoling for those in the media to know that the norm for morality in sexual activity is also a norm for health in sexual activity. It can be indicated in the media that sexual abstinence outside of marriage is physically healthy, and is not merely a spiritual ideal of the Judaeo-Christian tradition.

Dramatic programs on television could and should present a positive image of family life. Without neglecting the various temptations which came at all ages, dramatic programs could well illustrate the possibility of victoy over such temptations, the great psychological and even physical cost of surrender to temptation and the need for forgiveness, reconciliation and unselfish support in difficulty. Thus, dramatic programs can not only promote the virtue of abstinence, but also compassion with those who suffer either from disease or from a struggle with strong temptation.

Advertising campaigns could carry the message the Bishop of Gibraltar had printed on the pen: "Fight AIDS with a new lifestyle". If advertising campaigns have been able to say, "Smoking is dangerous to your health", why can't they say the same thing about promiscuous and extramarital sexual activity?

There have been advertising campaigns against drunken driving – why not such campaigns against promiscuous sexual activity?

If it is a fact that the best way to avoid lung cancer is not to smoke, and if it is a fact that the best way to avoid becoming addicted to drugs is to abstain from them completely, and if the media are encouraged not only to report such facts but to construct public service advertising campaigns around them, why are the media not encouraged to conduct campaigns encouraging abstinence from promiscuous sexual activity and extra-marital sexial activity – "Say 'no' until marriage".

It is now fashionable not to smoke; it is now fashionable not to take drugs; it is now fashionable not to drink before driving and, in fact to have a designated driver. Why can it not be fashionable to abstain from sexual activity before marriage – to be able to offer oneself in marriage pure and unblemished to one's beloved? I am sure that most women do not want to marry a gigolo and that most men would prefer to marry a virgin; why are we afraid to say it – and to advocate it?

While the question of AIDS has now gone far beyond the question of homosexual activity, it remains nevertheless true that the highest incidence of AIDS, at least in the United States, is traceable to promiscuous sexual activity and the second highest incidence, at least until recently, has been traceable to shared needles among drug users.

If such activities are clearly a public health hazard, then why not have the courage to say so? The surest way to eliminate ot at least to control AIDS is to eliminate those activities which have been proven to lead to AIDS: promiscuous sexual activity, especially homosexual activity, and shared use of needles among drug users?

If smoking has been so actively and successfully discouraged, why cannot the media use the same norms in treating the question of drugs and sexual activity – to have sympathetic and appealing characters who themselves lead moral sexual lives who obviously abstain from sexual activity outside of marriage. It is a tragedy of many modern situation comedies that persons who abstain from sexual activity are viewed as anaemic; they should be viewed as courageous – or at least as having profound respect for others as well for themselves.

Perhaps the media can discover and even have the courage to make known that health, happiness and indeed holiness can go together – that rightly ordered moral activity can contribute not only to a healthier personal lifestyle but also to a healthier society.

H.E. Archbishop
JOHN P. FOLEY
President Pontifical Council for Social Communications the Holy See

ROUND TABLE

"Experiences and Future Prospects for Action and Programmes of a Preventive Nature Based upon Education in Values"

I: Italy - The CUAMM

Introduction

The CUAMM (University College for Missionary Doctors and Medical Students) was born from an idea of a Catholic medical doctor, Prof. Francesco Canova. That idea was to train Italian and foreign doctors, both men and women, who in the practice of their profession bear witness to evangelical charity. Its motto, which comes from the Gospel according to St. Luke, is '*Euntes curate infirmos*'.

The CUAMM officially came into being on 3 December 1950 and is an integral part of the Religious Foundation of St. Francesco Saverio of the diocese of Padua. It has its own legal, canonical, and civil status.

Since 1954 the CUAMM has worked in various continents of the world through the sending out of medical doctors, nurses and technicians – more than a thousand in number – to be involved in hospital health care projects; through primary health care; and through training (in medical schools as well). In so doing it has worked with Catholic dioceses, various religious missionary congregations, and non-governmental organisations at a local level. It has also secured the establishment of relationships involving co-operation, not least with the governments of the local countries.

At the present time the health care projects of the CUAMM are concentrated in Africa, and more specifically: in Angola, Ethiopia, Kenya, Ruanda, Uganda, Tanzania and Mozambique. The CUAMM largely works and operates, though not exclusively, in rural areas.

This paper is based upon the experience of actions and initiatives taken by the CUAMM to combat AIDS in certain rural hospitals in North Uganda.

This paper is based more upon the methods of dialogue and the identification of future prospects than on the defence of personal positions and concentration on the contingent situation. Firstly, the situation of AIDS in Uganda and our experiences with regard to prevention will be examined. Attention will then be turned to a number of reflections on three key elements: taking care of the cut in half couple, helping young people to escape from loneliness, and linking personal responsibility with social responsibility.

Uganda: a Statistical Profile

Total population	20.4 million
Urban population	2.2. million
Rate of annual population growth	2.5%
Rate of HIV infection amongst adults	9.5%
Rate of infant mortality	97/1000
Life expectancy	41 years
School attendance levels: Males	68%
Females	45%
Average *pro capita* income	$240

Source: UNAIDS, 1998.

Uganda and AIDS

Calculations carried out by UNIADS indicate that 930.000 people are infected by HIV or suffering from AIDS, that 1.8 million have died because of the disease, and that 1.7 million orphans have lost one or both of their parents because of this scourge.

A containment of the epidemic of AIDS is a tendency which has been registered in Uganda. The data on seropositivity in pregnant women indicate the occurrence of a gradual decrease in infection by HIV in the urban context since the middle of the 1990s (UNAIDS, 1998).

This decrease seems to be particularly marked in young women in the 15-19 age band.

Two surveys carried out six years from each other seem to indicate a real change in sexual behaviour above all else amongst young people in the same urban areas where investigations into seropositivity were carried out.

The changes in sexual behaviour in young people revolve around:

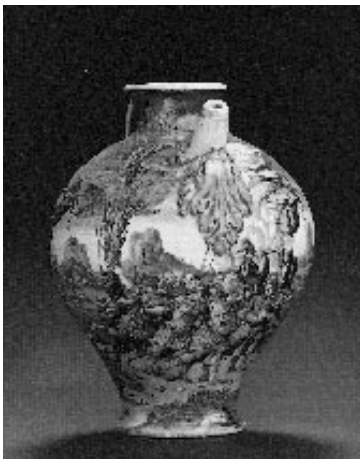
– a raising of the age of the first sexual experiences;
– a raising of the age of marriage;
– a decrease in sexual relations with non-regular partners;
– an increase in the use of the condom.

Experiences in Prevention

A large number of associations are active in the field of prevention. Two non-governmental organisations in Kampala – the TASO and the AIC – have launched a project called the 'Philly Lutaya Initiative' whose goal is to change sexual behaviour through the co-operation of young seropositive people. These are ready and willing to describe their personal experiences and their situation, in particular to students.

The 'Alive Youth Club' also directs its attention to young people. It was founded in 1992 by Sister Myriam Duggan, a member of the Missionary Francescans of Maria and a doctor at the Nsambya hospital in Kampala. Beginning with the Gospel, young people are asked to understand the meaning of sexuality in the life of man and thus to take consistent decisions with the help of individual and community prayer.

In all the hospitals of the Catholic dioceses, including those in which the CUAMM is active, and in many parishes, there are sections which are involved: in providing information to local communities, in education and prevention, in the diagnosis and treatment of sexual illnesses, in counselling, and in the mobilisation of the communities in order to help people afflicted by AIDS.



The Future Prospects: Tackling Certain Central Questions with Courage

Over recent years a great deal has been done in Uganda in the struggle against AIDS. The information and awareness-raising campaigns have reached increasingly vast areas of the population. New and vigorous initiatives have been developed in the field of education, prevention, and counselling. The health care services for the diagnosis and treatment of sexual diseases and the adoption of correct methods in the transfusion of blood have been improved both in terms of accessibility and in terms of effectiveness. And lastly, communities have been directly involved in the provision of services of help and support to the victims of AIDS.

The results are undeniable, demonstrable and encouraging. They are the fruit of a set of factors such as the openness and transparency of the government of Uganda in recognising the seriousness of the problem of AIDS and its determination to fight the epidemic through the implementation of a national programme. To this should be associated the decisive action of the Churches, which have been involved in campaigns of awareness-raising, in educational work, and in helping the sick. Finally, the massive involvement of non-governmental organisations and the support which has been provided by international aid should not be understated.

These results should also be ascribed to the contribution which has been made by those afflicted with AIDS, who have borne witness with moving courage and touching humility to their personal journeys made up of suffering and of acceptance of their illness. These sick people are known to us by name. To them we must pay great homage for having inspired people, and ourselves, to reflect upon, and to struggle against, this terrible affliction.

It is certainly the case that this is a valuable inheritance which we must recognise and defend, however I believe that we must not fall into the trap of facile optimism. It is our duty to be discerning, to be realistic: the epidemic of AIDS will be with us for quite some time and even the positive results achieved in Uganda run the risk of evaporating if we do not tackle certain key aspects with courage – questions which are at the base of the widespread presence of forms of behaviour at risk and the cultural, social, and economic causes which foster the diffusion of the virus.

If the problem, as everybody recognises, is that the sexual behaviour of the population must change, then a great deal remains to be done in order to spread the message of sexual responsibility, and the value of faithfulness and chastity, in an effective way.

At the heart of the prevention of AIDS are the problems of sexual ethics.

In order to advance in this area I believe that we must face up to certain forms of resistance which are surrounded by silence and embarrassment, in much the same way as this disease provokes fear.

In this sense I believe that the future prospects with regard to the prevention of AIDS must take into account the plurality of prospects which we have before us.

Taking Care of Halved Marriages

I would like to begin with certain constant realities in the personal experience of the medical doctor. It is well known that most people infected with, and ill from, AIDS, are women. It is also the fact that the clinics for sexual diseases, and the meetings for the responsible regulations of births, are attended for the large part by women. In contrary fashion, choices in matters concerning sexual relations, family planning, certain traditional practices such as the mutilation of the genitals, polygamy, and the fact that a widow has to become the wife of a brother of her deceased husband, all belong to the sphere of influence, if not of dominion, of men.

Halved marriages are not based only upon a system of unilateral decisions about the marriage but also on a substantial absence of dialogue and spousal communication with respect to delicate and intimate matters such as those which are under consideration here. This is also reflected in behaviour directed towards avoiding the accurate communication of a condition of sexual disease, or of a condition of seropositivity, to one's own marriage partner. To this should be added the persistent tendency to attribute the social stigma which arises to the woman when she becomes infected by sexual diseases, or becomes seropositive, or becomes afflicted by AIDS, when it is known that often it is the sexual behaviour of many men which renders the couple vulnerable to venereal diseases or to infection by HIV.

There is an urgent need to help to foster the spread of the spousal virtues through the equal, mutual and corresponsible involvement of the marriage partners in their life choices and choices regarding sexuality.

To educate people in the Christian values of being a responsible marriage partner, faithfulness, and charity could then mean having the courage to read the taboos, the superstitions and the negativities which are present within, and practised in, all cultures, at all times and in all places, in the light of the Gospel. I am thinking here of those which provoke oppression and immiseration in the couple, and that of the woman in the couple in particular.

It could also mean recovering in a Christian sense those religious and social values which every culture manifests in relation to the meaning of sexual relations, and in addition promoting those exemplary, concrete forms of witness which demonstrate that the Christian value of the integral couple is not only a precept, in the sense that it is to be placed amongst the declarations of principle, but is also something which can be transformed into a criterion for action, into a moral principle according to which the married couple directs and guides its choices and sustains them through an intense and enriching dialogue. Not enough is known, and not enough is done, as yet, in this field.

Helping Young People to Escape from Loneliness

Sexual violence, unwanted pregnancies and abortions, and sexual diseases, are phenomena which are present, at times in a very widespread way, in the world of young people.

We become aware of this in a limited and rather late way in our hospital clinics where only a small proportion of young people present themselves, shy and ashamed as they are, with this baggage of problems which have to be solved. In this case, too, the medical and health care response is in general only partial and insufficient.

In Africa there are very large numbers of young people but in many contexts such as that of sexuality they are alone or abandoned. This is a loneliness which continues for some time and which has many causes.

Firstly, the family has not taken the place of the social rites of initiation into sexuality. Indeed, the silence which is present within the couple is accompanied by an absence of dialogue between the parents and their children. And when dialogue actually takes place it seems to be dominated by the rebukes and remonstrances of the parents and the possible failures, errors or dishonouring effects on the part of the children in matters connected with sexual behaviour. Only rarely does dialogue become for the parents an opportunity for the transmission to their children of knowledge, ideas and experience about why sexuality, one's own sexuality, is a human and Christian factor of identity and growth in which the child can – if he so wishes – measure himself, recognise himself, and engage in imitation.

The absence of adults extends to schools as well where sexual education is a rare event which is often translated into embarrassed and furtive explanations about physiology and the reproduction of humans with a few or ineffective answers to the many questions which young people, and especially adolescents, bring with them. These questions, indeed, are destined to remain unanswered.

Even pastoral realities often leave a great deal to be desired when it comes to the proposals and initiatives made to young people. Unease and difficulties are felt by young people and married couples in drawing near with feelings of trust to the Church. I have the impression that for historical and cultural reasons, rather than for evangelical reasons, the Church continues to give the impression that there are moral reservations about speaking openly about the positive value of sexuality, about dealing with sexual problems openly, and about involving oneself with determination in education about the ethics of love.

The absence of adults within the family and the community is counterposed by a widespread polytheism of values in society. Tea rooms, discos, hotels and magazines are widespread in the urban and rural contexts and involve models of behaviour in which there prevails a 'dominant, masculine sexual culture where excitement, transgression, pleasure, violence and danger are part of the same semantics'.

Furthermore, there are by no means a small number of male and female students in secondary schools who, not satisfied with the standard of living which is offered to them by their families, or out of sheer necessity, prostitute themselves in order to obtain a monetary income. At the root of these forms of behaviour we find profound problems such as sexual abuse, low self-esteem, relationships lacking in affection, and a lack of 'vision and goals'.

The results which have been achieved in Uganda with respect to changes in the sexual behaviour of young people should be greeted in a positive spirit. However, the challenge which we have to meet is even greater. I believe that in order to meet and defeat this challenge the learning of mere techniques – perhaps learnt through occasional educators – by which to avoid the infection is merely a minimal and insuf-

ficient solution if it is not accompanied by a wider approach to the deep relational meaning of human sexuality which is made up of self-discipline, harmony of growth, self-respect and self-esteem, respect and esteem for others, and life projects. In order to respond to the complexity of the hopes of love in young people and in adolescents we need well-directed programmes which are administered by adults and young people who have been suitably trained as educators. We also need centres where young people can meet, where dialogue can take place, where young people and families can meet each other and exchange ideas, and centres which can offer protection and security to young people who have no rights.

Linking Personal Responsibility with Social Responsibility

At the roots of the spread of AIDS there is not only the problem of human behaviour and the ethical responsibility of the person but also certain social an economic causes located in inequality and injustice. There is also, therefore, a problem of social ethical responsibility.

It has been said that AIDS is a problem for all people and for each individual, but in reality it is a question primarily, and once again, which afflicts the poor. It is an incontestable fact that the greatest burden of the disease of AIDS weighs in large part upon the shoulders of the poor countries and of poor people. This is also true in Uganda where, despite the strong recent increase in *pro capita* income, that income only reached its 1970 levels this year. But poverty is not only a question of economic growth.

The status of inferiority of women, widespread unemployment, armed civil conflict, disordered urbanisation, the increasing privatisation of public services, the difficult – and at times denied – access of young people and women to education and to health care services – these are all factors which help the spread of the disease.

Faced with this reality we must doubt whether prevention on its own can stop the AIDS epidemic, unless, that is, it is accompanied by other measures which help to build a favourable social and economic context which is able to support and broaden programmes which promote prevention. It is the question of growth and development, the process of social change, which liberates people and the community from the bonds of poverty, which widens the possibilities of choice in relation to different options, which strengthens the ability of people to be self-sufficient, which promotes participation, and which, finally, improves the quality of life.

This approach 'matches the very nature of HIV and the form it takes as an invisible (asymtomatic), visible (symptomatic) and fatal disease'. As a result, all the programmes involved should be based not only on access to prevention, to the HIV test, to care and support provided by the community, but more in general on a continuum between prevention and development.

The path to take could be that of the construction of so-called 'social capital'. This is a long path, but one which is open to everybody.

The non-governmental organisations could play an important role if they stopped competing between each other and instead worked with the variegated social tissue by favouring the participation of people in formal and informal networks, by encouraging positive social norms, by building up high levels of trust, by promoting social cohesion, and by mediating between people and public institutions.

The very action of the Church would be more effective if her social teaching was disseminated amongst priests and the laity, if she promoted innovative forms of political and economic pastoral care, as well as experimental models of intra- and inter-ecclesial solidarity.

The mass media of the North and the South could increase their role as vital channels of health care education by giving more space to news about medical advance, problems and cases connected to questions and issues of health and security, and health care policies rather than selling objectivity and independence for reasons of commercial gain.

Researchers and men of science could help in the analysis of the economic, demographic, socio-cultural and organisational factors which influence people's behaviour in terms of the perception of diseases, and of sexual diseases in particular. They could also help in the search for forms of treatment and care.

Given the prohibitive costs of the drugs and medicines involved, a responsibility of primary importance for the Western scientific world is that of developing an effective vaccine which is safe and reasonably cheap. The present-day emphasis on combined anti-viral pharmacological forms of treatment runs the risk of concentrating efforts on benefiting a few rather on the potential benefits which could be guaranteed to many.

Local governments and the international community should be asked to act responsibly in terms of fairness in the distribution of resources and in providing sustainable help for development.

I am convinced that dialogue and relations between the North and the South with reference to AIDS presents many affinities and similarities with the discussions about the global economy, world trade, the role of the United Nations, and other similar questions.

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II: India

Introduction

HIV did not arrive in Asia, home to half the world's population, until the late 1980s and early 1990s. Today, the region accounts for 20 per cent of all infections world wide. Experts worry about the potential for epidemic expansion in India, where more than 4 million people have already been infected – the largest number of infected individuals in any single country in the world (UNAIDS: 1999).

In India (NACO: 1998) the HIV-AIDS epidemic is now a decade old. Within this short period it has emerged as one of the most serious public health problems in the country. The initial cases of HIV-AIDS were reported among commercial sex workers in Mumbai & Chennai and injecting drug users in the north-eastern state of Manipur. Even though the officially reported cases of HIV infections and full blown AIDS cases are in thousands only, it is realised that there is wide gap between the reported and estimated figures because of the absence of epidemiological data in most parts of the country.

Making an accurate assessment of the situation is not an easy task. The UNAIDS and National AIDS Control Organization (NACO – India) maintain statistics on the number of persons with HIV-AIDS, and does its best to keep them up to date. Yet the disease progresses faster than statistics (Lebel: 1988), which are very approximate (and sometimes totally lacking for a number of countries. While there is much we do not know about persons with HIV, we know even less about people living with HIV who have not developed the disease and who may not even be aware that they are carriers. In fact we live in a world "where there are 16,000 new HIV infections a day, and where 9 out of 10 seropositive people do not know they are infected (UNAIDS: I999).

Situation of HIV-AIDS in India

The HIV-AIDS population in India is not uniformly distributed, nor is it rising at a uniform rate. The determining factors are (Thomas & Pereira: 1999):

a) The time and place where the infection first appeared

b) The effectiveness of prevention campaigns

c) The effectiveness of testing system

d) The socio-cultural and religious background of the people

e) The routes of transmission

f) The presence of other STDs and communicable diseases

g) The type of health delivery and reporting system available in the country,

and

g) Other factors (Panos Dossier: 1990), such as an under funded and understaffed health surveillance system, suggest that it is not always possible to estimate the extent of infection in a country accurately.

The first few seropositives reported in the country were from Chennai in 1986 (Shiv Lal & Sengupta: 1995). Since then over 8,000 cases of AIDS and over 85,000 cases of HIV have been reported to NACO, Ministry of Health and Family Welfare from 32 States and Union Territories till August 1999 (NACO: 1999). There is certainly a substantial increase in the number of new cases in the country. Much of this increase is attributed to better case finding and reporting which have resulted from various NACO activities.

The nationwide sentinel surveillance data collected (NACO: 1998) clearly indicate that HIV infection is prevalent in all parts of the country. In recent years it has spread from the urban to the rural areas and from individuals practising high risk behaviour to the general population. Studies show that more and more women attending ante-natal clinics are testing HIV positive which indicates the increase in risk of perinatal transmission.

The 97-98 NACO report shows that about 75 per cent of infections occur by sexual route (both heterosexual and homosexual,) about 8 per cent through blood transfusion, and another 8 per cent through drug use. Over 90 per cent of the reported cases are occurring in the sexually active and economically productive age group of 15-49 years. One in every 4 cases reported is a woman.

Some of the attributable factors for the rapid spread of the epidemic across the country today are: labour migration and mobility in search of employment from economically backward to more advanced regions, promiscuity, low literacy levels leading to low awareness among the potential high risk groups, together with gender disparity, sexually transmitted infections and reproductive tract infection among men and women.

There have been cases of the refusal of admission of AIDS patients in hospitals and nursing homes both in government and private sectors. This has compounded the misery of the

AIDS patients. More often it is taken to be a contagious disease and patients are isolated in the ward creating a scare among general patients. In the workplace there are instances of discrimination leading, in some occasions, to loss of employment. HIV infected people have been thrown out of village communities, women have been tonsured, children of HIV infected people have been thrown out of schools, institutions providing shelter to the AIDS patients have been stoned or attacked, and refusal to dig graves for those who have died of HIV infection, are some of the ways in which people have reacted to this deadly disease and its victims. Table 1.1 show the cumulative occurrence of HIV-AIDS cases and the number of blood samples screened across the country as on 31st March 1999 (NACO: 1999).

HIV-AIDS Prevention Programmes: Government Initiatives

Soon after the reporting of the first few HIV-AIDS cases in the country in 1986, a National AIDS committee was constituted in the same year by the Government of India and a National AIDS Control Programme was launched in 1987. The components of National AIDS Control Programme (NACP) are given below:

a) Programme management by establishing various national and state level organisations

b) Information, education, communication and social mobilisation (IEG) by developing IEG multimedia packages, training programmes, and awareness campaigns.

c) Condom promotion and its social marketing.

d) Blood safety: the supreme court of India has banned professional blood donation with effect from 1st January, 1998.

e) Surveillance by the establishment of voluntary blood testing centres in all government medical colleges.

f) Control of sexually transmitted diseases by the strengthening of 504 existing STD clinics.

g) Clinical management by the training of physicians in government hospitals with more than 200 beds, and

g) Reduction of impact by the implementation of a pilot continuum care programme in the state of Manipur and the development of a national training programme for counselling.

Critique

The efforts of the government have been largely supported by several Non-Governmental Organizations (NGOs) spread across the country. However, these programmes and the efforts made so far have not yielded the desired results primarily because of the adoption of programmes and policies followed in developed countries which are not in tune with the social, cultural and religious values of Indian society. For example a message like "use condoms to have safe sex" is not generally welcomed by parents and teachers although promiscuous activities are no less widespread among the Indians.

Most of the printed materials are duplications of materials from other countries or publication of UN bodies and bilateral donor agencies which have been developed without taking into account the socio-cultural background of Indian society.

The Existing AIDS Education Programme in India

The AIDS education programme in India is still in its infancy. There are many areas in which the concerns about the AIDS pandemic interact with the fabric of society. Such interaction becomes particularly intense and conflictual

Table 1 – State-wise distribution o the reported cases of AIDS on 31st March 1999

S. No	State/Union Territory	Blood samples screened	HIV +	AIDS
1	2	3	4	5
1.	Andhra Pradesh	74.566	704	48
2.	Assam	12.717	173	22
3.	Arunachal Pradesh	495	0	0
4.	Andaman & Nicobar Islands	14.447	115	0
5.	Bihar	10.194	41	3
6.	Chandigarh	56.687	260	
7.	Punjab	1.488	65	100
8.	Delhi	317.457	1.282	219
9.	Daman and Diu (UT)	250	8	1
10.	Dadra & Nagar Haveli (UTa	160	1	0
11.	Goa	69.395	2.104	15
12.	Gujarat	451.464	1.675	137
13.	Haryana	160.330	494	1
14.	Himachal Pradesh	3.851	92	9
15.	Jammu & Kashmir	8.981	40	2
16.	Karnataka	402.142	4.845	172
17.	Kerala	44.547	215	106
18.	Lakshadweep (UT)	1.194	8	0
19.	Madhya Pradesh	96.083	587	210
20.	Maharashtra	429.045	47.408	3.354
21.	Orissa	83.127	217	2
22.	Nagaland	8.548	429	10
23.	Manipur	38.362	5.644	310
24.	Mizoram	37.251	122	7
25.	Meghalaya	14.250	60	8
26.	Pondicherry (UT)	84.579	2.971	141
27.	Rajasthan	22.446	465	79
28.	Sikkim	510	6	2
29.	Tamilnadu	741.774	13.375	1.881
30.	Tripura	5.613	4	0
31.	Uttar Pradesh	106.936	1.253	125
32.	West Bengal	163.991	649	57
	Totale	3.457.080	85.312	7.012

around the issues of AIDS, family life and sex education – subjects that appear erratically in the curricula of our medical sciences, let alone all other disciplines (Thomas & Ranga: 1995). This is true for the schools, conventional universities and open learning institutions. To date there is no enrichment programme or a certificate, diploma or degree programme on AIDS, sex or family life education anywhere in the country (Thomas: 1998).

This anomaly in scholarship with regard to the provision of authentic and adequate knowledge for creating awareness on AIDS, sex and family life education through appropriate educational programmes cannot be explained by rational considerations because there are few areas of life that touch everyone so profoundly. Although research on substance abuse, AIDS, sex and sexuality related topics is hardly lacking and intellectuals are well aware of the AIDS threat and the consequences of its unchecked spread, no legitimate avenues are made available for the prevention and control of the disease in an intelligent manner (Thomas: 1998).

The University Grants Commission (Gangurde: 1994) proposed the introduction of a compulsory course on AIDS at the undergraduate level. Some of the social work training institutes, medical and nursing schools have introduced AIDS as a unit into their curricula. In 1991, a programme called Universities Talk AIDS (UTA) was started by the National Service Scheme, Department of Youth Affairs and Sports in collaboration with the WHO and the Ministry of Health in 59 universities in the country (Shiv Lal: 1993). Later this was extended to most of the universities in the country. Apart from these, several NGOs are involved in creating awareness about HIV-AIDS among their beneficiaries through community organization and development programmes. However, it may be noted that those responsible have decided not to incorporate sex education into the school curriculum (Inderjit: 1994).

Critique

The above contradictions in purpose and strategies exacerbate the crisis in a land such as India with its vast population (980 million) and linguistic, communal and geographical differences (with 18 officially recognized languages and 1652 dialectics and 23.5 per cent of her population comprising tribal groups). There are 32 states and union territories and the literacy rate according to the 1991 census is 52.1 per cent (Manorama: 1994). It is quite reasonable to argue that the tide of crisis could be stemmed only if AIDS, sex and family life education programmes are launched quickly and efficiently by the various educational establishments in the country.

A review of the materials prepared for schools, colleges, universities, medical and nursing institutes clearly show that hardly any change in content, style and presentation exists. It looks as if 'the same soup is served' in different plates. Similarly experiences at various seminars, workshops and conferences are the same where the same things are discussed by and large by the same participants and resource persons with one or two exceptions. In short, one may conclude by saying that hardly any concerted effort is made to widen the scope of such efforts made in conventions, and national and of international meetings.

Intervention Strategies and Programmes of the Church in Indian Health Policy: 1992

The Catholic Bishops' Conference of India (CBCI) initiated timely action to address the issues pertaining to HIV-AIDS. The CBCI's policy and strategy is clearly spelt out in the *Health Policy of the Church* in India which has been circulated among all bishops and Catholic health care institutions across the country. It calls for "correction of permissive habits and sexual promiscuity and the need to educate people about AIDS". The main policy and strategy outlines are (CBCI: 1992):

Policy:

Our institutions will give loving and compassionate care to all patients with AIDS. Prevention is the only force against AIDS at present. It calls for the correction of permissive habits and sexual promiscuity and the prevention of infection through blood and needles, and attention to high risk groups.

Strategy:

1. Creates an awareness of the problem and educates people about AIDS.
2. Welcomes patients with AIDS; at the same time precautions will be taken so that the disease does not spread inadvertently among other patients or public or health personnel.
3. Orients people towards orderly sexual behaviour.
4. Promotes voluntary blood donation by health donors, after testing for the human immuno-deficiency virus and discourages professional donors.
5. Uses sterile needles and syringes and disposable ones to the extent necessary and possible.
6. Keeps close check on all blood products for statutory HIV test certificates.
7. Collaborates in the national programme against AIDS.

CBCI Response to HIV-AIDS: 1996

In 1996 the CBCI brought out its second policy statement on HIV-AIDS which was given wide circulation. The statement entitled *"The Response of the Catholic Bishops' Conference of India to HIV-AIDS"* called on the Catholic educational institutions to embark on a mission to launch a comprehensive *family life education* programme with accurate and complete information on HIV-AIDS. It further states: "The time has come for teachers in Catholic educational institutions and parents to become increasingly aware of

the fast changing social perspectives of young people. It is important and apt that our children receive prompt, accurate and truthful answers to their questions on sex, sexuality and HIV-AIDS. The CBCI calls upon all Catholic brethren to recognize *the great values enshrined in the Bible and in the teachings of the Church* regarding male-female relationships, God's plan for procreation and for the realisation of His love from the total and unconditional sharing of one's self with the life partner" (CBCI: 1996).

Policy for the Management of HIV-AIDS patients: 1997

The St. John's Medical College, Bangalore (the only Catholic medical college in the country), has evolved its policy for the management of HIV-AIDS patients which was approved by the CBCI in September 1997. The policy states: "*Continuing education should be organized for all categories of employees* with special emphasis on those at greater risk. The objectives of these sessions should be to raise awareness that treating HIV infected person is safe provided recommended precautions are taken" (St. John's Medical College: 1997).

CHAI Policy on AIDS

The Catholic Hospital Association of India (CHAI) in its policy statement issued in 1994 states (CHAI: 1994):

– CHAI commits itself to a programme of prevention of spread of HIV infection through a process of education and training at all levels and to the unconditional care of those affected by the infection.

– CHAI policy will focus attention on *ethical social and spiritual values* apart from physical and caring needs, as well as on the justice dimensions without being judgemental.

– CHAI and the mernber institutions will promote *comprehensive education on human sexuality and values for a meaningful life* with responsible sexual behaviour.

Critique

A analysis of the above mentioned policy statements of various Church bodies in India show that the Catholic Church has been responding to the problems associated with HIV-AIDS ever since the emergence of this disease in the Indian Sub-Continent. The Church and its educational and health care institutions are very much concerned about the onslaught of HIV-AIDS and are committed to providing value education to the general masses and employees, and providing treatment, care and spiritual support to those infected with HIV and their families within its limited resources – that is to say both finance and personnel expertise.

Other Value Based Educational Interventions

Publications

The CBCI Commission for Health has developed and published printed materials on HIV-AIDS which provide a policy framework and guidelines to the clergy, religious, school teachers and other laity. Some of these are:

a) HIV and pastoral care comprising 14 chapters, glossary, a bibliography and details pertaining to HIV surveillance centres and zonal blood testing centres in the country. This book has been written keeping in view the biblical perspective, particularly the New Testament. The book was authored by a priest and a lay man, edited by a moral theologian and has a foreword from the President of CBCI, namely Most. Rev. Alan de Lastic, Archbishop of Delhi.

b) The Prevention of HIV-AIDS. A test book for schools comprising 12 chapters with five exercises in each chapter in the form of role play, debates, group discussion and other content-based classroom activities. It has a number of illustrations and has been prepared keeping in view moral, social cultural spiritual and family values. This book is available in two languages, namely, English and Hindi.

c) A curriculum on HIV-AIDS, sex and family life education was prepared in consultation with experts from various fields like physicians, psychologists, social workers, counseliors and other specialists on the subject. This volume is meant for educational institutions to help them in developing value based programmes of study in the above mentioned areas to suit local needs.

d) A brochure on: *"AIDS: CBCI call for prevention and control of HIV-AIDS"* was prepared for free distribution among the masses during meetings, conventions, training programmes etc. Due to public demand this brochure has been reprinted with certain modifications under the title *"A call for the prevention and control of HIV-AIDS"*. Moral and spiritual values are enshrined in this brochure.

Collaboration with the National Open University

The CBCI has entered into an agreement with the Indira Gandhi National Open University (IGNOU) to develop and launch programmes of study on HIV-AIDS, family life education and social service in the larger interest of teachers, paramedicals, parents, NGO functionaries etc. spread across the country.

To begin with the university initiated processes to develop a certificate programme of study

on *"HIV and Family Education"* to be offered through a "distance learning mode". This is the first ever endeavour by a university in India (India has about 250 universities) to develop and launch a programme on this subject. The beneficiaries could number thousands.

It gives us great satisfaction to report that the university has endorsed the stand of the Church as far as the approach and strategies for the prevention of HIV-AIDS in the country are concerned.

The expert committee members appointed by the university comprise several Christians (priests, moral theologians and other eminent academics). The curriculum designed by them which has the approval of the university is in tune with the stand of the Church as far as moral issues and values are concerned.

I am also pleased to state that IGNOU has accepted a folder entitled *"HIV-AIDS prevention guide for students"* prepared by the lone Catholic faculty in that university. This folder which also upholds moral, social and family values has the approval of NACO as well as WHO. In fact, NACO and WHO have agreed to print this folder which will be sent by the university to its cumulative strength of 800,000 students (0.8 million).

In short we may say that the approach followed by the Church in India in sensitive subject areas like HIV-AIDS and family education is gaining momentum in academic institutions in the country. Much more can be done provided there are adequate funds for any similar initiatives.

A Study on Diocesan Level Initiatives

The CBCI Health Commission has undertaken a country-wide study to find out the initiatives taken by the 144 dioceses with regard to the prevention and control of HIV-AIDS. A questionnaire to find out various aspects of the programme such as HIV-AIDS education, family life education, AIDS awareness, training programmes, seminars, rehabilitation, treatment facilities, care, support, counselling and HIV testing facilities etc. has been developed for the purpose. This questionnaire has been dispatched to all the bishops and responses have started pouring in. It is expected that within six months time this study will be completed. On the basis of the data being collected, I would like to present a couple of case studies which highlight the experiences of some of our institutions involved in HIV-AIDS work.

Case studies

St. John's Medical College Bangalore

The St. John's Medical College is situated in Bangalore which is the capital of the South Indian state of Karnataka. It is in the Archdiocese of Bangalore.

When the Indian Council of Medical Research (ICMR) began to establish nodal testing centres all over the country during the late 1980s, St. John's refused to become a nodal centre. Only in 1990 did the hospital introduce ELISA lab tests for HIV-AIDS as testing blood for HIV became mandatory in the country.

Pre-test counselling is provided to clients before a blood test is conducted and confidentiality is protected. Even when a patient is discharged, the discharge summary only mentions that the patient is suffering from human retroviral infection.

The first AIDS case was diagnosed in 1989 and a single bed was allotted in the isolation ward to take care of the AIDS patient. In 1992 the hospital started handling more and more cases and now the patients are treated without any discrimination and are not separated or isolated. In early 1992, a separate labour room was allotted for handling HIV infected mothers. Now there is no separate labour room and adequate precautions are taken to prevent HIV transmission during labour.

The nursing staff and aides do not express any misgivings about handling HIV patients although many of the surgeons are afraid. During the last three years, there were reports of five needle prick injuries to doctors and all these occurred due to carelessness and fatigue. The pathologists are still unwilling to do autopsies on patients who have died of HIV-AIDS.

The social work department provide all types of assistance to the patients as well as their families which include finding a job, housing, emotional support and at times financial help to meet urgent needs.

Continuous education of the staff on HIV-AIDS is an important aspect in St. John's. Regular courses are being conducted for physicians and para medicals, not only for the hospital's employees but also for the staff of other medical and health care institutions.

To coordinate and give direction to the HIV-AIDS programme, St. John's has established an AIDS cell which consists of a physicist, a microbiologist, a dermatologist and a psychiatrist. It also has an advisory council which consists of the members of the administration and the heads of major departments. They meet periodically to review and plan for the future.

Shalom – a Rehabilitation

Shalom is a centre for the rehabilitation of substance abusers (mostly HIV infected), and for creating awareness on HIV-AIDS. It is situated in Dimapur which comes under the Kohima Catholic diocese in the North-Eastern state of Nagaland. Nagaland and its neighbouring state of Manipur accounts, comparatively speaking, for the largest number of drug addicts and HIV positive cases in the country.

Easy availability of the drugs at relatively cheap prices is the major cause behind this deadly habit among the youth of this region. This region borders the gateway to the Golden Triangle, the traditional global drug trafficking route.

Roughly 2.5 per cent of the total population of Nagaland are reported to be drug addicts, excluding those using alcohol and other mild types of drugs. Most of these addicts are also I.V. users.

Shalom has the capacity to admit 20 patients at a time. They are given treatment and a follow up programme for about 6 months. Shalom also provides counselling services to the drug addicts lodged in the central jail of Dimapur. Professional medical help is provided by the resident doctors and staff located at a nearby health centre.

During the last seven years of its existence, Shalom's priority has been to provide treatment and rehabilitation to the economically backward HIV positive and drug addiction cases who could not afford for costly treatment.

The unique characteristic of Shalom is that three former addicts are employed as animators and counsellors in Shalom. Apart from this, several other addicts who received treatment from Shalom are serving in other de-addiction centres as counsellors. Experience has proved that these animators are very effective in providing rehabilitation services and counselling to other patients.

During the short span of its operation shalom has extended its education and awareness programmes to scores of schools, colleges and youth groups in the North-East by organizing film shows on drugs and HIV and conducting workshops.

Shalom also offers a distance learning package comprising eight lessons on drug abuse and HIV-AIDS. More than one thousand students are participating in this programme. Shalom also provides regular training workshops on HIV and drug addiction to priests, religious, school and college teachers, medical professionals and other youth workers. Shalom is also planning to introduce a vocational training programme for the drug addicts who have received treatment as well as those under vanous stages of rehabilitation process.

The efforts of Shalom in this part of the country seem to be reasonably successful as far as their intervention in the area of prevention and control of HIV-AIDS and drug addiction is concerned.

Snehadaan:
The St. Camillus
Home of Charity

Snehadaan belongs to the Society of the Order of St. Camillus. Camillians have a presence in three states in India and have been present in this country since 1980. The organisation has a preferential option to take care of people with HIV-AIDS (PWAs) and as a result of this Snehadaan was formally started on 14 July 1997 in Bangalore.

Snehadaan has a prophetic vision of care for PWAs. They say that they have seen that there is hope even after the diagnosis of an individual being HIV+ve – the individuals' prognosis depends significantly on how they are treated by the health services. Those who are admitted to Snehadaan are encouraged to become part of a family in which each individual can love and be loved by the other members of the community. Therefore, each resident is accepted on the basis of his or her own character and becomes a part of the whole community.

Snehadaan accepts PWAs as a priority for care at whatever stage of the disease process that they are in. Preference is, however, given to the sickest – those whom the disease has already devastated. Snehadaan's community offers 24 hour care for PWAs and treats any kind of illness that is HIV related. Snehadaan also offers support when the person's home environment may not be sufficient, may put him or her at risk, or where it does not exist at all.

Snehadaan is a respite home for those who need shelter and convalescence while they are being treated. It also acts as a half-way home after an individual has been admitted to hospital and cannot return to his or her home environment. Both aspects of care provide timely interventions for minor or major ailments that may occur in the course of disease. It ensures safety as well as security to the residents. Special attention is given to those in need of physical rehabilitation. Snehadaan also provides palliative (or 'hospice') care for those in the last stages of their life. The latter is seen as a priority. Snehadaan has a vision of a dignified existence of those living with HIV. It seeks to help them to accept with dignity their bereavements – be they physical, familial, psychological, financial or emotional.

In line with its core values, Snehadaan promotes a holistic vision of care and strives towards maximized rehabilitation. PWAs living in Snehadaan are empowered to grow morally, spiritually and socially as far as they are capable. Each person is treated as a unique individual with power to change and control his or her own lives. At the end of the person's stay at Snehadaan, social readmission as well as family reconciliation is sought and warmly encouraged.

Snehadaan feels that the most urgent need is to train families and communities in how to care for PWAs. In addition, there are constant calls for training programmes tailored to the needs of particular NGOs or government bodies – from nursing schools, radiographers, students at the institute of management, pastoral care workers, hospice teams etc. The Camillians are doing a wonderful service for PWA.

Other Similar Endeavours

Several religious communities and dioceses are involved in large and small ways in HIV-AIDS work. A brief note on some of their experiments are given below.

St. Catherine Home: Snehalia

Snehalia in Bombay is involved in the care and rehabilitation of children born to HIV-AIDS mothers. Snehalia has 24 children. Almost all of them came totally shattered, physically and mentally. Three of them tested negative. Some of those tested HIV negative are being adopted or will go back to either their home or to some relative. Home care and acceptance are the main strategies involved in the care and rehabilitation work of the nuns in this home.

Sneha Bhawan

Sneha Bhawan is situated in Imphal, the capital of Manipur in the North-East of India. At Sneha Bhawan, female drug addicts and those infected with HIV are provided with care and support. Most of the residents are in the age group of 15 to 25. Sneha Bhawan provides counselling, home care and other rehabilitation services to female clients. Almost all the residents were found to be HIV positive in this home.

The Holy Redeemer Hospital: Theni

The Holy Redeemer Hospital is situated in the South Indian state of Tamil Nadu. The sisters here are involved in a unique way to spreading HIV-AIDS awareness. Their entry point is through the barber community. Over 200 barbers are associated with the project for spreading HIV-AIDS awareness. Men folk from every home visit barber shops at least once every two months. Therefore it is a sure way of reaching every home through this medium.

The HIV-AIDS intervention programme in Theni also integrates reproductive health care programme as well as the T.B. control programme in collaboration with the government. The sisters from them also work among nomadic groups, auto-drivers, construction workers, as well as commercial sex workers.

Experience, Achievements, and Limitations

The analysis of some of the initial responses gathered from various parts of the country show that our health care providers, teachers, social workers, priests and religious have gained rich and varying experiences during their work with HIV-AIDS and related issues. The methodologies and intervention strategies adopted include: counselling services, occupational therapy, yoga and exercise, awareness, education, vocational training, recreational programmes, spiritual care and emotional support.

Many of our institutions are also involved in networking by organizing support group for HIV positive people, care and support group meetings in hospitals, home based care teams, decentralized institutional care, the sharing of information and the dissemination of knowledge to people from every walk of life.

Some of the limitations or areas that require improvement are:

a) Difficulty in finding long-term funding.

b) Non-availability of drugs at affordable prices.

c) Indifference on the part of hospitals and staff.

d) Difficulty in monitoring family members and care givers.

e) Rehabilitation and discharge to the community.

f) Lack of community participation and acceptance.

g) Staff stress etc.

Suggestions

The Church in India has initiated a number of programmes across the country for the prevention and control of HIV-AIDS, particularly in areas where the problem has come to light. However the vast geographical area, the huge population, limited resources, under funded and understaffed health care systems, the large number of HIV infected, the increasing number of AIDS cases, and the multifaceted needs of those affected, have all posed an almost insurmountable task to the Church in terms of immediate response. Some of the aspects to which the Church needs to respond immediately are:

a) There is a need to evolve a strong, comprehensive, feasible and “one common policy” to confront the HIV-AIDS problem in the country. At present various Church bodies have brought out their own policies. These need to be integrated with a holistic approach to include various actors such as socially disadvantaged groups, women, children, youth, parish community etc.

b) There is a need to evolve

workable strategies which will have adequate room for: the sharing of experiences at the national, regional, diocesan and parish level. There is also an urgent need to mobilize resources (for short term and long term projects) in terms of funds, expertise and infrastructure facilities.

c) For proper implementation of the policies and strategies the Church has to train a large contingent of personnel from among the health care providers, teachers, social workers, counsellors etc.

d) The Church in India needs to discuss and make draft plans to meet any eventuality because more and more children are becoming orphans, more HIV positive children are born, more and more house-wives are getting infected and more and more people are reported to be dying of HIV-AIDS.

e) It is not enough for the Church to project its strong opposition to 'condom culture and safer sex campaigns' only. It has to publicise its own strategies, policies, achievements and experiences in working successfully with HIV infected people across the country without adopting immoral practices.

f) The Church in India and the international Church must educate its people not to be carried away by suggestions, arguments and teachings which are opposed to human values, ethics, social justice and which are challenging the very fabric of our Catholic community.

The recently released UNAIDS Report of June 1999 states in page 35-36:

"Opponents of safe sex campaigns have disseminated misinformation about condoms – one of the most effective tools in stopping HIV transmission – alleging that they do not work or actually contribute to the spread of HIV. Persistent advocacy is needed to counter unscientific arguments and to support those governments and institutions who implement best practice". *Has the Church a response to this statement? Is it right for us to ignore such arguments?*

Summary

Reports released and published at various national and international conventions indicate that among all the nations India has the largest number of HIV infected individuals. It is alleged that India has the dubious distinction of becoming the AIDS capital of the 21st century. The relentless spread of HIV-AIDS in India in recent years has had grave consequences for the health and behaviour pattern of people from every walk of life.

In the absence of a drug which cures and a vaccine for prevention, education for prevention is the only effective option available to contain the further spread of HIV. The Church in India and the CBCI Health Commission in particular have embarked on a mission to address the issue through the launching of *value based education* in spite of its limitations, and especially financial constraints. It is hoped that the Church in India will continue its efforts to contain the further spread of the AIDS virus through *value based education* and awareness campaigns. The Church also has to engage in introspection with regard to its policies, strategies, and methodologies adopted for the implementation of various programmes so that adequate measures can be taken on time to meet any future eventuality.

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III. Spain: the Foundation 'Dimensiò Sida'

1. Introduction

The Foundation 'Dimensiò Sida' of Barcelona thanks the Spanish Episcopal Conference for having entrusted it with the task of representing it at this conference on AIDS organised by the Pontifical Council for Health Pastoral Care (the Vatican City, 9-11 December 1999).

In order to avoid possible confusions we would like to observe that the Foundation 'Dimensiò Sida' does not in the least depend upon the Spanish Episcopal Conference or upon any other body of the Catholic Church or upon any other institution. We are a *private and civil* (non-ecclesiatical) foundation rooted in Christianity inspiration which is of an inter-denominational character and legally constituted in Spain and Catalonia. We are simply a non-governmental organisation which provides service in the field of AIDS (AIDS/NGO) with the advantages and the disadvantages that this involves.

AIDS: Three Epidemics

We must begin with the fact that AIDS covers three distinct, albeit interdependent, epidemics:

1) The epidemic of HIV (infection)
2) The epidemic of AIDS (opportunistic illnesses)
3) The epidemic of the psychological impact and social rejection which afflicts those people who have been struck by this disease.

It would be a good idea to bring to mind the epidemiological data on HIV-AIDS in the world and to note the serious imbalance which exists between the so-called developed countries and the developing countries. The need to establish interaction and realistic policies of co-operation and aid between countries, and in particular with those which find themselves in especial difficulty, is more than evident.

Spain is the European Country with the Highest Number of Cases of 'Full-Blown' AIDS

The situation of cases of 'full-blown' AIDS in Europe shows that Spain is the European country with the highest number of such cases, indeed it has double those of the most hard-hit countries such as Italy and Switzerland and three times those of France.

2. AIDS: a Challenge for the Churches

The Pastoral Care of the Church in Spain

The Pastoral care of the Catholic Church in Spain in the field of AIDS is principally carried out and organised in the following way:

1) Diocesan delegations of the health care ministry
2) Diocesan Caritas organisations
3) Religious congregations
4) Religious assistance and care in hospitals
5) Christians in AIDS-NGOs

ICASO

Thanks to the support provided by the World Health Organisation (WHO) and the UNAIDS programme there is in existence an international body bearing the name of ICASO (International Council of AIDS Service Organisations) which promotes at an international level the voluntary work of non-governmental organisations which offer service in the field of AIDS. It has a simple structure and is present in the five continents of the world.

The International Conference of the AIDS/NGOs (Paris, 1-4 November 1990)

From 1-4 December 1990 the 'Second International Conference of the Non-Governmental Organisations Offering Service in the Field of AIDS' (AIDS/NGOs) was held and its subject was 'Policies of Solidarity'. 1,200 people from 80 countries of the world took part, of whom a significant number were seropositive or afflicted by AIDS.

The work group 'Religion and AIDS' drew up a resolution which was presented to the final assembly and fully approved by the participants. This resolution wanted to be a cry of alarm on the part of the various religions and religious denominations of the world:

'The participants at the Second International Conference of Non-Governmental Organisations Offering Service in the Field of AIDS (AIDS/NGO) on the Subject of 'Policies of Solidarity' – believers, Christians of various Churches, and atheists – inform the members of these Churches and their authorities:

1. That the people who live with the AIDS virus increasingly hope that believers will help them in their search to give meaning to their lives and in spiritual accompanying.

2. That although they receive this help they often meet with incomprehension, distrust and rejection on the part of these Churches.

We maintain that AIDS is

neither a punishment nor a gift of God, but an illness which involves:

– the possibility of living positively in a world struck by the AIDS virus;

– the possibility of sharing resources in a society which is fundamentally unequal;

– a challenge for the truth and the spirit;

– a challenge for the Churches'.

ICAN: The International Christian AIDS Network

The ICAM (the International Christian AIDS Network) is at the present time based in Amsterdam and works within a Christian and ecumenical framework. Non-governmental organisations of different countries of the world which work in the field of AIDS and have the Gospel message as their point of reference belong to it.

3. The Nature and Objectives of the Foundation 'Dimensiò Sida'

Having the approach and the freedom of an AIDS/NGO and a member of ICAN, the Foundation 'Dimensiò Sida' of Barcelona will now present to this conference held in the Vatican its paper on 'experiences and prospects in the prevention of HIV/AIDS: education in values'.

Nature

The Foundation 'Dimensiò Sida' was established in Barcelona on 7 March 1995. This is a private and civil (non-ecclesiastical) foundation rooted in Christian principles which works within an inter-denominational framework.

Objectives

The objectives of the Foundation 'Dimensiò Sida' are as follows:

1. To stimulate the inner and spiritual dimension of people who live with the AIDS virus, with full respect for their own special path in life.

2. To foster the sensitivity and work of the different Churches and religious denominations with regard to:

– welcoming people who are afflicted;

– the spiritual accompanying of people afflicted by the virus and their relatives and dear ones, if they ask for such accompanying or need it;

– solidarity and living together between people who have made different life choices;

– the prevention of the infection.

3. The gathering together and publication of information and documentation, in particular on the subject of spirituality and AIDS, which can help individuals, groups, Churches, and religious denominations.

4. The promotion of other useful activities, above all with young people, and cooperation with public authorities and non-governmental organisations (NGOs).

4. The Values and Activities of the Foundation 'Dimensiò Sida'

Some of the present-day members of the Foundation 'Dimensiò Sida' have worked within various organisations and initiatives connected with HIV-AIDS ever since 1985. The Foundation 'Dimensiò Sida' was created in 1995 to bring together the efforts to uphold certain values which we believe to be of fundamental importance. We will outline here the values which guide us and the principal forms of activity by which we seek to foster them and defend them.

Value 1: Courage

The pandemic of HIV-AIDS calls on everybody – and also the Catholic Church and other religious denominations – to have the COURAGE to see the reality before us in all its various aspects and features.

Speaking about AIDS in our Churches

The wording on a manifesto on 'Christians and AIDS' from France declares as follows: 'AIDS, we can also speak about it in our churches' No aspects or feature of this whole question must be extraneous to the Church.

Value Activities 1

The Foundation 'Dimensiò Sida' wants to deal with the three faces of the HIV-AIDS epidemic with different forms of activity. Some of these require great COURAGE on our part. We here outline the two most important forms of such activity in terms of their impact on the public:

1) The Publication of 'The Church in Catalonia and AIDS' (1997)

The drawing up and publication in Catalan of the book 'L'Església de Catalunya i la Sida: Esperiènces, Reflexions i Propostes' ('The Church of Catalonia and AIDS: Experiences, Reflections, and Proposals'). The book is divided into three major parts:

– A REALITY of our time

– Some PEOPLE who discuss, act and live

– Some SERVICES of care, accompanying and consciousness raising

2) The Report which was Presented and Discussed in the Vatican (1998)

The drawing up and the publication of the report presented at the meeting of the AIDS Group of the Vatican (18-19 December 1998) on behalf of the Spanish Episco-

pal Conference. This report bears the title: 'the pastoral action of the Catholic Church in Spain and HIV-AIDS'.

The report deals with:

– Epidemiological and health care questions

– Psychological and social questions

– Pastoral questions and the pastoral action of the Church

– The Foundation 'Dimensiò Sida'

– And has enclosed and appended documents.

The Secretary of the Spanish Episcopal Conference, Mons. Asenjo, sent a copy of this report to all the bishops of Spain. Subseqently, the same episcopal conference asked us to send a copy of the report to the delegates for the health care ministry in every diocese of the country. The Foundation 'Dimensiò Sida' did this with great pleasure and employed notable economic means to do so.

Value 2:
LISTENING to Scientists and Professionals

Another value which we constantly encourage is that of LISTENING to those who are expert in matters connected with HIV-AIDS in the fields of epidemiology, medicine, psychology, sociology, human rights and so forth. We strive to be aware of the constant contributions made by scientists and professionals to the various aspects of this pandemic.

We are in permanent contact with the World Health Organisation (WHO) and with UNAIDS, as well as with national and international organisations.

The Activities of Value 2

We would like to draw attention to two principal forms of activity connected with this value:

1) 'AIDS: the Facts, the Hope'

Some members of our Foundation were the promoters in 1993 of the translation, publication, and distribution in Catalan and Spanish of the work of Prof. Luc Montagnier, the discoverer of the HIV virus at the Luis Pasteur Institute of Paris, published under the title 'AIDS: the Facts, the Hope'.

This work is divided into three parts:

– the AIDS virus and its tranmission

– Infection by HIV and its treatment

– Prevention.

2) The Publication and Distribution of Millions of Copies

The 'Caixa' Bank which has a very large number of branches in Catalonia and throughout Spain – and indeed abroad as a well – accepted our work and printed a million copies (500,000 in Catalan and 500,000 in Spanish). The publication was distributed free to the customers of the bank, to schools, and to youth organisations. The Foundation 'Dimensiò Sida', like many other NGOs/AIDS, uses this work in the conferences it holds for the purposes of instruction.

Listen!

Scientists and those who work in the field of research into, and the treatment and prevention of, HIV-AIDS have uttered a cry of alarm: 'Listen!'. This is directed towards citizens, associations, civil and religious institutions, and even the Church, on the basis of the facts provided by science and experience which call for a change in attitudes and forms of behaviour at risk. It is wise to pay attention to the new scientific results which are produced in this field without locking oneself away in beliefs and attitudes which are now obsolete.

Value 3:
Scientifically 'Healthy' Forms of BEHAVIOUR (Interdisciplinary Dialogue)

In many parts of the world many citizens and also many members of the Catholic Church and other Churches have borne, and are still bearing, great witness through the expression of solidarity and fraternity towards people who live with HIV-AIDS.

Centres for such sufferers which are run by members of male or female religious orders, priests, and members of the lay faithful exist everywhere.

Value 4:
DRAWING NEAR to those who Live with HIV-AIDS

In the gospels Jesus gives us the parable of the Good Samaritan (Lk 10:25-37), a model and example for the attitude and behaviour to be adopted towards every marginalised and in-need person. The first thing which must be done is to DRAW NEAR these people wherever they are to be found: 'But a certain Samaritan, who was on his travels, saw him and took pity at the sight; he went up to him and bound up his wounds, pouring oil and wine into them, and so mounted him upon his own beast and brought him to an innn, where he took care of him. And next day he took out two silver pieces, which he gave to the inn-keeper, and said, Take care of him, and on my way home I will give thee whatever else is owing to thee for thy pains'.

John Paul II and those Afflicted by HIV-AIDS

The Holy Father has supplied us with numerous examples of DRAWING NEAR to people who live with this illness. We remember his pastoral visit to the United States of America when he took a child who was ill with HIV-AIDS in his arms. Various male and female religious, priests, and members of the laity dedicate great energy to caring for and accompanying those who live with HIV-AIDS, and in particular those within society who are most in need. They are the authentic personification of the Good Samaritan.

In this drawing near the first thing to do is to bind up the wounds, the pain, the feelings and the wishes of the person we draw near to. We need above all else to see and to listen. The following words, spoken by a patient to his doctor, are valid for us as well:

The real words of a patient to his own doctor:

Doctor, please, listen to me
without judging me,
without evaluating me,
without labelling me.
Doctor, please, be good with me,
and be serene.
Doctor, please, in listening to me
do not allow my silence to frighten you
and be patient with me:
I will find the moment for my real words
when you speak about this body which I do not know well,
whose pains
often conceal great suffering.
Doctor, please, teach me to experience
and to take my steps in this fruitful journey
where you walk at my side,
where you teach me to accept myself.
I want to cure myself, or at least
to go beyond myself.

(Dr. Françoise Roday,
Docteur s'il vous plait, Ecoutez-moi! Pour une Médicine Rélationnelle,
Editions Jouvence, Geneva, 1992).

Activity Value 4

We describe here the four principal forms of activity of the Foundation 'Dimensiò Sida' connected with its drawing near to people who live with HIV-AIDS.

1) Personal Care and Accompanying

The Foundation 'Dimensiò Sida' looks after and accompanies various people afflicted by HIV-AIDS, as well as their family relatives and friends when these ask for such an approach. Some of these sick people are still alive, but other have since died. Their psychological needs and their spiritual and religious worries are the objects of special attention.

2) Publications on People who have Died from AIDS

In order to describe our work of accompanying we would like to mention two publications on people who have died of AIDS. We contributed to the production of both publications because we had accompanied the people in question during their personal journey:

– Joseph M. Mercader, *Secret Search*

– Joan Ferrer i Sisquella, *AIDS, a Stimulus to Life?*

3) The 'Proyectos de los Nombres' Memorial

We also work with the association 'Proyecto de los Nombres' which wants to keep alive the memory of those who have died because of this illness.

4) Guide for the Pastoral Accompanying of People who Live with HIV-AIDS

The World Council of Churches (Geneva) has published in French and English a 'Guide for the Pastoral Accompanying of People who Live with HIV-AIDS'. Our Foundation has translated this work into Spanish and Catalan under the following two titles:

– *Guia per l'Accompanyament Pastoral de Persones gue Viuen amb VIH/Sida* (Editorial Claret, Barcelona, 1996).

– *Guia para el Acompanamiento Pastoral de Personas que Viven con el VIH/Sida* (Gayata Ediciones, Rubì, Barcelona, 1997).

Value 5:
Human Rights
(Justice and Solidarity)

We often observe a lack and even a violation of human rights in the treatment of people who live with HIV-AIDS. We should be very careful and concerned about the forms of discrimination which these people have to endure and we should seek to defend their rights.

Activities Value 5

We would like to draw attention to our publication on 'Human Rights and HIV-AIDS'.

The Publication 'Human Rights and HIV-AIDS'

To mark the celebration on 10 December 1998 of the fiftieth anniversary of the Universal Declaration of Human Rights (Geneva, 10 December 1948) the Foundation 'Dimensiò Sida' published its work book n. 4 (157 pages) which bore the title 'Human Rights and HIV-AIDS'.

The organisation of the documents for this publication was the work of David Xancho, the co-ordinator of our Foundation. The publication is made up of three parts and has accompanying enclosures.

The three parts are:

– General documents on human rights

– Specific documents on HIV-AIDS and human rights

– The resolution of the Catalonian Parliament on the protection of personal privacy and secrecy with regard to the results of diagnostic tests for AIDS.

The accompanying enclosures are:

– Documents by the United Nations on the history of the defence of human rights in the field of HIV-AIDS (New York and Geneva, 1998).

– The message of John Paul II to commemorate the fiftieth anniversary of the Universal Declaration of Human Rights by the United Nations Organisation (*L'Osservatore Romano*, n. 51, 18 December 1998).

– The Foundation 'Dimensiò Sida'.

Value 6:
Religious Reflection:
'HIV-AIDS -
a Sign of the Times'

Our Foundation stresses the need for greater religious reflection on the question of HIV-AIDS by all those who make up the Church, in terms of its being the 'people of God'. The pandemic of HIV-AIDS is an authentic 'sign of the contemporary times'. God is speaking to us through this harsh and universal reality. He invites us to engage in solidarity towards those who are afflicted by it and in the prevention of the infection so as to prevent its diffusion. For this reason we collect documents produced by the ecclesiatical hierarchy, and at times the

thoughts and criticism produced by those who live with this affliction.

Activities Value 6

We would like to record three publications produced by our Foundation:

1) John Paul II and AIDS (1987-1997)

This contains seventeen speeches and writings by John Paul II on AIDS from 1987 to 1997: two in the United States of America, seven in the Vatican, and eight in Africa (Burundi, Madagascar, Malawi, Rwanda, Tanzania and Uganda). The introduction to the dossier is the work of a person who contracted the disease in 1989 and bears the dedication: 'to my brother John Paul II from the experience of HIV-AIDS'.

2) Declaration of the World Council of Churches (Geneva, 1998)

Our Foundation translated into Spanish and published the 'Declaration of the World Council of Churches', based in Geneva, of 1998.

3) Bishops and Episcopal Conferences in the World and AIDS (1986-1999)

We have also collected and published forty-nine documents on AIDS produced by bishops and episcopal conferences of twenty countries from the five continents of the world. Some documents have been published in only one language and others in two or three. The total number of documents which have been collected, including those published in different languages, amounts to seventy-six.

It should be observed that we have transcribed all the documents that we have been able to find in journals, libraries and elsewhere. We have not selected or rejected any documents bearing on AIDS which have been issued by bishops or episcopal conferences of the world that have come into our possession. Our work has needed honesty and respect for 'episcopal collegiality' and all its various manifestations. We have worked with the freedom which is required in the search for existing material and which characterises the approach and the activity of the Foundation 'Dimensiò Sida', which is 'private and civil' in character.

The document which achieved the greatest resonance at the level of the international press was that issued by the French bishops (cf *Le Monde*, 13 February 1996).

Value 7:
Inter-religious Prayer

The Foundation 'Dimensiò Sida' believes deeply in the value of both shared and individual prayer. Jesus told us: 'Ask, and the gift will come; seek, and you shall find; knock and the door shall be opened to you' (Mt 7:7-8). 'And moreover I tell you, that if two of you are agree over any request that you make on earth, it will be granted them by my Father who is in heaven. When two or three are gathered together in my name, I am there in the midst of them' (Mt 18:19-20).

Activities Value 7

We would like to point out two forms of activity involving shared prayer in out Foundation:

1) Monthly Prayer Meetings

Every second Thursday of the month we hold a prayer meeting for people who live with HIV-AIDS, for those who are dead and their friends and family relatives. We also pray that all members of society will demonstrate a greater capacity for non-discrimination, respect for human rights, and fraternal solidarity.

These monthly encounters take place in the crypt of the Basilica of Santa Maria del Pi in Barcelona at 20.30 and last for half an hour. From November 1995 until today (December 1999) we have organised forty-five such meetings. Usually from thirty to forty people take part.

2) Annual Inter-religious Prayer Meeting on AIDS

On every World Day of AIDS (1 December) since 1996 we have organised an inter-religious prayer meeting on AIDS at which representatives of various Churches and religious denominations have taken part.

Because of AIDS many people end up on their own, but this malady unites together Anglicans, Buddhists, Catholics, Jews, Muslims, members of the Orthodox Churches, Protestants, and people of every creed and persuasion.

In 1999 we celebrated the fourth of these prayer meetings and over a thousand people took part.

Value 8:
Spiritual COMMUNICATION and AIDS (Web Page)

The Foundation 'Dimensiò Sida' has become specialised in the inner and spiritual accompanying of people who live with HIV-AIDS and in the raising of the awareness and sensitivity of the spiritual and religious forces with regard to this pandemic. For this reason, the Foundation has sought to make known, and make available to all those who ask for it, the existing material on 'spirituality and AIDS'. This material requires communication and interaction.

Activities Value 8

We would like to point out two principal forms of activity in this area:

1) The 'Spirituality and AIDS' Centre for Documentation and Publications

In appendix 1 we include the publications of our Foundation, which belong to the following five areas:

1) Books.

2) The document 'The Church and AIDS'.

3) Work books.

4) The 'Spirituality and AIDS' series.

5) Memorials of the Foundation and Projects of Primary Importance.

2) The 'Spirituality and AIDS' Web Page

Our Foundation seeks to help the users of our web page and electronic mail in the following ways:

– by gaining access to the documents and publications of the Foundation;

– by knowing about the Foundation:

– by reflecting on the material which exists and is available;

– by communicating with the Foundation and other users;
– by getting into contact with other institutions and web pages concerned with the subject of 'spirituality and AIDS'.

4. Summary and Conclusion

To summarise this paper we would like to express the values and the areas of practical action of the Foundation 'Dimensiò Sida'.

Summary of Values:

Value 1: COURAGE in the face of the HIV-AIDS pandemic

Value 2: LISTENING to scientists and professionals

Value 3: BEHAVIOUR which is scientifically 'healthy' (interdisciplinary dialogue)

Value 4: DRAWING NEAR to those who live with HIV-AIDS

Value 5: HUMAN RIGHTS (justice and solidarity)

Value 6: RELIGIOUS REFLECTION 'HIV-AIDS – a sign of the times'

Value 7: INTER-RELIGIOUS PRAYER

Value 8: COMMUNICATION 'spirituality and AIDS' (web page)

Areas of Practical Action of the Foundation 'Dimensiò Sida'

The chief fields of practical action of the Foundation 'Dimensiò Sida' are:

1) Pastoral care for, and the accompanying of, people who live with HIV-AIDS.

2) The raising of the awareness and sensitivity of Churches and religious denominations.

3) Shared and inter-religious prayer.

4) Publications.

5) The documentation centre (web page 'spirituality and AIDS').

Conclusion

We would like to finish this paper by quoting the German manifesto of the congress on AIDS which took place in Hamburg in 1992: 'if we do not communicate, AIDS will win'. This means that if we close our senses and our minds to the complex reality of AIDS and its various aspects and features, if we do not communicate with people afflicted by HIV-AIDS and with their environments, if we do not dialogue with scientists and professionals about the various forms of prevention and care, then *AIDS will defeat us*.

Dr. ANTONI MIRABET
President of the Foundation 'Dimensiò Sida'
Spain

IV: Aids and Caritatis Internationalis

HIV has been a reality in all our lives for well over a decade. Now the arrival of combination therapy, despite its limitations, has fundamentally changed our perception of the impact of the virus. Biomedical technology is moving at such a pace that HIV is increasingly being managed as a chronic infection in the North. We have reason to hope where once we had little reason for hope.

However, the widespread provision of combination therapy in the North highlights in a very vivid way the vast chasm between what is available here and what is available in the South. The most recent statistics available from UNAIDS (Dec. 1998) show that over 47.3 million people have been infected with HIV since the start of the epidemic and 14 million adults have died from HIV related disease.

Many people question why there is such a focus on HIV-AIDS when so many people die from treatable conditions like malaria. Last year the WHO estimated that 2 million people lost their lives to malaria. Death from AIDS last year amounted to million 2.5 million. So for the first time, AIDS-related deaths have surpassed those from malaria.

A glance at a map of the worldwide picture of HIV as it was in December 1997, shows the stark reality that the pandemic is concentrated in countries of the South.

Reduction in life expectancies for adults is becoming a stark feature in a number of African countries, reversing the health and economic gains of recent decades. This is just one more indicator of the devastating effect of the pandemic, especially on countries of the South.

With every passing hour the majority of people living with the virus, who are to be found in the South, receive proportionally less and less of the worlds resources spent on HIV-AIDS. UNAIDS estimates that less than 10% of expenditure on HIV-AIDS is spent on the 95% of the global population of people living with HIV in the South.

In places like Zambia, Malawi, Tanzani and Zimbabwe, the national governments are not able to ensure that people living with HIV and AIDS get even the most basic drugs such as anti-bacterials, anti-fungals, anti-diarrhoeals and

pain killers. TB incidence has risen exponentially in areas where HIV prevalence is high and national TB programmes are either struggling to control it or are often miserably failing to diagnose and treat those infected with it. NGOs are increasingly being asked to back up and support previously functioning health care systems. TB is a treatable infection yet it accounts for 3 million deaths in the world each year. 30 to 40% of people dying from TB will be co-infected with HIV. People are dying every minute of the day somewhere in the developing world from infections and conditions that could be so easily treated with medication that costs less than the price of a daily newspaper. This is a scandal.

The impact on local communities is enormous. Parents are dying prematurely leaving orphaned children destitute. Just over 95% of the children orphaned by AIDS are living in Africa.

During recent field visits by CAFOD staff to Eastern and Southern Africa, the problem of the increasing number of orphans was the number one concern expressed by local partners. Traditional family and community structures are no longer able to respond adequately and are desperately crying out for assistance. In Zambia, less than 50% of children are attending any sort of schooling. The long-term impact of this on Zambia is frightening.

Another area of widening inequality is that for the past six or seven years effective therapies to prevent mother-to-child transmission have almost eliminated the risk of a baby being born with HIV in the North. In the South approximately four babies out of ten born to HIV-infected mothers will be born with HIV. The problem of lack of access to appropriate treatment and interventions has led some public health officials in Zimbabwe, and elsewhere, to question whether they should even prescribe this intervention because the babies will inevitably be orphaned as the mother will not have any long-

term access to treatment for herself. This is a harsh example that demonstrates the cruel and unjust inequality between North and South and the ethical issues raised by such inequalities.

It is not just in the area of treatment and resources that there is such disparity between North and South. According to UNAIDS's estimations only one out of every ten persons infected with the virus knows that they are infected. Access to voluntary counselling and testing is woefully inadequate across the world. Many argue that it is not advisable to offer testing where treatment and care of those found positive is not assured. In many respects those who argue this are right. However, many people who suspect they are infected want to know their status and are denied that right because voluntary counselling and testing are not available locally.

HIV thrives in conditions of poverty. Fikansa Chanda, of the Ndola Diocese AIDS Programme in Zambia, when asked about access to combination therapy in a recent British television news item, remarked that for the majority of people in the Copperbelt region of Zambia, getting enough food to eat was their main concern. I quote "What is the point of giving people sophisticated drugs when they will die from hunger anyway".

In a community wealth-ranking exercise in rural Uganda, Seeley *et al* (Medical Anthropology Quarterly 1994, 8(1): 78-89) concluded that among both men and women, the poorer the household, the more likely it is that the head of the household is HIV-1 positive ($0.02<p<0.002$). As AIDS depletes these societies, agricultural output reduces as a result of illness, deaths and time spent in funerals.

We know that many young women find that the only way they are able to feed their families is by the sale of their body. Realistic and meaningful risk reduction strategies have to be put in the context of the wider reality of economic and structural barriers to development. Let me tell you Margaret's story.

Margaret is nine years old and lives in Kitovu, in rural Uganda. Margaret's mother kept the family fed and alive by trading sex for food, school fees or clothes for her children. No one, including Margaret, considered her to be a sex worker. Margaret and her mother and the community knew that this was how she ensured the survival of her family. Margaret's mother died of AIDS. So too have various aunts and uncles. Margaret is one of 13 grandchildren cared for by her grandmother. Margaret is also infected with HIV. Unaccompanied, she sits in line in the hospital clinic for people with HIV, the only child queuing among hundreds of adults. When it is eventually her turn she approaches the counsellor clutching her medical records. She tells the counsellor she has been sick on and off in recent months, but she is well at present. When asked why she hasn't been at the clinic for a long time she replies that her grandmother didn't have the money to pay the (tiny) fee the hospital has recently introduced. (Word had also got around that the clinic had free food supplies this month, an added incentive to attend!).

Caritas Internationalis is concerned that as Church communities focus on individual responsibility we need also to raise our voices against the injustice of structural and corporate sin as perpetuated by IMF/World Bank Structural Adjustment Programmes and highlight how these directly affect the poor.

An Uncertain Future?

The inequalities highlighted by HIV-AIDS paint a picture of huge uncertainties for the future.

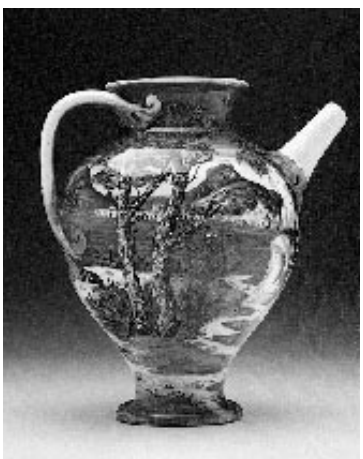
What future can the people of the South look to with regard to treatments and vaccines? The combination therapies that give the impression in the North that HIV is just a chronic but manageable infection are beyond the wildest dreams of the people of the South. Sporadic and unmonitored use of these therapies in the context of an inadequate health infrastructure, as and when funds permit, conjures up a potential nightmare scenario of drug-resistant HIV becoming the prevalent viral strain across vast stretches of Africa and South Asia. It is worth noting that recent UK media coverage of the whole issue of access to treatment focussed on the risk to the North from drug-resistant HIV coming from the South. In fact, we know that this is already a major problem in the US and Europe with evidence of resistant strains of HIV to anti-retroviral therapy detected in a significant number of those on treatment.

In any case, how can people aspire to accessing anti-retrovirals when the medicine cupboards are empty of basic and cheap painkillers or antibiotics? Dr Kevin de Koch, formerly of the London School of Hygiene and Tropical Medicine, observed in his paper to the AIDS in Africa Conference held in Kampala in 1995: "We already have effective, affordable treatments for TB yet the incidence of TB, particularly in countries of the South, is higher than ever and rising constantly. If we can't get this right how can we ever hope to tackle HIV effectively?".

A huge area of uncertainty is that of vaccine development. Although current attempts to prevent HIV have shown small signs of success in a few countries of the South scientists agree that the best long-term hope to end the epidemic is to develop a vaccine. However, because of the technical difficulties inherent in attempts to develop any vaccine, success in this area is very much a matter of "hit and miss". Pharmaceutical companies and research institutions have been dragging their heels in developing an HIV vaccine focusing instead on the more profit-oriented treatments that have made such an impact on the course of infection for thousands in countries of the North.

By contrast there seems to be a reluctance to put money into difficult research that promises little financial return. Countries most in need of a vaccine are those where companies are least likely to make a profit. Vaccine development is also fraught with ethical challenges. In our rights-conscious North any research is subject to rigorous ethical guidelines which may not always be applied so scrupulously when trials are re-located to the South. Indeed some of the early work in the South by vaccine researchers from the North raised important ethical concerns regarding who were the beneficiaries of their research.

More encouraging is the news earlier this year that the International AIDS Vaccine Initiative (IAVI) is investing $9.1 million in two international vaccine research partnerships. The first involves researchers at Oxford University and the University of Nairobi, Kenya and the second is between the University of Cape Town and AlphaVax Corporation of North Carolina. The resulting vaccines will be derived from strains of HIV circulating in Kenya and South Africa and both initiatives contain organisational and intellectual property provisions to ensure the fruits of the research are made readily available in the countries most severely affected by HIV.



The statistics of HIV-AIDS add to the uncertainty for the future. The sheer enormity of the epidemic and its impact on Africa leads many to wring their hands in despair, protesting that the problem is just too big to know where to begin. Others will dismiss it as being "Africa's problem (yet again), and nothing to do with us." Most of the countries of Africa envisage a future where, because of AIDS, they will be written-off as "no-hopers" by those who control the purse strings in the North.

Uncertain too is the effectiveness of the international community's response to HIV in countries of the South. International NGOs, Northern governments, UN bodies and church bodies are still all too often implementing programmes with little or no participation or consultative discussion with the local communities. The involvement of people living with the virus is often overlooked, particularly in the design and visioning of programme activities. HIV-AIDS continually challenges all of us to question the authenticity of the language of partnership in our development work.

We pride ourselves at the end of this millennium on the huge strides forward that have been taken in recognising everyone's basic human rights. In many respects the AIDS pandemic has sharpened our awareness of many abuses inherent in our societies and has increased efforts to fight discrimination based on gender, sexual orientation or health status. However, in many countries North and South, the prejudice provoked by HIV or just the sheer pragmatic interest in cost effectiveness have led to heightened discrimination against those infected or affected by HIV and the withdrawal of their basic human rights to housing,

education and employment.

Mandatory HIV testing, too often used as a filter in employment, insurance, student selection (in church and state institutions) and immigration screening, is gaining acceptance in some quarters as a pre-marriage requisite. Increasingly in parts of Africa, for example, in Tanzania, and Malawi churches are commending mandatory testing as a requirement for those wishing to marry and are refusing marriage to those found HIV positive. They hold that such actions are justified by the magnitude of the epidemic afflicting their country or diocese, and they see their action as a necessary HIV prevention measure. Offering *voluntary* HIV testing and counselling that is confidential and as part of a wider preparatory process for couples deciding to marry is indeed commendable. However the most likely consequence of *mandatory* testing is to drive the "problem" underground. It is also a violation of one of the recognised basic human rights, the right to marry.

We have seen the huge social and economic consequences for communities and countries with high levels of HIV infection. The loss of a skilled workforce is already impacting negatively on the productivity of countries of East and Southern Africa. In the commercial and service sectors absenteeism due to illness and family bereavements is reaching unmanageable proportions. In some instances, employers are limiting staff to two or three funerals per week, or to the funerals of spouses, parents or children only. In the agricultural sector, fields lie uncultivated as people become too sick to tend their crops. AIDS must increasingly be recognised as a factor, along with the ravages of war and of natural disasters, intensifying the hunger of millions in Africa. Agricultural neglect has its long-term consequences for the environment too as uncultivated areas return to vast dusty wastelands and soil erosion follows the failure to re-plant forests. What then will be the shape

of Africa in this Third millennium?

Mention of war and natural disasters reminds us that in all continents it is no mere coincidence that areas of major conflict concur with high incidence of HIV-AIDS. The mass displacement of peoples, breakdown of basic services and infrastructures, and movements of indigenous and international military forces all heighten people's vulnerability to HIV. For example, UNAIDS-WHO surveillance statistics show that in Rwanda, Liberia, Mozambique and Sierra Leone there was a striking increase in HIV incidence in the period following their respective "emergencies". While the truth of these situations is more complex than depicted here, these statistics are indicative of a link between emergencies and HIV incidence. UNAIDS data for Cambodia shows an increase in HIV incidence among sex workers in Phnom Penh from 10% in 1992 to over 40% in 1996. It is widely believed that the presence in Cambodia of the UN peace-keeping force is one of the factors contributing to such a sharp increase.

Behaviour Change
Hope for the Future?

Leading on from Margaret's story we need to understand the reasons why Margaret's mother behaved the way she did if we are going to be able to offer her daughter and other women realistic help. The Medical Missionary of Mary congregation has been running a "Home-Based Care Programme" from their hospital, St Joseph's, Kitovu, since 1987. As a result of their experience they developed a programme of behaviour change called *Education for Life*. The sisters had witnessed the deaths of hundreds of people in the surrounding villages, had cared for large numbers of them up to their death, and had then continued to work with the communities to provide care for their orphaned children. In time many of these children, now adolescents, became infected with HIV. This was heart-breaking for the sisters, the siblings of these young adults, who depended on them, and of course a tragedy for the young person. Despite years of good education and awareness-raising on HIV the young people were becoming infected. The sisters realised that unless deeper issues were addressed more young people would continue to be infected and die.

Behaviour change is concerned with three major and complimentary considerations:

Behaviour change is concerned with enabling attitudes and practices that minimise people's vulnerability to infection with HIV. This requires that individuals and communities are empowered to make choices that, in their specific circumstances, will reduce the risk to them of HIV infection. Such a focus emphasises the responsibility of Church programmes to provide, within a wider holistic framework, accurate and comprehensive medical information that might reduce an individual's risk of HIV.

Behaviour change also involves a process whereby attitudes and practices of prejudice, discrimination, hostility and violation of the human rights of those affected by HIV-AIDS, are reduced or eliminated. This process of change can happen at the level of individuals and communities, as well as within the practices enshrined in cultural or religious norms and in national and international legislation.

In addition HIV prevention programmes that do not take account of economic deprivation, gender inequity, and societal pressures will not succccd in slowing the spread of HIV. It is clear from Margaret's story that poverty is a root cause of the spread of HIV, particularly for women and girls.

As a result of a Review[1] carried out CAFOD in 1998 the following recommendations emerged.

Felt Needs. It is essential to make these the starting point of any work; hence the importance of spending time exploring and acknowledging a community's felt needs and locating a programme within this framework. When partners in Zimbabwe were questioned about why HIV-AIDS as an issue did not feature in their diagnosis of community problems they replied that there is no point in talking about HIV-AIDS when the community's main concern is that the elephants are trampling their crops!

Their programme not ours. Starting from the community's felt needs and ensuring all sectors of a community are active players in every stage are key elements in strengthening a sense of community ownership and relevance and in minimising the dangers of dependency.

Holistic approach. This stresses the importance for the funding agency, and its partners, of recognising the complexity of issues involved in any HIV programme work/approaches to behaviour change.

Gender analysis. Any work on behaviour change needs to examine the roles of women and men, the relationships between them and the factors that determine the power/powerlessness of each.

Needs of PLWHAs. The varied needs of people living with HIV and with AIDS need to be acknowledged and addressed. They have care needs, but they also have needs for income generating activities, for developing their own sexual health risk reduction strategies, for confidential and supportive advice, and so on. Organisations also need to ensure that people with HIV-AIDS are active players in planning and implementing programmes and in decision-making processes or fora.

Clarity of agenda/philosophy. It is essential to clearly define what agenda and philosophy are informing programmes addressing behaviour change.

Peer groups/age- and gender-specific groups. The Review stresses the importance of working with separate peer groups, based on gender and age, and at times on other locally relevant criteria (e.g. HIV status, socio-economic wellbeing, religious group, employee's position within an organisation etc). Integral to the success of such an approach is the step of also bringing the separate peer groups together regularly to enable intra-communal learning and sharing to take place. This also ensures that activities developed with a specific group are endorsed by the wider community.

Balance between practical and strategic needs. In as far as is possible, it is important to ensure that a community's strategic needs are accounted for even as the more immediate practical needs are being addressed. Working at strategic needs in a holistic fashion requires organisations to incorporate a gender analysis and to question traditional, religious, social and cultural factors that define women's and men's roles within communities and thus determine their behaviour and their relationships with each other.

Monitoring and evaluation. Funding agencies and partners need to introduce and further develop locally meaningful and useable systems for defining goals and monitoring progress, which can be adopted by community members themselves. This is based on the assumption that if people are interested in and able to chart their own progress they are more likely to feel involved in the programme, which will in turn make it more likely that programme goals are achieved.

Gender violence. Gender-based domestic violence is widespread in communities. This includes sexual violence, physical violence and psychological abuse. The Review highlighted the connections with vulnerability to HIV and the need for all programmes to address this issue as a central part of their work.

Young men: self-esteem, a future. Young men are particularly uncertain about their own roles with the new found self-sufficiency and economic independence of some young women. Young men need to be supported in their own definitions of future employment and relationships in order that they may find meaningful and valued new roles for themselves in society. Programmes need to identify and develop ways of reaching young men "where they're at".

Burden of Home Based Care and Orphan Care programmes. The huge burdens that these programmes impose on women need to be acknowledged and addressed. Communities need to be engaged in developing ways of reducing this burden. These will need to involve men, particularly young men, in direct or indirect care work. It will be necessary to develop methodological approaches that will enable these strategic changes to traditional gender roles to take place.

Sustainability and ownership. These two issues need to be expressed more explicitly in programme work. Currently many programmes are considered to belong to the partner organisations, both by partners themselves and by the com-

munities with whom they work. This has led to many communities developing an unhealthy welfare dependency on the project implementers or the funding agency. For their part, organisations risk imposing a programme that is unrelated to communities' needs.

The extreme stress that HIV is bringing to these communities means that programme sustainability is not likely in the short term. However, in terms of sound development practice, it is an element that, at least, needs to be considered. Although Church programmes expect to be working with (and from within) a community for good, endeavouring to ensure sustainability is key to a programme's longer-term effectiveness. The concept of sustainability in the African context is complex and fraught with difficulties.

Rural/urban. HIV is increasingly having a devastating effect on rural as well as urban communities. Organisations need constantly to review their programmes to examine whether these are focused exclusively on more urbanised areas or solely in rural areas with greater infrastructure (e.g. parts nearest a hospital etc).

Community-based but with wider links. Agencies and their partners need to sustain and develop an approach that combines their community-based focus and liaison with NGOs, other Church groups and local government. This approach is important in ensuring local community needs are addressed and in facilitating the mutual learning and sharing of experiences. It is also important in terms of programme ownership and sustainability.

Conclusion

As we approach the 21st century we are faced with an increasing number of countries and continental regions where conflict and extreme political unrest are the norm. What then can we anticipate for communities also hugely affected by HIV-AIDS in these circumstances?

In a country of Southern Africa a workshop participant described a not untypical scenario where the husband frequently beat and raped his wife when he returned from the bar at night. When she finally appealed to the local priest to intervene in her unbearable situation she was told to go home and bear her suffering bravely.

In a country of East Africa all the local priests refused to visit a woman who was sick with AIDS because she had been a sex worker. When he heard about this the bishop himself visited her regularly until her death. When she died, the bishop celebrated her funeral Mass, a solemn requiem Mass, in the cathedral.

In a country of Asia a priest who was found to be HIV positive was withdrawn first from his parish and then from all diocesan activity and sent to a retreat centre hundreds of miles away, with no further contact from his diocese.

At a conference in July in southern Africa a bishop, when asked how he would advise a woman whose husband was HIV positive replied that she should sacrifice her life for the sake of her marriage. The sign of courage came from other women participants who walked out in protest.

In countries of the South women are the most vulnerable sexually. Indeed most of the women worldwide who are living with HIV have been infected by the person they considered to be their single, life-long partner – their husband. The gender imbalances underpinning so many cultures and societies leave women powerless and dependent on men in the domestic, social and economic spheres.

Recent HIV statistics give us some small grounds for hope. Reports from Uganda, Thailand and latterly, Zambia, suggest that in some parts of these countries the number of young people newly infected with HIV is decreasing. This is attributed to the concerted efforts of government and community initiatives to educate people about HIV-AIDS. It is early days yet and perhaps premature to read too much into these results. But still we dare to hope.

Along with the statistical evidence, we see signs of life-enhancing shifts in cultures and traditions. Discrimination resulting from fear and ignorance is gradually giving way to understanding and acceptance in many communities. Traditional practices (e.g. wife inheritance, dry sex, ritual scarification and circumcision using unsterilised instruments etc) that heightened individuals' HIV risks from sex or blood are being replaced in many places by alternative rituals or safer skin-piercing practices. This too makes us dare to hope.

In Caritas work with our many HIV-related programme partners we are constantly helped and strengthened by the witness of the hundreds of volunteers mobilised by various home care, orphan support, education and counselling programmes. The following reflection by Rev Jon Sobrino SJ, written with regard to the political situation in El Salvador, best expresses how, when confronted by such powerful witness in the face of the pain and injustices of HIV, we too can find hope.

"It is not easy to know how to keep on hoping
And we must all answer this in our own way.
It seems that everything is against hope.
But for me at least,
Where I see that there has been great love
I see great hope being born again.

This is not a rational conclusion and perhaps not even theological.

It is simply true. Love produces hope

And great love produces great hope".

Jon Sobrino, El Salvador

These volunteers give selflessly of their time and resources, not from the luxury of their store of leisure time (usually non-existent) but from precious time that would otherwise be invested in tending their own families or providing them with much needed food or income. They themselves are often affected or infected with HIV and yet they push on tirelessly so that they and those they serve might bear witness to life and not death. They are our strength and inspiration. They beget new hope born out of their great love, and so we dare to hope.

In the Church too we see signs of hope. Increasingly we find communities willing to embrace the Gospel message of justice and acceptance preached by those living with HIV or AIDS. We glimpse instances where those marginalised because of sexual behaviour or orientation lead us to recognise them anew as sisters and brothers of the same Christ. We see cracks slowly appear in our masks of self righteousness as the words of today's lepers-turned-prophets hit home. We finally begin to admit that the Church, Christ's body, has AIDS. We see signs too, at a pastoral level, that seemingly insuperable differences between and within Churches, and between people of different faiths, are being overcome in efforts to respond to the HIV pandemic.

A key member of the Khartoum Archdiocesan HlV education and health care programme is a Muslim doctor.

In Ethiopia religious leaders more inclined to score points off each other put aside their differences to attend a CAFOD-hosted conference on HIV-AIDS.

A diocesan programme in Dar es Salaam, that provides voluntary HIV testing, counselling and support, and home-based care, is staffed by Christians of different denominations and by Muslims, all of whom work and pray together happily and effectively.

In Botswana just recently a UNAIDS-sponsored workshop which CAFOD and the Salvation Army helped organise drew together Church andfaith leaders from different continents to consider the pastoral challenges posed for them by HIV-AIDS.

We draw hope too from CAFOD's experience as lead agency for Caritas Internationalis for the last 12 years. Over this time and despite the huge challenges and struggles, numerous church-based programmes have been set up, offering counselling and support for all affected by HIV, providing education, home care, orphan support, income generation projects and advocacy and lobbying groups for those suffering discrimination because of HIV. National and regional gatherings of bishops and other Church leaders willing to acknowledge that HIV-AIDS concerns them and their Churches have taken place. These Church leaders are willing to learn and to foster pastoral responses within their jurisdiction. We have seen an investment of huge resources by Caritas agencies in responding to the needs posed by HIV-AIDS worldwide.

Perhaps from a sense that the millennium jubilee is a time of reconciliation there are some indications that the Church and governments North and South are beginning to acknowledge past wrongs. Sometimes we hear articulated the sins of our greed and of the financial manipulation of South by North, the sins of corruption and misappropriation of resources by governments South and North.

A key aspect of biblical jubilee is cancellation of outstanding debts. At the "AIDS in Africa" Conference that took place in Lusaka last month, the Hon. Godfrey Simasiku, Zambia's Minister of finance, reiterated his country's proposal that at least part of Zambia's international debt burden be "exchanged" to make additional resources available for the country's response to HIV-AIDS. Rev. Peter Henriot SJ, from the Jesuit Centre for Theological Reflection, and the Jubilee 2000 Campaign based in Zambia, pointed out in his paper to the forum: "Your concerns about HIV-AIDS – about looking to the future – are integrally linked to what we in the debt campaign are about: the building of just, sustainable and people-centred development, as we enter the new millennium". Jonathan Simon of the Harvard Institute for International Development observed that even if the absolute amount of money released for social programmes by debt relief is modest it is likely to have a significant effect on HIV prevention efforts.

	Per capita spending on HIV prevention and care in 1996	Potential per capital saving from bilateral debt relief (as of 1997)
Zambia	$ 0.73	$ 10.73
Kenya	$ 0.76	$ 5.24
Nigeria	$ 0.03	$ 1.69
Uganda	$ 1.81	$ 3.66

Source: Paper by Jonathan Simon Harvard Institute for International Development, presented at 11th ICASA Conference, Lusaka, September 1999.

Uganda, whose national campaign against AIDS has succeeded in reducing the HIV prevalence rate among teenagers from nearly 28% in 1992 to just 10% in 1996, has not invested more in controlling the epidemic than could be released to most other Sub-Saharan countries through bilateral debt relief.

As we add our voices to the Jubilee 2000 Campaign calling for debt relief for the poorest countries (among which can be counted some of those hardest hit by the AIDS pandemic) we also dare to hope.

As Christians we are frequently confronted with the question where is God in all of this? I am reminded of a story that Rev. Enda McDonagh, the Irish moral theologian and consultant to the Caritas lnternationalis AIDS Task Force, tells when reflecting on this. Enda recalls an account of how, in a concentration camp in Nazi Germany three Jewish prisoners, two men and a boy, were to be executed by public hanging for some minor misdemeanour. All the other prisoners were marched out to watch the hanging. The two men died quickly but the boy, being lighter, had a slow and painful death and hung still struggling and choking as the prisoners were made to parade past him and return to their barracks. One of the prisoners angrily shouted out "where is your God now?" to which another solemnly replied "Our God is there, hanging on the gallows".

In this time of AIDS we must denounce those who claim the pandemic is the punishment of an angry God. They do not know the Jesus of the Gospels. Only in as much as we align ourselves with the God "hanging on the gallows", only in as much as we embrace and proclaim God present in those infected and affected by HIV, can we be bold enough to dare to hope.

Background information

Introduction

Caritas Internationalis (CI), the global confederation of Catholic Church-sponsored humanitarian assistance and development organisations first included HIV-AIDS activities among its programme priorities at its 1987 General Assembly. Since that time, the Confederation has mobilised a response to HIV-AIDS in keeping with its overall mission of *Animation, Co-ordination, and Representation* and has engaged in such activities as the following:

– Sponsored regional, national, and local consultations on HIV-AIDS to assist Church leaders as well as those engaged in the Church's educational, socio-pastoral, health care and spiritual services to attend to those affected by HIV-AIDS within their own respective apostolates;

– Raised funds to support national and local educational and service efforts;

– Organised theological consultations on HIV-AIDS in Africa, Asia, Europe, and North America;

– Served in a representation role at the United Nations and in other international fora;

– Formed an international Working Group on HIV-AIDS (between 1988-1995) and a Task Force on HIV-AIDS (1995-2003) to monitor the spread of the pandemic; to motivate the most comprehensive response possible by Caritas Internationalis member organisations and other Church-related organisations; and to share experience across the continents.

The present, and fourth, CI AIDS Task Force was reconstituted in July 1999 by the Secretary General of Cl to assist the Confederation in fulfilling the 1999-2003 Confederation Work Plan, which once again identifled HIV-AIDS as a priority theme for reflection and action. The Task Force is closely linked to the CI Liaison Agency for HIV-AIDS, CAFOD, and has been charged by the CI Secretary General to co-ordinate the Confederation's activities in this field. CAFOD, which is the Caritas member organisation for England and Wales, has served as the Caritas Liaison Agency for HIV-AIDS activities since 1987. Thus the Task Force provides to the Liaison Agency a reference point and forum in which to discuss and report on its coordination activities. The Director of the Liaison Agency CAFOD, Mr Julian Filochowski, and Rev. Robert Vitillo were re-appointed co-chairpersons of the Task Force following the CI general assembly in June this year.

The current Task Force has been given the following mandate:

To assist the Caritas Internationalis (CI) Confederation in maintaining priority attention to the HIV-AIDS pandemic within the activities of its member organisations and within other relevant organisations and structures of the Catholic Church.

Objectives

1) To share information within the Task Force and the Caritas Confederation on the status of the pandemic in relation to the medical, pastoral, spiritual, social and developmental issues raised.

2) To support theological reflection on the issues and problems raised as a result of the HIV-AIDS pandemic.

3) To encourage the Caritas Confederation to deepen or initiate action in response to people affected by HIV-AIDS in the local context.

4) To network on behalf or Caritas Internationalis with Catholic and other organisations, including UNAIDS, in order to ensure an adequate response to those affected by HIV-AIDS.

5) To build on the momentum of the CI/CISDE Confer-

ence on HIV and TB so as to ensure that the lessons learnt are disseminated and incorporated into the activities of the Confederation.

Since 1987 the CI Confederation has dedicated much energy and expertise to consciousness-raising among Church leaders and other Church workers. Some of the publications produced under the auspices of the Task Force are: The *Caritas Training Manual on the Pandemic of HIV-AIDS* (1994); *Proceedings of the CI/CISDE Workshop on Sustainable Health Care* (1995); *The Church Responds to HIV-AIDS* (1996); *AIDS, Emergenza Planetaria (AIDS: A Planetary Emergency)* (1997). In addition CAFOD has undertaken several participatory evaluations of Home-Base Care Programmes in Kenya, Uganda and Brazil. More recently CAFOD conducted a study on Behaviour Change entitled: *Safety Through the Night* (1998) in collaboration with partners in Malawi, Tanzania, Zimbabwe and Zambia and produced a report on access to treatment and care entitled: *Valuing Life* (1999) which is based on partners' experiences in Zambia.

CI has reached out to Church leaders and pastoral workers by means of sponsoring or participating in HIV-AIDS training workshops in many part of the world. In the workshops, members of CAFOD staff and of the CI Task Force on HIV-AIDS have served as presenters and facilitators. During the years 1995-1999, such programmes were made available in many parts of the world, including the following:

These workshops included:

1. Follow-up Consultation in the Asia/Pacific Region

With the help of the Caritas Internationalis Task Force on HIV-AIDS and CAFOD, representatives of 12 Asia/Pacific countries, as well as colleagues from Europe and North America, gathered to share experiences of Catholic Church-sponsored HIV-AIDS services from 2-6 February, 1998, in Manila, Philippines. The local host organisation was Caritas Manila.

2. Workshop on Sustainable Health Care

As a result of their engagement in HIV-AIDS education and services, the member organisations of Caritas Internationalis have witnessed the significant impact of HIV-AIDS on Church-sponsored health care services in countries of the South. It was noted that the lack of health care infrastructure in such countries was one of the root causes of the rapid spread of HIV-AIDS among the most poor and vulnerable populations. Thus the CI Task Force on HIV-AIDS joined with Caritas, CIDSE, and other international Catholic organisations to sponsor a Seminar on Sustainable Health Care in the Netherlands in October 1995.

3. Conference on Tubercolosis (TB) and HIV-AIDS

Tuberculosis has been declared a global health emergency by the World Health Organisation (WHO). In response to this dire situation, the CI Task Force on HIV-AIDS joined with other Church-related health and social service organisations to sponsor a Conference on Tuberculosis and HIV-AIDS in Würzburg, Germany, from 8-12 March 1999. The aim of the Conference was to bring about an improved response from CI/CIDSE organisations in relation to HIV and TB, to strengthen appropriate structures, to ensure that operations are more cost-effective, ethically appropriate, and attentive to scientific evidence.

4. Theological Consultations on HIV-AIDS

In an effort to encourage additional theological reflection on the social justice implications of the HIV-AIDS pandemic, Caritas Internationalis joined with other Church-related organisations in inviting theologians to learn more about this global phenomenon. In addition theologians were invited to share theological insights on the most appropriate response both by the Church and by the global family of humankind. During 1995-1999 these consultations were held in France (for Francophone Europe and Africa) and in Southern Africa.

AFRICA	Benin¸ Burkina Faso, Burundi, Cameroon, Congo, Congo-Brazzaville, Côte d'Ivoire, Ethiopia, Ghana, Lesotho, Madagascar, Malawi, Mali, Niger, South Africa, Sudan, Swaziland, Tanzania, Togo, Uganda, Zambia, Zimbabwe
ASIA	Burma/Myanmar, India, Korea, The Philippines, Thailand
EUROPE	Lithania, Poland
LATIN AMERICA - CARIBBEAN	Dominican Republic, Peru

CI and UNAIDS

Since 1987, Caritas Internationalis has undertaken advocacy at the global and national levels, with both national governments and inter-governmental organisations, on issues of concern to those affected by HIV-AIDS. On 7 January 1999, Caritas Internationalis signed a Memorandum of Understanding with

the Joint United Nations Programme on HIV-AIDS (UNAIDS). CI's then Secretary General, Mr Luc Trouillard, and the Executive Director of UNAIDS, Dr Peter Piot, jointly signed the Memorandum to foster co-operation on a response to HIV-AIDS at the local national, and international levels.

The agreement specified the following areas of cooperation:

– Access to care: in order to address the needs of people living with HIV-AIDS, UNAIDS will work with Caritas Internationalis to document its experience in the area of care as an example of best practice which could be used by other organisations in creating and strengthening their own programmes. UNAIDS will also share best practice developed by other organisations with Caritas Internationalis.

– Policy development: in order to reduce the discrimination and stigma associated with HIV and to strengthen community approaches to care, Caritas Internationalis and UNAIDS will share experiences on the development of HIV-related policies on human rights, gender issues, culture, ethics and law, and their dissemination in the private and public sector, including Church networks, the workplace, among professional associations, youth organisations and government agencies, taking into account their differing perspectives.

– Public information: HIV-AIDS prevention needs accurate and timely information to motivate responsible behaviour, to keep HIV-AIDS on the world agenda, to ensure that the human rights of people living with the virus are respected and to inform policy-makes. Caritas Internationalis and UNAIDS will reinforce public information activities on HIV-AIDS as appropriate and will strive to maintain the highest ethical standards.

H.E. Mons. FOUAD T. EL-HAGE
Maronite Archbishop of Tripoli
President of
"Caritas Internationalis"

Note

[1] (1998) *Safety Through the Night: A Report of the Thematic Review carried out by CAFOD and Four Partner Organisations between October 1997 and October 1998 on Behaviour Change in the Context of HIV and AIDS* (CAFOD, London).

V: AIDS in Africa

Introduction

For two decades a terrible and fearful epidemic has afflicted millions of people in the world regardless of race, ethnic group, socio-professional condition, sex or age.

No infection has ever before mobilised so many researchers of every kind, and so many financial resources.

In Sub-Saharan Africa, where there already existed serious difficulties with regard to securing the health of the population, AIDS then arrived to make this bad situation even worse.

Poverty worsens the life conditions of the populations of this continent:

– the inability on the part of most of the population to gain access even to essential medicines;

– the inability to achieve good nutrition;

– bad conditions of hygiene;

– a lack of health care education.

The treatment of this disease requires the professional skills and expertise of various categories of professionals: medical doctors, biologists, researchers, socio-anthropologists, psychologists, members of religious orders, communities, and so forth.

During this paper I will discuss:

– the present-day situation with reference to specific groups;

– the current existing system to deal with this epidemic and the relationship between this system and the response of the Catholic Church at the level of:

– national countries;

– the international community.

How can we strengthen this system?

The experience which we have gained in Africa and other continents, thanks to the exchange of experiences, allows us to focus this paper on the African continent.

Objectives

1. To guide the questions and issues connected with AIDS according to the papal Magisterium.
2. To co-ordinate the movements and groups of the Catholic Church which work in the field of HIV-AIDS.
3. To promote help to seropositive people and those who have AIDS.

Some Epidemiological Data on AIDS in the World and in Africa in Particular

	Average Incidence amongst Adults	Incidence
Southern Africa	17%	22.7%-27.0%
Eastern Africa	9.6%	3.2%-14.5%
Central Africa	4.3%	0.1%-11.1%
Western Africa	2.4%	0.5%-10.1%

Strategies of Prevention

Transmission by blood

– To ensure that systems of blood transfusion are safe according to established standards in all countries throughout the world (both in industrialised countries as well as in developing countries).
– To combat traditional practices which use cutting instruments (excision, scarring, tattoos).
– To ensure the sterilisation of medical materials.
– To promote the use of throw-away material.
– To ensure the provision of equipment or other material which is needed to prevent transmission through professional error.

Sexual Transmission

– To encourage voluntary identification of the disease before engaging in any relationship (marriage, living together) with a view to procreation.
– Faithfulness.
– Abstinence.
– Sexual education within a religious context.
– The teaching of the moral values of respect for the human body and of the meaning of love.
– To include an AIDS unit in the programme for the teaching of the catechesis.

Transmission through the Maternal Womb

– To propose the voluntary identification of HIV prior to marriage.
– To propose the voluntary identification of HIV in prenatal counselling.
– To ensure the treatment of sieropositive pregnant women in order to reduce the incidence of transmission of the virus from mother to child.

What Can be the Role of the Catholic Church in the Strategies for the Prevention of AIDS?

The initiatives must be directed towards certain specific groups such as:
– young people (boys and girls);
– women;
– couples;
– men.

Young people are the category which is most afflicted by HIV and the incidence of the virus in this category is 27%. We should strengthen the education of young people with respect to the following specific subjects:
– the reproductive health of young people;
– those who suffer from this disease (MST-AIDS);
– pregnancies at an early age;
– sexual abuse at an early age;
– sexual relations at an early age.

The education of young people must be carried out in primary schools, secondary schools (menstruation, sexuality), universities, and the family (the strengthening of moral and family values through communication).

What Structures Presently Exist within the Catholic Church to Strengthen these Strategies of Prevention?

– Scout movements;
– the CVAV (courageous souls, courageous hearts);
– charismatic renewal;
– youth organisations (Catholic students);
– the Legion of Mary;
– the Rosary Group;
– all congregations;
– the lay faithful and the catechists;
– the Association of Christian Families;
– the Association of Catholic Leaders;
– the Justice and Peace Commission.

Discussion and debates on specific subjects could also be held:
– during holy mass;
– after holy mass;
– during the catechesis lessons for young people;
– etc.

Women

At the beginning of the epidemic the people infected balanced roughly equally between men and women. Today of every twenty Africans infected by the virus, twelve to thirteen of them are women.

At the end of 1999 12.2 women and 10.1 men between the ages of nineteen and forty-nine were seropositive in Sub-Saharan Africa.
– A high level of illiteracy;
– the socio-cultural factors prevent women from advancing and engaging in decision-making.

Women are subordinated to men, economically weak (dependence, the need to give of themselves in order to meet their needs), divorce, separation.

What Exists in these Structures to Help Women?

Education and development projects should be engaged in to give women greater opportunities because they play a very important role in the family unit:
– they educate children;
– they take care of their children and husbands;
– they look after the house and the hygiene of the home.

How can the Catholic Church help them through its existing structures? Are there centres for listening and support for women who have no financial support or are abused? How can the religious movements take up present-day questions and integrate them into their activities?

At a national level there are groups of young people engaged in co-operatives for women, and these could be taken as a model for action.

Men

Sexually transmitted diseases manifest themselves clinically very early on in men. Hence the need for awareness-raising to achieve an early interest in treatment. Education amongst men should try to change forms of behaviour:
– to abstain from extra-marital sexual relations;
– to provide education on sexual abuse;
– to promote communication within the couple (the involvement of men in women's movements);

– the strengthening of moral and family values;
– the use of the system of the confession to engage in counselling and psycho-social support.

The Couple

– Awareness-raising and education to ensure respect and faithfulness within the couple;
– dealing with these various questions during preparation for marriage;
– some Christian movements must seize the opportunity offered by AIDS to organise discussions on this pandemic in order to encourage the avoidance of extra-marital sexual relations and other forms of behaviour which can damage the institution of marriage.

The Socio-Economic Impact

– A diminution in life expectancy.
– Absenteeism:
- the employee afflicted by HIV-AIDS is forced to often absent himself from work for repeated periods of rest after clinical manifestations of the disease.
– A diminution in productivity and performance.
– A diminution in the human index:
- The employee who is ill with AIDS at a certain point becomes unable to make his own contribution:
- dismissal or early retirement:
- following repeated absences the employer often has to engage in the dismissal or early retirement of his employee;
- the consequences of the payments made to employees;
- the cost of treatment is very high, the health care budget.
– Consequences for the family:
- the inability to meet the needs of the family; a decrease in monthly income;
- falling into poverty (pauperisation);
- psychological problems:
• abandonment;
• dependence;
• depression;
• AIDS orphans.

Accompanying the Sick Person who has AIDS

What does the international community do to look after people with HIV-AIDS?

Organisations such as the WHO, the PNUD, UNICEF, FNUAP, the World Bank, and the European Union have created a programme – UNAIDS – to think about questions and issues connected with the field of AIDS.

However, the World Health Organisation continues to be the organisation which acts to provide technical support in the implementation of initiatives directed towards seropositive people or people afflicted by AIDS.

Policy towards these sick people is very delicate because the psycho-social problems involved are of distinct relevance and importance.

In order to deal with the psycho-social question an approach has been developed through counselling, and there should be support groups in schools, companies and communities in order to ensure social integration.

With regard to forms of treatment, there are treatment services for patients with HIV-AIDS within the existing structures.

In order to avoid long stays in hospital by these sick people, in some African countries home-based treatment programmes have been developed which involve special kits. The patients turn to the health care structures whose professionals have been trained to this end.

To ensure the comfort of the patient:
– single and pleasant single rooms;
– clean clothes and sheets, good hygiene;
– assistance.
To fight against pain:
– the administration of strong pain-killers against the pain.
To ensure psychological support:
– listening to the sick person;
– affection;
– readiness to help.
To provide spiritual support:
– some patients ask to be baptised;
– preparation for, and acceptance of, death.

What exists at the level of the Catholic Church which we can strengthen? Catholic health care structures must:
– ensure the early identification of symptoms:
– supply treatment at an early stage, if possible;
– send those infected to the most specialised structures;
– ensure the training and education of professionals;
– involve the family in the care and treatment of the patient;
– ensure the education of the community with regard to health care questions (What should be done? Where should we go? Notices? Posters?);
– open up a VCT service;
– help patients at the terminal stage of their lives to make a will;
– allow the partners of those suffering from AIDS to take the test and provide them with post-test counselling and psycho-social support.

Conclusion

The pandemic of AIDS involves all of us. The involvement of the members of religious orders through the influence of the teaching of moral values to the young is very important in achieving changes in forms of behaviour.

Indeed, the age band which is most afflicted by this scourge is that of young people and adults between the ages of fifteen and forty-nine. This age band is exposed to forms of behaviour at risk such as sexual activity at an early age, different partners, the use of drugs involving the exchange of syringes, and all the rest.

Education and teaching with respect to attitudes which are damaging to life must be the central weapons used by members of religious orders in order to ensure that young people remain healthy.

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SECTION II ACCOMPANYING

Papers in the Programme "Assistance and people with HIV-AIDS"

I: Health Care Aspects

Of the many health care aspects which have characterised the AIDS epidemic over recent years it seems to me important to draw attention to some of those which, because of their impact on public health or the health of individuals, are of especial relevance.

1. The Prevention of Transmission through the Maternal Foetus

This subject is one of the most topical for a whole variety of reasons but above all else because of the scale of the problem and because of recent encouraging prospects which have been opened up in the field of prevention. As regards the scale of the problem, it has been calculated that last year 600,000 children were born who had the infection because their mothers were infected. The great majority of these children were born in Africa where the problems connected with poverty, malnutrition, very bad conditions of hygiene, and socio-political disorder make any preventive approach vastly more complicated than in industrialised countries. It should be remembered that every child who is born infected is also destined to become an orphan within a very short period of time. Indeed, the problem of AIDS orphans has taken on dramatic proportions in Africa. A great deal of research has demonstrated that a child becomes infected with HIV nearly always at the moment of birth and for this reason it is possible to reduce the incidence of the infection of new born babies thanks to anti-viral therapies during the last months of pregnancy and at the time of childbirth. For some years, in fact, treatment protocols during pregnancy for women who are HIV positive and for the baby have been established which reduce the transmission of the infection through the maternal foetus. These forms of treatment, which so far have been based upon the use of AZT (the first widely used anti-retroviral drug), have allowed a very substantial reduction in the number of babies who are infected during pregnancy and at the time of birth. A reduction of the rate of infection from 20-30% to less than 10% has been estimated in various studies. However, these brilliant results have only been achieved in industrialised countries because of the high costs and the organisational difficulties involved in such treatment. Where, in contrary fashion, the need for action is greatest – in the African countries – the economic constraints and the lack of effective health care networks have obstructed the widespread use of this measure of prevention. Recently some signs of hope have come from studies carried out with another anti-retroviral – nevirapine. This involves a much more simple system of treatment (a single dose administered to the mother and the baby during childbirth), much lower costs, and an effectiveness in terms of prevention similar or superior to that provided by AZT. A large number of international agencies, governments and NGOs are organising themselves to promote pilot projects or active measures to extend the use of this new and promising system of treatment as much as possible.

2. The HIV-Tuberculosis Co-Infection

The epidemic of HIV has aggravated the problem of tuberculosis over recent years. This disease was already serious in all countries of the world but it was (once again) especially serious in the south of the planet and in particular in Africa. It is calculated that in 1999 there were about 2.5 million deaths from AIDS of which at least 30% were caused directly by tuberculosis. It has now been scientifically demonstrated that the HIV infection encourages the acquisition of a tubercular infection or the clinical advance of a latent tubercular infection. In addition, the presence of tuberculosis accelerates the advance of the HIV infection which means that a relationship of negative reinforcement is established by the two infections. In patients with AIDS, tuberculosis can develop clinically and radiologically in atypical forms, something which means that there are greater difficulties in

diagnosis and possible delays in beginning treatment. This fact has important repercussions with regard to public health. It is known that the most important factor in the epidemiological control of tuberculosis is the rapid recognition and treatment of people who have it – a delay in diagnosis leads to an increase in the period of possible contagion and as a result a more effective diffusion of the infection. Another important phenomenon linked to the increase in cases of tuberculosis is that of the resistance of the *mycobacterium tuberculosis* (the bacillus responsible for the illness) to the most powerful anti-tubercular drugs. It is estimated that about 2% of the strains are resistant but this percentage figure is bound to increase. This resistance to drugs is influenced by various factors, the most important of which is the accuracy with which the long and complex systems of treatment are administered. An effective anti-tubercular therapy is effected with various drugs administered together for at least six months. It is clear that where the health care structures are not efficient or the costs cannot be met the risks of incongruous or overly brief forms of treatment are very high, and for this reason the probability that resistant strains become selected increases.

3. The Development of Diagnostic Techniques and the Appearance of Powerful New Anti-Retroviral Drugs

In the mid-1990s two important advances were made in treating patients infected with HIV. The first was the possibility, through sophisticated techniques of molecular biology, of measuring the quantity of viral genome in the blood and therefore indirectly the self-reproducing power of the virus in the individual patient. This is an analysis which, when carried out in conjunction with the more classical dosage of the CD4+ lymphocytes, enables us to assess and monitor the 'activity' of the infection, its development, and even to produce possible responses in terms of treatment. The other important advance was the creation of new and more potent anti-retroviral drugs, and in particular the protease inhibitors (saquinavir, ritonavir, indinavir, nelfinavir) and the non-nucleosidic inhibitors of the reverse transcriptase (nevirapine, efavirenz). These drugs, when used in conjunction with the more classic nucleosidic inhibitors of the reverse transcriptase (zidovudine, didanosine, zalcitabine, stavudine, lamivudine) have given rise to spectacular improvements in patients in an advanced state of the illness and the immunological and clinical stabilisation of patients in the intermediate stages of the infection. Of course this is not a definitive solution, primarily because a real elimination of the infection has not been encountered in any patient so far. It should also be observed that the systems of treatment are complicated and are applied without a time limit, are administered in a specialised environment, and are not without side-effects which at times are very serious. The principal difficulty of these new diagnostic and therapeutic approaches is that of the costs involved – they are already very high in the industrialised countries which have a high *pro capita* income and so for poor countries they are absolutely prohibitive. Unfortunately, there is no real possibility of these new diagnostic methods and forms of treatment being applied on a vast scale. This must make us reflect further on the crucial importance of programmes of prevention in relation to the HIV infection.

4. The Diagnosis and Treatment of the Principal Opportunistic Infections

In recent years there have been decisive steps forward in the treatment of the principal opportunistic infections. The drugs which have been used since the emergence of the epidemic remain substantially effective, such as, for example, cotrimoxazol for pneumonia caused by *pneumocystis carinii*, pirimetamine and sulfadiazine for cerebral toxoplasmosis, or the azoles for fungine infections. The prevention and treatment of the principal opportunistic infections is often accessible in terms of costs and thus this is one of the fields where we should concentrate our efforts in terms of future planning. Furthermore, it has been demonstrated that the prevention of opportunistic infections, even in the absence of anti-retroviral therapy, can improve the possibilities of survival and quality of life, and reduce the number of people admitted to hospital.

5. Treatment with Pain-Killers

Those who take care of people with AIDS have before them individuals with a terminal prognosis who will die in a rather short time. For this reason it is important for the principles of palliative medicine to be applied on a broad front. This is a branch of medicine which is concerned more with removing the consequences of an illness than its causes. In particular, much attention should be paid to the treatment of pain and the other symptoms which inevitably accompany the patient suffering from AIDS who is in an advanced stage of the illness. We must increase our efforts to accompany the patient on his path to a dignified death and avoid isolation from the family and the health care workers. We must improve the quality of the life which is left and avoid forms of treatment which are useless and heavy for the patient in a context where there are no reasonable prospects for improvement.

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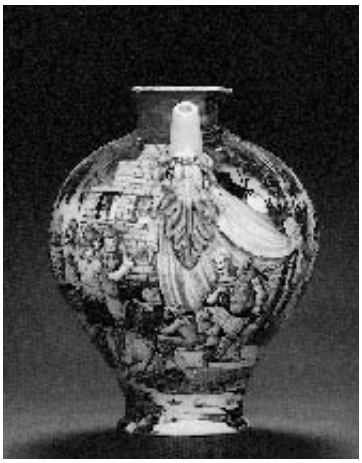

II: The Transmission of AIDS through the Maternal Foetus: New Possibilities in the Field of Prevention

The epidemic of HIV – the virus that brings about AIDS – has not halted. Indeed, it continues to spread throughout the world. The recent calculations of the World Health Organisation refer to 33.6 million people infected by HIV in the world, and estimate that five million adults and 600,000 children were infected last year. Last year, also, 2.6 million people died from the disease bringing the total number of deaths caused by AIDS to 16.3 million individuals.

There are in substantial terms three ways by which the disease can be transmitted: by haematic sexual means, through infected blood, and through the maternal foetus, that is to say from an infected mother to her child.

In recent years a great deal of research has brought out the fact that a child becomes infected by HIV nearly always at the moment of birth. For this reason it is possible to reduce the probability that the newly-born child will be infected through the use of anti-viral drugs during the final months of the pregnancy.

In recent years the proof that treatment with AZT (whose commercial name is Retrovir) is able to reduce the number of infections in babies has led in the West to the extensive treatment of mothers infected with HIV, and this in turn has led to a significant reduction in new cases in babies. In the United States of America between 1992 and 1997 there was a reduction of up to 80% in the infection by HIV of babies. The same took place in those European nations which employed the same preventive forms of treatment.

The caesarean operation also involves a reduction in the risks run by new born children of becoming infected by HIV. European studies on populations which use such precautions indicate that the risk run by newly-born children is reduced to a few percentage points.

These systems of treatment and prevention have significantly reduced the number of infected babies in Europe and the United States of America, but little has been done for Sub-Saharan Africa where at the present time over 70% of the people in the world infected by HIV live.

A very important research article was published at the end of 1999 in the most important European medical review *The Lancet* (L.Guay, *The Lancet*, 1999, 354, pp. 795-802). It observed that even very brief treatment of mothers at the moment of birth and of babies in the first hours of life is more effective than those more lengthy and more expensive forms of treatment which have hitherto been available in the richest countries of the world. In practical terms, a single pill of the strong anti-retroviral nevirapine (whose commercial name is Viramune) given at the moment of birth to the mother and to the child is sufficient to reduce the chances of the HIV virus being transmitted by a figure of 47%.

The advantages of this treatment are manifold and they are rooted in the simplicity of the treatment: one single dose being given to the mother and the child (at the very low cost of about $4 in all) and at a time (birth) when most women are in hospital or are being cared for by health care or semi-health care personnel.

Studies on the 'cost-benefit' ratio of this treatment confirm its very high advantages (E. Marseille, *The Lancet*, 1999, 354, pp. 803-809).

At an international scientific level there is a very great awareness of the social and public health possibilities of this research and the United Nations (UNAIDS) has displayed great interest in the promotion of, and support for, projects involving prevention at the level of maternal foetus transmission.

There are still a great many problems to solve, such as that of breast feeding which is also a source of contagion, or the illness of the mother and the fate of the orphans who, however, if they are not infected, have better life possibilities.

To summarise, the scientific proof that just one pill given just once can reduce the frightening number of six hundred thousand new cases of infection each year by almost a half urgently requires the creation of new strategies of prevention in all developing countries.

A very practical consideration leads us to recognise that if it were possible to apply this treatment to the roughly two million children who are born every year in the world to women infected with HIV, the total cost of this drug would be about 8 million American dollars, a truly irrelevant figure if one thinks of the social and human cost of this disease which could probably be prevented in at least 300,000 children. The capillary organisation of the distribution of this drug and the training of health care workers is a much more difficult question. Experience shows us, in fact, that even the easiest and least expensive to treat maladies (such as diarrhoea or measles) are not treated because of failings at the level of organisation and disinformation.

An initiative involving the Holy See and the United Nations (UNAIDS) as the promoters of activity designed to plan really incisive forms of action in relation to the health of babies has great possibilities of bearing fruit as a result of the union of the great organisational abilities of UNAIDS and the capillary and motivated presence of the Catholic Church at the level of institutions and on the ground.

A meeting to define the respective spheres of interest and action, and the human, organisational and financial resources available, is something which is much to be welcomed.

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III: Psychological Aspects

Introduction

AIDS is characterised in the collective imagination as being a 'social catastrophe', a 'blameworthy disease' which is full of unconscious symbolisms: it is contagious, involves prejudices, and leads to discrimination. It is incurable and fatal, and is associated with deviant, transgressive and amoral forms of lifestyle.[1]

For this reason it unleashes a pathophobic, emotional, social reaction,[2] of a psychologically defensive, ambivalent and contradictory character. This tends to distance the moral anti-value of the illness and to justify and legitimise the 'ghettoisation' of people suffering from it, for whom actions of solidarity, support and care – having to take into account both the right to individual freedom and programmes of protection and prevention of society as a whole[3] – are actions which are still very far from being fair, co-ordinated, effective and ethical.

A Moment of Diagnosis and a Person's Life Changes

However much the role of information-giving on the part of health care workers to outline the different stages of the illness is extensive, becoming aware of his own state of infection involves the patient in a state of anxiety which is so great that it becomes a sort of paralysing stress. This undermines the plans a person has for his life, provokes fantasies full of death, and all this with inevitable destructive repercussions on affective, interpersonal, social and work relationships.[4] It should, indeed, also be emphasised that the pandemic spread of AIDS and the publicity that is provided about it by the mass media,[5] induce in those who are psychologically disturbed and who are aware of forms of behaviour at risk that so-called 'worried well' of the Anglo-Saxon commentators.[6] These are hypochondiachal beliefs which can develop into a delirious framework, even though clinical symptomologies are absent.

Although recent investigations have observed a marked increase in infection amongst heterosexuals,[7] which is caused, at least in Western countries, by models of life-identity which are increasingly proposed and spread by the mass media and which are directed towards the liberalisation of habits and practices marked by a tendency towards the exaltation of transgression, it nonetheless should not be forgotten that infection by HIV particularly hits people with lifestyles and life histories which bear a high risk of infection, such as drug-addicts and homosexuals.[8]

The causes which bring about the difficulties they have to encounter are well-known: suffice to say here that the oscillation in the personality of these people goes from a serious psychological dysfunction to a more suitable psycho-social maturity.[9]

The personalities of drug-addicts, because of their psychological vulnerability, the immaturity of their characters, their low capacity to tolerate frustrations, and their spiritual alienation, tend to deny the seriousness of the illness and the risk of infection and to place trust in the ability of their bodies to react and respond to it. For these reasons, they are difficult medical subjects who are not very receptive to programmes of prevention, to health-care education, or to counselling.

In the case of homosexual patients, the diagnosis that they are seropositive and have AIDS brings about serious feelings of guilt with regard to their own sexual choices. They feel that they are responsible for the illness but at the same time they are more considerate and careful about the dangers of spreading the infection. Their greatest worry is that their condition will be discovered and they wish more or less to conceal the fact of being infected, something which stigmatises them both in terms of their life choices and their membership of a transgressive and amoral group which is seen as being potentially infected and infectious.[10]

An important element to be considered is the psychological problems which arise in their relationship with their seropositive partners. These are even more relevant and upsetting in the case of people who have been infected accidentally and who live out their lives with 'responsibility'.[11]

This leads to situations of anxiety and fear about a possible past or future infection, something that gives rise to profound changes in the nature of the couple's relationship. It is deprived of its day to day dimension. This relationship can be subjected to 'fracture' or to the maintenance of the bond, with an awareness of the risks involved and the sharing of markedly depressive responsibilities as if nothing in life mattered any more. Or a choice is made in favour of abstinence from sexual relations in the form of a withdrawal of the libido from an objective investment which runs high risks. However, this leads to the exhaustion of the relationship in a very short space of time.

Given what has been said so far in this paper, it is very evident how important and necessary it is to invest in action involving the promotion of prevention. This involves both providing suitable information and educating people to adopt responsible maturity. Such a maturity within the context of the couple leads to a rediscovery of the spiritual value of love which is given as the fundamental meaning of existence. This is a concept, as I will explain in greater detail later on, which should be diffused amongst adolescents so that they acquire the strength of character to avoid and rise above forms of behaviour at risk – opposition to which the Church holds up as a positive ideal – and which involves and

applies moral rules of behaviour which can prepare them for responsible and faithful love – the main guarantee by which to defend their and other people's health.

At the basis of this idea, as the Holy Father observes, is 'the proposing of forms of prevention of the illness of AIDS based upon recourse to means and remedies which violate the authentically human meaning of sexuality and are a palliative for those deep disturbances, where the responsibility of individuals and society is called into play... and a pretext for a yielding of ground which opens up the path to moral degradation, are deeply harmful to the dignity of the person and morally illegitimate'.[12]

People's Psychological Reactions to Being Told that they are Seropositive

The possible psychological reactions to a positive diagnosis for AIDS, which international scientific research has shown to interfere with the immunity parameters and the acceptance of treatment,[13] depend on a number of variables: on the characteristics of a person's personality and his capacity to respond by adapting; on the lifestyle which is followed, which exposes individuals to a high risk of infection; and finally, on the physical complications brought about by the infection itself. These reactions can be summed up in the following words: denial, anger, and depression.

Denial as an immediate reaction designed to exorcise the illness; an attitude which is at first one of incredulity, hypotrophic and later introspective, and which gradually changes until the person is driven towards a closing of interpersonal relationships.

Anger because the person is the victim of the infection. Most of the time this reaction involves expressions of desire for revenge which even end up, in extreme cases, in a wish to infect other people and to spread the disease out of an impulse towards revenge.

Depression brought about by feelings of desperation and very strong feelings of guilt in relation to an experience pregnant with death which strengthens and broadens the mythical and symbolic approach to AIDS.

The Various Stages of the Illness

In the period which goes from the infection and the anti-body positivity – defined as the 'window stage' – an individual is seronegative even though he has been infected and can transmit the disease. Here one can evaluate which potential serious dangers of transmitting and contracting the illness can be run by society as a whole because of forms of behaviour at risk, especially in the sphere of sexuality.

When the diagnosis of seropositivity is confirmed by clinical analyses, as has already been observed the patient has a number of psychological reactions which place him in a state of continuous oscillation between thoughts of life and death, which involve him in frequent cognitive and behavioural alterations, and new approaches which should allow him to experience new forms of psychological balance.[14]

The sensitive task of counselling the person with HIV should promote the acceptance of his own state and the reconstruction of a positive self-image which will allow him to establish future and realistic objectives, in which process the hope that such objectives can be realised should be maintained.[15]

In relation to this pathology recent therapeutic systems have brought about significant reductions in the viral assault and have also created new hopes about possible quality of life. Equally, they have given rise to unrealistic hopes of a cure which, when they come against the tragic character of the illness, see the patient lose control of his surrounding reality in a state of desperation and psychological decline which in extreme case even ends in suicide.[16]

As Nichols has observed,[17] the psychological *iter* of the person suffering from AIDS is characterised by three separate stages: the state of the initial crisis, the state of transition, and finally the state of adaptation leading to preparation for death.

The moral pain caused by social prejudice, in addition to the frightening loss of hope, the distress caused by isolation and by being abandoned by other people, and not least the identification with the death of a dear friend with whom the same life choices have been shared, are in conflict-ridden counterposition with the need for emotional, psychological and social support, compensated at the most by the maternal figure in a symbiotic relationship characterised by regressive-infantile traits. And this side by side with a renewed and rediscovered interest in the search for a skilled spiritual adviser who can be the new departure for many processes of moral rehabilitation and an important interactive element in the treatment which is received.

It is at this existential stage that the person suffering from AIDS rediscovers and reaffirms the fundamental values of life, side by side with a combative approach to the illness which, unfortunately and ineluctably, finishes the cycle of life.[18]

The Family of the HIV-AIDS Patient: Reactions

In general terms, people with HIV during the stage when they do not display any symptoms try to keep the situation under control and minimise to themselves as well the painful consequences of the illness. When the pathology is no longer containable because of complications which develop at the level of symptoms and the forms of health-care treatment, the diagnosis of AIDS often finds the family unprepared for the illness's revelation when it learns through this discovery about the drug-addiction problems or unfaithful or transgressive forms of behaviour of their relative.[19]

A change in the family environment takes place which changes, in an overall reorganisation, all the relational variables which are involved: in extreme cases the family dynamics are made more complex and come to disintegrate because of fears about moral condemnation and the stigmatisation carried out by public opinion in relation to a 'shameful' diagnosis.

The family tends to dissimulate and to close itself up in its own suffering from which there re-emerge very serious internal conflicts with accusations and the attribution of blame being levelled at the sick person to the point of his expulsion in order to achieve defence against feeling associated with the deviance, the lifestyle and the anti-values which have brought about the sick person's different approaches.[20] All this takes place with deep internal lacerations which impede both sides from constructive decisions which can achieve reconciliation with life. This is a dynamic which was emphasised by His Holiness in his speech of 1990 given to the international conference on AIDS organised by the Pontifical Council for Pastoral Assistance to Health Care Workers: 'the loss of family warmth provokes in those sick with AIDS the diminution and even the extinction of that psychological and spiritual immunology which at times reveals itself to be no less important that that of a physical character in supporting the reactive capabilities of the individual'.[21]

The Health Care Workers

The psychological implications of AIDS and HIV virus infections should be analysed in the relationship with the health care workers.[22] In addition to affecting the balance of the person himself, they frequently bear relevantly upon the functioning of the health care structure and the quality of care. The sick person develops a condition of psycho-physical dependence in relation to the health care workers, while his family, in recognising the authority of their knowledge, place themselves in a position of subordination to such workers. Both patients and families project onto the health care workers wishes for survival through a mechanism which I would define with the phrase 'anchoring on life'.

The health care personnel, for their part, can engage in two opposing defensive attitudes of a more or less unconscious kind which are used to distance worries about death and feelings of therapeutic powerlessness. They are: either an emotional distancing from the sick person who comes to be seen as a 'clinical case', the bearer of symptoms emptied of his humanity on the one hand, or, on the other, an affective hyper-involvement through a process of identification with the sick person which damages their professional image, something, however, which requires empathy, solidarity, and charity in the highest meaning of these words.[23]

The problem which is most felt by health care workers is certainly that of being infected themselves or of the family relatives of the patient being infected. The precautions which are taken, which at times are above what is really necessary, are a further psychological barrier placed in the relationship with the sick person, whilst the use of imprecise, equivocal and contradictory forms of communication tend to involve avoiding the assumption of responsibilities. This is something which can lead to the well-known phenomenon of 'burn-out'.[24]

It is very rare to encounter cases where people afflicted with HIV-AIDS are refused treatment. This would be something which would in dramatic form contravene articles 5 and 7 of law 135 of 18/9/1990 of the current Italian Deontological Code. It would also be a refusal indicative of deep personological and indeed professional disturbance.[25] It is very clear that it is necessary to offer the whole of the staff involved in looking after patients with HIV-AIDS psychological advice which helps in controlling anxiety and reducing stress in the work place and thus improves both their understanding of professional tasks and responsibilities and their ability to provide a dialogic relationship, in addition to present, capable and effective human help and assistance.

Reflections

All the subjects and issues which have been discussed here are of dramatic topical relevance, and they are made even more crucial because of the cultural divergences evident in the answers to the solution of the problem of the prevention of AIDS. These questions see on

the one hand the great guiding and teaching role of the Church, and on the other a cultural vision of modern society which because of the principle of scientific rationality – something not unconnected with involvements with political and/or economic power – is increasingly rooted in technology and the control of the real. These are differentiated approaches which give rise to opposing emotional currents which find ordinary man in a condition of dismay and of a worrying crisis of values. These, in turn, can lead to the covert entrance of an ethical subjectivity which tends to look for a model of the Church which is more responsive to personal needs, thereby producing an unreal, comfortable dualism between secular ethics and Christian ethics, between science and religion, and between the state and the Church.

As the Holy Father emphasised in the above mentioned speech to the international conference on AIDS: 'we are not far from the truth if we affirm that in parallel with the spread of AIDS there has manifested itself a sort of immunodeficiency at the level of existential values which cannot but be seen as a real pathology of the Spirit'.[26]

HIV-AIDS and its connected problems and issues, indeed, constitute, albeit in all the dramatic nature of the illness, merely the tip of an iceberg, the tip of a more complex psycho-physical and spiritual reality to which we must react and respond.

Here we encounter the real 'challenge': to avoid running the risk of the extinction of the conscience, of the negation of the dignity of the human person, in order to promote a *culture of life* of utility in the building of a more just and human society. This challenge is accepted by the Church which in this sense, mother and teacher,[27] has always worked in this direction, responding with her heart, knowing how to speak to men, aware of their fragility, and understanding their upsets and difficulties. The Church untiringly promotes new readings of human behaviour with the courage of a person who searches for the truth, the truth of values, of the sacredness of life, with respect for the inescapable principles of her Magisterium, of the Faith, and of Ethics.

However, as is confirmed by the facts which emerge from the questionnaire carried out by the Pontifical Council for Pastoral Assistance to Health Care Workers, historical acceleration today requires new strategies of evangelisation and hope which the Church, beyond any admirable local initiative, must, and will know how to, organise for those suffering from AIDS and their families; that is to say practical, solidarity-inspired, charitable and spiritual help which will give them relief, taking over, for example, old convents which could be transformed into nursing homes or by entrusting female religious orders with caring for orphans of AIDS in a natural environment. This help, through the establishment of a central observatory having the task of co-ordinating human, social and scientific resources in relation to AIDS, could be a nucleus of information which could be spread amongst, and act to stimulate, all the complex local ecclesial realities, in addition to being a just recognition of their pastoral work.

Help provided by the Church, therefore, which must take practical form, in addition to the active exaltation of the great values at the basis of life, through programmes of information, education, formation and prevention implemented in capillary fashion in all social sectors and made more productive by determined, involving and highly publicised actions in synergy with other government or private initiatives.

The Church herself must be a *trait-d'union* between the state and the scientific community in order to encourage society in her ideals – 'authentic values' through which can be overcome sterile positions of demagogic politics and scientific determinism in favour of more mature and responsible attitudes, beginning with the very young, as an aware choice of life, the founding value of that human project which is based upon moral and spiritual incisiveness and meaningfulness.

All this will be possible through the use of actions designed to uphold universal principles proposed and implemented in the most difficult contexts with pragmatic methods which respect and are suited to the differing political-economic, anthropological and cultural realities of the planet, and which can counter the impoverishment and moral degradation which unfortunately often find freely conquerable spaces amongst the problems of ignorance, illiteracy, unemployment and prostitution in social contexts which are undeveloped, or technologically advanced but often depersonalising.

To this end the work of diplomatic mediation by the Church with governmental authorities must be pressing and urgent, directed towards reducing the gap which exists between the poor and the rich countries through the defence of health in general and the struggle against AIDS in particular-scandalous and inhuman inequalities for which we must bear our full responsibility.

Only in total co-operation will it be possible, with a humanitarian impulse, to withdraw these suffering people and their families, afflicted in both body and soul, from the dramatic loneliness and the desperation that the illness of AIDS involves through a valid and fair health care and psychological assistance (in order to then proceed to a cathartic approach to the illness which recodifies it internally), flanked by spiritual comfort as sensitive as always but specifically trained in the knowledge of the techniques of counselling (crisis counselling, problem-solving counselling, decision-making counselling),[28] in order to help sick people to open their hearts to hope through the rediscovery of their own dignity as men and as children of God.

Through an action of feedback early educational initiatives can be made more incisive if directed towards *personological* factors (lack of self-esteem, the search for a role, anxiety provoked by the crisis that one will be abandoned or die, profound conflicts, insecurity, the search for gratification, etc.); *social* factors (marginalisation, changes in social structures with a marked process of historical acceleration, immigration, urbanisation, unemployment, etc.); *health care* factors

(access to treatment, costs, etc.) and by taking into account two fundamental objectives which are as important and as noble as ever in relation to contemporary society, which, indeed, often seems to have lost its own points of reference. These are on the one hand the re-evaluation of the role of women in their essence as mothers, wives and daughters, the spiritual delegates of love which gives of itself and a special witness in the journey of every human being,[29] and on the other the recovery of the importance of the family, which is today far too often below standard because of forms of disharmony, crises, conflict between parents, or which paradoxically does not exist in terms of its institutional essence, when instead, as Cardinal Trujillo observes, it is in fact 'witness to loyalty to the plan of God and the heart of the civilisation of love, gift and commitment for the future of mankind'.[30]

The commitment of the Church, with the mission of her 'heralds of the Gospel',[31] as the Pope has defined the female and male religious and priests, as well as all the Catholic workers who look to her ideals, can facilitate, through the recovery of a moral conscience, the achievements of objectives placed to combat and defeat aberrations and negations of the values of the person, in order to allow them to reach that dignity and fullness of life which must recover its true essence, its spirituality, and its transcendence.

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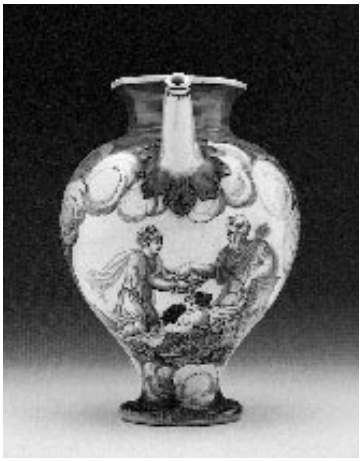

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IV: Ethical and Moral Aspects

The Conflict between Values

The ethical-moral approach from which to examine people infected by HIV or AIDS is something which I have had to deal with since the first appearance of this epidemic and its strikingly large number of problems. One could say, indeed, that the HIV infection has acted to catalyse the many ethical conflicts which have emerged, as it were, from a Pandora's box of the twentieth century. It has raised questions for the consciences of individual workers both at a personal level and in terms of health care policies.

At the beginning of the century the famous clinical doctor, Sir William Osler, in discussing syphilis – a disease which is often compared to AIDS when this latter is discussed – wrote the following words in the preface to his famous tract on internal medicine in which he emphasised the complexity of the clinical ways in which it could express itself: 'study syphilis in all its manifestations and clinical correlations and every other pathology will be learnt about even more'. In the same way today one could say that to know AIDS in all its ethical-moral correlations means to address oneself to all the questions and issues of biomedical ethics, or at least to most of them given that HIV infection has a whole series of aspects and manifestations.

If one examines the various ethical-moral questions and issues which caring for and treating people infected by HIV has raised, one sees that one is dealing with problems which are very different from each other but which, in substance, revolve around the conflict between: a) the right and duty to prevent infection in healthy individuals, to protect that is to say society, and b) the right and duty to assist and protect the infected individual who is only seropositive or is also afflicted by the illness the infection gives rise to. From this conflict spring all the questions which, already faced up to in other fields of bioethics, become particularly critical in the case of infection by HIV because of the special nature of the disease, which still does not have definitive forms of treatment, and because of the ways in which it is transmitted.

In particular, this conflict emerges when one has to define the ethical principles to be referred to, and even more when one has to place them together and harmonise them. The ethical literature on the subject, indeed, brings out a plurality of values and consequent ethical-moral duties which are brought into play in caring for and treating people who are infected by the HIV virus.

First and foremost there is *the principle of respect for the dignity and autonomy* of the individuals concerned, and in particular the seropositive or sick person who cannot be made to disappear as a person because of his condition, however he may have contracted the illness. He must, instead, be helped to face up to the consequences of his condition through personal and responsible choices which go from thinking about his own forms of behaviour to decisions about telling other people about his condition, about getting married, about procreation, and about refusing or accepting experimental treatment, etc. One is dealing here, therefore, with promoting the responsible freedom of individuals so that such responsibility can encounter the responsibility of society and avoid the occurrence of moments or acts of discrimination or the violation of the privacy of patients.

In truth we should also underline that often in the name of the principle of autonomy freedoms have been claimed which are not always associated with the practice of full responsibility, for example wanting to continue with disordered and dangerous forms of behaviour. Indeed, during the first years of the appearance of the HIV infection the ethical debate often emphasised the meaning of the individual autonomy of infected individuals and AIDS was strongly ideologised by social pressure groups involved in forms of behaviour at risk. These groups made the infection into a banner by which to legitimise their forms of behaviour and to claim a series of 'privileges'(special laws, funds from the state for their associations, for their projects to distribute condoms freely and on a very wide scale, absolute respect for their privacy, and so forth). Concern for the protection of the infected individual, in substance, often took pride of place over concern for society, as a common good and as a good of healthy individuals who run the risk of becoming infected.

An article which appeared at the beginning of the 1990s in *The New England Journal of Medicine* with the title 'An End to HIV Exceptionalism?' described the policy which had been adopted until then in relation to the appearance of AIDS in the following way: 'During the first decade of the epidemic a community of interests made up of the spokesmen of homosexuals, defenders of the freedoms of the citizen, medical doctors and administrators of health services, came to develop a policy of behaviour towards the disease which was based upon the concept of 'special treatment'. Not only in the United States of America but also in many Western industrialised countries health policy was determined by an alliance which placed individual freedom above responsibility towards one's neighbour and towards society. In this way the aim was achieved of bestowing upon HIV infection a special status amongst the infectious diseases

and sexually transmitted diseases in particular.'

Today the disease is so widespread that those infected with it live – and can infect – for a longer period of time; the utilisation of health care services cannot necessarily be correlated with the infection; and amongst health care workers themselves there are many individuals who are infected. Indeed, mutual fear between doctors and patients now seems to be changing the debate. There is a tendency, that is to say, to sideline the autonomy of the individual and his right to absolute privacy and to give space to the need for the greater right of the community and institutions to know about the condition of being infected in order to protect shared interests within a context of responsibility. In other words, there are no medical reasons, or reasons of another kind, to require AIDS to have a special status, or for this disease to be treated on the basis of criteria which have already been acquired for infectious diseases, and especially those transmitted sexually. These criteria are: the protection of those who are not yet infected; the identification of those people who have been infected; the strengthening of a sense of responsibility and of the intention not to propagate the disease; coercive measures in a minority of cases where a sense of responsibility is absent; and care for the sick person in order to reduce his suffering.

This need – which in truth has foundations which go well beyond the contingent sociological modifications encountered by the HIV infection – confirm the fact that the principle of autonomy is insufficient when it does not refer to personal and social responsibility.

Another principle at stake is *the principle of benefit*, a principle which is invoked both in relation to the infected person – who must be cared for and treated in the best way possible – and in relation to healthy individuals and society as a whole (and the family in particular) whose health has to be defended against infection through effective and suitable programmes of prevention which also envisage the control of immediate, remote and concomitant causes such as drug-addiction and the disordered use of sexuality.

In the name of the principle of benefit, for example, it is the duty of the medical doctor to care for and treat those who are infected. He cannot refuse to provide the required assistance merely because he is afraid of becoming infected himself. It is the duty of researchers to dedicate themselves to advancing research in order to find remedies for this pathology. And society must act with suitable prevention campaigns in order to contain the spread of the infection and protect healthy individuals.

Reference is also made, lastly, to *the principle of justice*, which is applied not only in the sense of social fairness in the distribution and allocation of burdens but also in the sense of actions to meet the needs of each individual (needs which are not equal for all people) and of the ability of each individual to meet these needs himself. This principle, therefore, invokes solidarity and subsidiarity and does not mean mere egalitarianism.

Upon the principle of justice, in addition to the principle of benefit which has already been referred to, is also based the duty to inform and to be informed about the condition of seropositivity of an individual in order to implement all those actions and initiatives which are necessary to prevent infection. Only if one knows about the risk is it possible to implement preventive actions and initiatives, and for this reason it would be wrong to keep quiet about information which would be decisive in bringing about a change in behaviour. This argument is, for example, supported with reference to the question of professional secrecy. Such secrecy, specifically in the case of AIDS, has been profoundly called into question with regard to the criteria which should be applied to it, not only for legal reasons but also for socially relevant reasons, such as, for example, the imminent danger of an individual who is unaware of the risk of becoming infected.

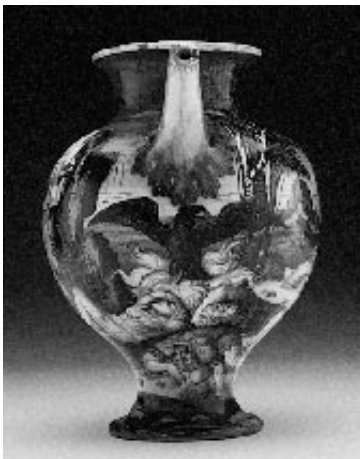
In the light of the principle of justice as well one cannot but be surprised by the direction taken by much legislation in not inserting HIV infection within the list of existing infectious diseases, and thus providing for the application of the measures designed to combat such diseases, but acting, rather, through the creation of *ad hoc* legislation. This direction is only partly justifiable taking into consideration the special characteristics of AIDS as compared with other infectious diseases. The reasons which brought about this choice, however, have emerged with much clarity. These reasons are not external to those forms of behaviour and those social groups (drug-addicts and homosexuals) which from the onset have been connected with the systems of infection. The infection, in other words, was an opportunity, as has already been observed, to reaffirm at an ideological level that one could not call into question certain forms of behaviour and that all that had to be done was to continue to defend them, albeit with greater safety when it came to the transmission of the infection.

And in this regard there was no lack of condemnation on the part of eminent clinical doctors to the effect that this 'special' treatment of AIDS – special laws, the allocation of funds for research and care and treatment – seemed to be unfair when compared to the health care policies applied to other pathologies which are equally serious and which involve a certainly not inferior number of patients, such as neo-plastic pathologies. In Italy, for example, despite the high incidence of these maladies, there have never been special laws for them; nor were there, at least for a long time, public funds specifically dedicated to supporting research and treatment into them.

Apart from these considerations, however, the principle of justice also emphasises that the social dimension of AIDS is closely bound up with the ethical dimension, and that it has a particular relevance in the case of this disease because it involves the person not only as an individual but also in his relationships with others. Everybody, therefore, must feel themselves committed to a series of forms of social responsibility and professional duties which refer to values and indicate moral obligations.

The principles which have been outlined above came into being in particular in the North America literature on bioethics and have meaning and significance only within an ethical model which places them in agreement and harmonises them. From the methodological point of view of ethical thought, indeed, it is important to be clear about the framework of values which one wishes to follow so as to be able to achieve their harmonisation. The harmony which should be achieved is not a mere compromise obtained through a pragmatic 'weighing of values'. It involves the search – by no means always easy at a practical level – for a hierarchy of the values in question because man is unitary, grows upwards, and maintains himself in personal and ethical rectitude only if he constantly strives for that convergent unity which is made up of a harmony-hierarchy of values.

The central and primary value involved in the problem of AIDS, as in every health care problem, is the human person: it is within the human person, and to the advantage of the human person, that there converge the action of the medical doctor and the scientists, the action of pastors of souls, the action of society, and the action of culture. The human person, because of a vision which arises from a successful philosophical anthropology, is not only the central point of the ecosystem – which is seriously disturbed by the appearance of the phenomenon of AIDS in the same way as it has been seriously disturbed by other serious epidemics at other times in history – but also the point of reference, and the very spring, of society. He is, finally,



the good or the objective and transcendent good of the cosmos itself.

Special Ethical Problems in Caring for and Treating People with HIV/AIDS

We will now briefly examine some of the ethical questions and issues which are raised, and which spring precisely from that conflict which has already been referred to between the duty to protect society and the duty to protect the rights of infected people. I have chosen some of the most significant of these questions and issues and the reader can consult the vast literature which has grown up on them for a more detailed analysis.

A) One of the first questions which has been raised is that of the *refusal of health care personnel and staff to care for and treat AIDS victims*. Section 2 of the Charter for Health Care Workers (Pontifical Council for Pastoral Assistance to Health Care Workers, 1995) declares that such activity is 'a meeting between trust and conscience. The trust of one who is ill and suffering and hence in need, who entrusts himself to the conscience of another who can help him in his need and who comes to his assistance to care for him and cure him.'

Unfortunately, today there is a wish to eliminate this meaning of the profession by emphasising the aspects of the *contract* between the medical doctor and the patient rather than *providing benefit in trust*. For this reason it becomes more difficult to uphold the obligation to care for and treat sick people: I as a health care worker am obliged after I have accepted the contract but I am not obliged to accept the contract!

The refusal to receive and treat infected patients, indeed, is, however, contrary to the very meaning of the profession, a meaning which today needs to be rediscovered by health care workers – people who are strongly tempted by the idea of the contract.

In agreement with what was said by the Episcopal Conference of the United States of America, it must be said, therefore, that health care workers cannot refuse to provide care and treatment. This is primarily because the obligation to care and treat patients without engaging in forms of discrimination is a part of the professional code of ethics. Secondly, it is because there are effective and sufficient precautions by which a person can avoid becoming infected when he is in a health care environment. These measures, as is well known, are no greater or more difficult than those required in the case of other virus infections, such as, for example, hepatitis B.

Obviously enough, on the part of the patient who knows that he is seropositive there is a moral obligation to inform the medical doctor and the personnel and staff who are looking after him so that they can engage in precautions to defend themselves and the other patients, always knowing that a risk exists, and indeed is more dangerous, when too much weight is given to the negative result of a test, and this given that the so-called 'window period' which follows the event of contagion can conceal the presence of the infection.

However, the various obligations of the medical doctor to engage in care and treatment must be interpreted in the light of their balance and their real operational effects. At the same time they must be shaped by the needs of the safety of the medical and nursing staff from whom professional, diligent and non-discriminatory service must be asked. These last, however, must not be called upon to engage in forms of useless heroism.

B) The special area of the terminal stage of the illness is also to be placed within the sphere of the duty to care for and treat. Assistance to the AIDS patient during the terminal stage of the illness involves a concrete perspective – of a more or less short duration – which involves health care workers and the whole of society being placed in front of a disease which still cannot be definitively cured. From the moment of the diagnosis of the illness, indeed, AIDS enters a stage when it seems that nothing can be done to block the illness, although much can and

must be done at the level of assistance. In this assistance the medical doctor who is responsible for the patient must take into account the real emotional qualities of the patient, the flexibility of the role that he can adopt during the advance of the illness, the possibilities of treatment – both technical and non-technical in character – which are intended solely to help the patient and do not have a clear therapeutic objective in mind because of the absence of good motives. Rejection of euthanasia and therapeutic overkill must be supported by the use of pain-killing drugs, in which treating pain, all the normal forms of treatment due to the patient, the communication of truth, and human and religious assistance, play their part.

Today there are people who theorise a sort of 'rationality' in the decision to commit suicide on the part of patients who are diagnosed as having AIDS. It is argued that there is even a 'moral obligation on the part of people to protect and indeed to favour to the greatest extent possible – where this is allowed by the law – the rationality of this choice'. In discussing this kind of 'assistance', *Evangelium Vitae* strongly declares that: 'to concur with the intention of another person to commit suicide and help in carrying it out through so-called "assisted suicide" means to cooperate in, and at times to be the actual perpetrator of, an injustice which can never be excused, even if it is requested... Moreover, the act of euthanasia appears all the more perverse if it is carried out by those, like relatives, who are supposed to treat a family member with patience and love, or by those, such as doctors, who by virtue of their specific profession are supposed to care for the sick person even in the most painful terminal stages'.

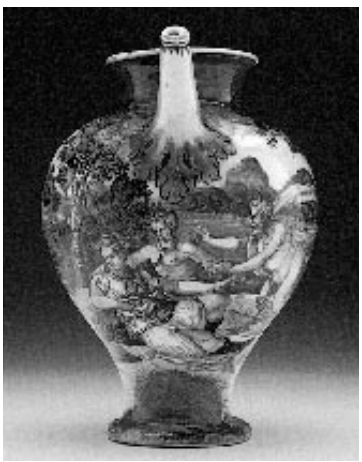
C) The *duty to engage in secrecy* requires ethical-moral discussion given that the question of secrecy has become a critical issue for a series of reasons: 1) before the appearance of AIDS professional secrecy had never before been so called into question to the point of bringing about profound conflicts between law, deontology and ethics; 2) the ethical approach soon came into conflict with the difficulties to be found in the interpretation of ethical principles, above all else in the practical application of the theoretical approach; 3) the problem of whether to keep quiet about the disease or whether to reveal its presence gave rise to renewed interest in the relationship between the medical doctor and the patient, a relationship which is certainly the primary point of reference for the clarification of certain 'grey areas' which can emerge in the case of ethical decisions and which are not always interpreted in a unanimous way when it comes to the duty of the medical doctor to engage in benefit towards society as a whole as well as the individual patient. For this reason, although the maintenance of professional secrecy in medical activity remains of absolute importance and is recognised in fundamental terms, there also emerged with great force the need to pay (if not greater at least equal) attention to those individuals who, as a result of a rigorous respect for such secrecy, would run very great risks to their lives.

The social health interest, indeed, can at times require the breaking of the secret (and such is the case with the situation of infection by HIV as long as this disease continues to be incurable and fatal) which, together with the classic principles of medical ethics with their recourse to the principle of the necessary respect due to the human person, converge in indicating the nature of the relativity of professional secrecy and the conditions which must exist when one can consider the provision of secret information to third parties as something which is legitimate.

From an ethical point of view, awareness that the principle of autonomy, as has already been pointed out, cannot play an absolute part in the sphere of the relationship between the medical doctor and his patient leads to a certain breach being opened in the wall of secrecy. The foundation of the breaking of such secrecy is to be found in the principle of justice, that is to say in the need to avoid an unfair wrong being done to a third party who is innocent, or to oneself. This is because the person who is benefiting from the secret is an unjust aggressor. It is evident that the priority which is established must not go beyond what is strictly necessary or be the source of certain forms of discrimination.

D) Lastly, the subject of *scientific research and the experimentation of new medicines and drugs*, which belongs to the full to the sphere of the duties to help infected people. It is certainly the case that we are face to face with a disease whose origins and epidemiology are known but whose cure is not yet available to us. Our first task, therefore, is to plan effective and valid prevention. However, we also need to encourage scientists in their search for new drugs and vaccines which will be able to defeat the virus. AIDS is different from other major serious diseases for which clinical trials are organised because it is an epidemic illness of an infectious nature which gives rise to great hopes about the possibilities of finding effective measures of control along the lines of what has been done for other infectious diseases during the course of this century. As a result, there is a very striking development of new drugs and medicines which are proposed in the form of single treatments or as combined treatment – often publicised without any good reasons and thereby giving rise to false hopes – which must be assessed and evaluated clinically.

Today, great hopes surround experimentations with vaccines against HIV. Recently in Italy such measures have been announced. The ethical questions and issues which arise with the experimentation of these vac-



cines are manifold, and they are subjects which ethical committees are called upon to assess and evaluate.

In particular, I would like to briefly examine the ethical problems which are raised today during the third phase of the development of vaccines, a phase when their effectiveness within the population at high risk is assessed and evaluated. From an ethical point of view it seems to me that we cannot 'limit ourselves' to administering the vaccine to individuals at risk and waiting to see its possible effectiveness, leaving the individual to continue in his forms of behaviour. It is appropriate, and morally imperative, that during this phase there is adequate counselling which can remove, where this is possible, the causes of the risk even at the cost of sacrificing the possibilities of assessing and evaluating the effectiveness of the vaccine when the counselling in itself is sufficient to remove or limit the causes of the infection.

The problem becomes more complicated when the experimental plan envisages the use of a control group, that is to say a group of individuals who will not receive the vaccine but merely a placebo: will it ever be possible to accept the fact that this group continues with its forms of behaviour at risk in order to act as a control measurement for those to whom the vaccine is given? It is certainly the case that the absence of standard preventive therapy makes the use of the placebo and other methods which reduce forms of interference (randoming and double blinding) acceptable in this case, but it is also clear that for the control group as well it is ethically necessary to provide for suitable counselling which corrects their forms of behaviour at risk.

These are some of the ethical questions and issues which can arise in the experimentation of new drugs and medicines to combat HIV, but they are sufficient to enable us to express the belief that the solution to such questions and issues cannot come about by laying stress solely, or in a reductive way, on the freedom of scientific research or solely on the autonomy of the individual to subject himself or otherwise to experimentation or solely on social utility in terms of costs and benefits. Above these individual values, and as a point of contact, we must consider the value of the human person in his wholeness and concreteness, a value which harmonises autonomy, therapy, prevention, and social intervention.

As has been seen, ethical thought appears with ever greater force in all the spheres in which the effects and consequences of infection by HIV are present. In addition to technical and professional skills, there are the ethical responsibilities of health care workers and for this reason there presents itself the need to include in their programmes of training and of professional up-dating the contents of biomedical ethics as well, and this should be an integral part of their training and a pre-requisite of full service to life which is such only when there is loyalty to moral law.

It was, indeed, directly to health care workers that John Paul II directed his speech to the participants at the fourth international conference on AIDS organised by this Pontifical Council ten years ago: 'up-date your training, make yourselves promoters of action directed towards raising the awareness of the social community, be spokesmen for the worries, the needs, and the hopes of those you care for and treat'(n.13).

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V: Spiritual Aspects of Accompanying People with AIDS-HIV

The history of every person is a mosaic made up of relationships and failures, loves and betrayals, opportunities taken and realities lost, actions of loyalty and examples of inconsistency.

In this framework is also to be placed and located the history of people with HIV-AIDS, individuals whose spiritual needs are to be read through the filter of their specific autobiographies.

From the point of view of their inner needs there are three horizons in which we can place the experience of these sick people:

a) *The religious horizon.* This is represented by those who for good or for evil have an experience of faith which is received, fought or recovered and who feel the need for prayer, reconciliation with God and with the Church, and the wish to face up to religious questions.

b) *The spiritual horizon.* This is represented by those sick people who cultivate their own spirituality whose elements include the search for the meaning of illness and death, the balance of their own lives, the meaning of the limits to, and the acceptance of, themselves, the positive appreciation of the transcendent, the affirmation of values such as peace and altruism, the joy of profound relationships, and the need to say goodbye.

Today, there is an urgent need to build bridges with this spiritual language which places us in contact with the values and the hearts of people.

c) *The human horizon.* This is represented by those who do not believe in God or in the Church, who reject the presence and the approach of religion, who disdain those who try to give a meaning to suffering and death, who ridicule the idea of a life beyond this one, and who adopt aggressive attitudes and attitudes made up of escape. We also need to offer these people the gift of humanity without blaming them or trying to convert them. We should, rather, bear witness, through the practice of respectful communication, to their human dignity and also

help them to move out of the tunnel of protest and build up their identity as humans.

In the various paths which are taken and followed the spiritual search does not so much involve entering the fragility of the sick person in order to direct him towards God, but a policy of adapting his language of keeping vigil next to his mystery as a suffering man in order to discover the mystery of God which works within him. God is not the slave of our *schemata* – He knows, rather, how to shape the human clay in His hands.

Placing ourselves in a way so that we can to listen to these people who suffer helps us to understand three wounds which often afflict those who suffer from HIV-AIDS:

1) *The Wound of Condemnation*

AIDS is often brought about by sexually promiscuous or transgressive forms of behaviour. Its victims are often homosexuals or drug-addicts, even though today the number of those who contract the illness through heterosexual relations is on the increase. As a consequence these sick people feel that they are judged, in particular by the Church, and they tend to have negative images of God, seeing Him as a severe, sadistic and vindictive judge. This intensifies their feelings of guilt, alienation and resentment.

At a spiritual level the pain of this wound becomes less when we become *witnesses of welcome*, in the fashion of the icon of the prodigal son who is embraced and joyfully welcomed by his father without him receiving questions about the nature of his past behaviour.

2) The Wound of Isolation

In the relational context, people with HIV/AIDS often experience a feeling of marginalisation and of segregation in relation to society.

It is their families which reject them above all else. They do not accept what their son or daughter has done or they feel stigmatised by his or her illness.

At times this rejection expresses itself in the prohibition of a return to the family home; on other occasions contact is broken off for ever.

Secondly, there is also isolation from society, abandonment of the Church, marginalisation in relation to work, the betrayal of friends, and the depersonalisation of relationships with health care personnel.

At the heart of Christianity we encounter the injunction uttered by Jesus: "when you did this to the least of my brethren here you did it to me" (Mt 25:40).

At a spiritual level the pain of isolation and loneliness can be reduced when we become *witness of nearness* as exemplified by the icon of Jesus with the leper where our Lord, through human contact, restores him to the human community.

Isolation can be cured through the promotion of projects of hope and solidarity which dissipate the false fears of contagion which are blown up by ignorance, and which involve actions of tenderness and warmth which help the sick person to recover a sense of belonging and security and to feel that he or she is loved.

3. The Wound of Grief and Death

The advance of the illness involves an increasing number of losses which have to be dealt with: the loss of health and security, the loss of self-image, the loss of work or of productivity, the loss of independence, and the loss of the future and of life projects, and this until the ultimate loss represented by death.

Every loss has its price which is in line with the various separations which it involves.

When faced with the presence of the break-up of the different pieces of the personal mosaic, spiritual care involves listening to the various feelings of anger and dismay, guilt and sadness, and anxiety and turbulence which accompany these various separations.

Separation is not only a psychological experience but also a spiritual experience... it is the Holy Friday of what people have to undergo.

In the background of these feelings are to be found memories and disappointments, and an awareness of lost opportunities and unrealised dreams.

In the unfolding of grief the troubled spirituality of the creature who experiences his fragility and mortality comes to the fore. It also expresses his nostalgia for health and for salvation.

At a spiritual level the pain caused by the gradual succession of these losses becomes reduced when we are *witnesses of listening and comprehension*, something that is represented by the icon of Emmaus where Jesus accompanies the pilgrims on the road and guides them from dismay into hope.

St. Paul reminds us of the trial of existence: "But we have this treasure in earthen vessels... we are afflicted in every way, but not crushed; perplexed, but not driven to despair; persecuted, but not forsaken; struck down, but not destroyed; always carrying in the body of the death of Jesus, so that the life of Jesus may also be manifested in our mortal flesh" (2 Cor 4:7-10).

The Journey of Illness: An Inner Journey

The person with HIV-AIDS is cured when the journey of the illness is transformed into an inner journey and when he encounters on this journey Good Samaritans who help him to redeem his personal history, to recover his own dignity, to give a new meaning to a changed life, to discover positive images of God who is seen as being near at hand, compassionate, a good shepherd, a healer, and a helper.

These witnesses of the goodness of God respect the beliefs of the sick person, welcome his states of mind and his silences, help him to die in peace, and where the conditions are favourable accompany him with prayer, the sacraments, or the comfort of the promises of the faith.

I would like to conclude with the words of a drug-addict who was dying of AIDS, words which were spoken to the pastor who was visiting him:

"I used to think that God had punished me with this illness. Now I have begun to think that He really loves me if he has sent me a friend like you".

May these words also inspire our way of being present next to these sick people!

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I: The Catholic Church in the Kingdom of Thailand

Thailand, known as Siam before 1939, is located in the Southeast Asian region. The country now has a population of 61 millions. Buddhism is the main religion (95%), followed by Islam (4%) and Catholicism accounts for only 250,000 of the total (0.4%). The Church in Thailand has 10 dioceses. There are 400 native fathers, 225 consecrational fathers, 1445 sisters and 120 brothers. Although the number of Catholics is quite small, the Church in Thailand plays a very important role for in the development of the Kingdom, especially in the area of modern education and community development. The Church runs approximately 300 schools distributed in every dioceses and also one university in the capital city. There are 4 hospitals for services and care for all diseases.

HIV-AIDS Situation in Thailand

The first case of AIDS was reported in 1984. During the first five years there were few AIDS cases. Starting in 1988 the country has faced four big waves of the HIV epidemic among target populations of injecting drug users (IDU), commercial sex workers (CSW), male clients of sex workers, and pregnant women. Principal HIV diffusion is by heterosexual transmission through commercial sex and other types of casual sex, especially among young adults of the ages of 18-29. Here are some facts on HIV/AIDS in the country.

– Cumulatively, there are approximately 900,000 people living with HIV in the country. Although all of the epidemics peaked during 1993-1994 there are still 40,000 or new cases each year. Most of the new infections are caused by sex related activities.

– Annual cross-sectional surveys by the government agency found at least 80,000 women involved in commercial sex at any particular time. The most recent surveillance data of June this year found a prevalence of HIV among direct sex workers in brothels of 17% and 6.5% among indirect sex workers who work in other sex establishments.

– No less than 100,000 people are drug addicted. The number of IDUs is around 60,000 persons. The latest prevalence of HIV is still as high as 50%.

– Each year there are 1 million pregnant women and the lastest prevalence revealed a HIV infection of 1.7% in this population which will result in 17,000 HIV infected pregnant women with approximately 3,000 HIV infected newborn children this year.

– The number of new AIDS cases for 1999 which need medical treatment is estimated at around 60,000 persons and this figure will reach its peak in 2002.

– The cummulative number of orphans due to AIDS problem is as high as 200,000.

Pastoral Experience

The Catholic Church in Thailand started HIV/AIDS services, responding to the call of His Holiness Pope John Paul II, in 1990. From our last survey in October 1999, there are at least 28 organizations dedicated to some kind of HIV/AIDS service or activity. However, these services are available only in 5 out of the 10 dioceses in Thailand. The type of services and activities can be classified as shown here.

Table 1. Type of services or activities to prevent and alleviate the problem of HIV-AIDS organized by the Catholic Church in Thailand, 1999.

Type of services/activities	Number
Community rehabilitation for drug addicts	2
Social center for commercial sex workers	2
Orphanage home and related activities	8
Caring for AIDS in different stages	3
Counseling and sheltering for people living with HIV	11
Hospital for HIV/AIDS treatment	3
Family and youth activities	2

To give some idea of the kind of services or activities related to HIV/AIDS, here are some examples of pastoral work:

The rebirth center is a therapeutic community where men and women afflicted with drug addiction live, learn and work together to help each other to gain a drug-free life and become productive members. It was started in 1979 and the present location is in Rajchaburin province in the central region of

Thailand. The center is operated by the Society of Our Lady of the Most Holy Trinity. Almost 400 drug users are in this rehabilitation center.

The foundation of life center is a place for nuturing friendship and support for women, young girls and children who are engaged in or vulnerable to prostitution. It is located in Pattaya, a famous tourist seaside resort which is well known for many entertainment places. The center has been operated by the Good Shepherd Sisters since 1988 and provides different kinds of services such as skill training, language proficiency, adult education, ect.

The Ban Mettha Tham in Payao, a norther province, provides pastoral care to persons living with HIV-AIDS (PLW HIV-AIDS) and their families. The project is run by the Sisters of the Daughters of Charity. Because many people have died of AIDS in the area, the project also has to take care of almost 100 orphanage children.

St Clare's Hospice is a 16 bed hospice for AIDS patients who are in the last stages of AIDS. The Franciscan Friars saw a great need to care for poor and homeless persons with AIDS. The hospice received its first patients in 1993 and up to now 400 patients have been taken care of. Because of the advance of antiviral therapy, late stage patients can live longer. This is a new problem for the hospice because some patients are getting better and can live for months or years.

The budget to support this work comes from donations from both domestic and overseas sources. Some organizations received seeding money from the government AIDS program. The Church in Thailand has established a Catholic committee on AIDS to plan, coordinate and support HIV-AIDS work in each diocese.

However, the work is still limited when compared to the problem load.

In a recently review, it was found that the Catholic Church in Thailand needs to develop a master plan and action plan for the next decade, establish a strong network for the sharing of resources and experiences in all dioceses, and mobilize funds and human resources for a more effective response.

Policy Framework for the New Millennium

In October 1999 the Catholic committee on AIDS organized a seminar in order to outline a policy framework on HIV-AIDS in the first decade of the next millenium (2000-2009). According to the recommendations, each diocese will develop its own action plan which will give priority to the following activities:

1. The development and implementation of appropriate educational processes for family life and sex education in all Catholic schools.
2. The development action plan in all Catholic schools to prevent and detect AIDS at an early stage, and refer for rehabilitation those students who are addicted to drugs. This will be done without any loss of student educational opportunity.
3. The building of more community rehabilitation centers for drug users.
4. The promotion of family life activities, premarital education and counselling programs for premarital, spouses, and youth.
5. The establishment of community centers or programs providing care for orphanages, the elderly, sex workers and people living with HIV-AIDS
6. The launching of a home-based care program in all parishes for people living with AIDS.
7. Educating general public about HIV-AIDS prevention and care.

Conclusion

AIDS causes a lot of sufferings and social problems for the Thai people. The Catholic Church in Thailand has started many activities to show the love of Christ for people who are vulnerable and affected by HIV-AIDS. However, the responses of the Church are still small when compared to the current magnitude of the problem. With the new policy framework for the coming decade of the new millenium, it is hoped that the Church will be able to mobilize more internal and external resources to carry out its pastoral work.

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Catholic Committee on AIDS
Bishops Conference of Thailand

II: Africa - The Congo

Introduction

The Democratic Republic of the Congo is in the centre of Africa, has a surface area of 2,345 KM2, and a population of 52,000,000 inhabitants of whom 50.6% are women and 46% minors under the age of fifteen.

The first cases of AIDS appeared in this country in October 1983 and in 1984 systems of control and prevention were set in motion with short and medium term plans of resistance to the disease looking forward to 1987 and 1991. These, however, did not achieve their objectives because of political instability. In July 1999 a national plan to combat AIDS was drawn up and adopted with a strategic national programme involving three and ten year time spans.

1. Some Medical-Health Care Parameters in 1998

The Democratic Republic of the Congo is one of the African countries which is most afflicted by AIDS. The statistics which follow have to be up-dated and will certainly be more alarming given the widespread contact of the population with people who have come over the border

from Uganda, Rwanda and Burundi (countries which are heavily infected by the epidemic), a process which began in 1984.

Of the 22,600,000 seropositive people in the world, 14,400,000 (63%) are to be found in Africa and 2,000,000 in the Congo (8.8%). Of the 1,600,188 full-blown cases of AIDS, 578.172 are in Africa (35%) and 38.426 in the Congo (2.3%). The distribution by province of observed cases in the Congo is as follows: Kinshasha 45.9%, Eastern Kasai 11.2%, Bandundu 6.8%, Western Kasai 6.5%, Lower Congo 6.2%, Katanga 4.7%, Equator 4.3%, North Kivu 2%, South Kivu 1.5%, and Maniema 0.2%. The disease prevalently afflicts people between the ages of 20 and 49, with a statistical peak between 20 and 29. This reality lowers the number of young people in the ages of reproduction and procreation.

There are 410,000 young orphans under fifteen years of age and 310,000 of these have lost both their parents.

The incidence of this disease is on average 4.35% in the 15-49 age band, a figure which is higher in the urban areas than the rural areas. This higher incidence is also to be seen amongst habitual blood donors and the family relatives of AIDS victims, workers in companies (5.3%), pregnant women (6%), prostitutes (30%), and people suffering from tuberculosis who have been admitted to hospital (33%).

In addition to AIDS, the other following social facts are equally worrying:

– the rate of infant mortality is 119 every 1000 live births;

– the rate of maternal mortality is 870 every 100,000 live births;

– a weight deficiency in 34% of babies;

– life expectancy in 1996 was 48 whereas in 1993 it was 52;

– GDP per capita is $117;

– accessibility to treatment for the urban population is at 40% whereas for the rural population it is at 17%, making an overall average of 26%.

2. Care and Treatment

Our understanding of access to care and treatment is gained from the organisation of the Congolese medical-health care service. In 1978 the Congo signed the Alma Ata Charter and in 1998 adhered to the Health Development Charter of Africa. The provision of basic health care has been the strategy which has been adopted, and this is essentially based upon scientifically valid methods and practices which are socially acceptable and accessible to all the members of the community who belong to that community in a spirit of self-determination. Because of economic, population, geographical and cultural factors the Republic of the Congo is divided into 305 health care zones of which 30% are so far operational at various levels. The forms of health care which are provided are curative, preventive, promotional, and rehabilitative in character.

Three kinds of care are to be encountered, and they are as follows:

– outlying: in the health care zones where preparation and implementation are carried out as a basic operational element;

– intermediate: at a provincial level where the health care zones are organised and co-ordinated in a general sense;

– central: at the level of the Ministry of Health where programming, co-ordination and general organisation are carried out. Here we encounter the various plans and specialised health care programmes, amongst which are those which deal with AIDS and other sexually transmitted diseases.

The national policy against AIDS was adopted in July 1999 with the creation of a three year plan for the years 1999-2001. Its aim is to stop the spread of this epidemic and its impact on families and individuals. An effective approach is required which is decentralised, multi-sectorial and integrated into the pre-existing basic system of health care.

The objectives of this policy are as follows:

a. To strengthen the ability to act of the agents and institutions involved in the fight against AIDS at a central and intermediate level in 60% of the health care zones;

b. to reduce the risks of sexual contamination and of transmission of the virus through blood throughout the health care zones;

c. To improve the access of people who live with HIV to structures of treatment, medical follow-up, psycho-social accompanying, and the development of such access to levels where it provides a broad response.

The fields of action are as follows:

– social mobilisation and community participation;

– the prevention of the transmission of the disease within certain specific groups;

– the prevention and treatment of sexually transmitted diseases;

– the creation of an effective national network to guarantee infection-free blood;

– assistance and pyscho-social accompanying for people who suffer from, and have to live with, HIV;

– the establishment of an ethical and legal committee to create a favourable environment for people who have to live with HIV;

– the strengthening of the national system for the epidemiological surveillance of AIDS and other sexually transmitted diseases;

– a general policy involving the actors in the fight against AIDS and sexually transmitted diseases;

– a strengthening of the capacities of the institutions and agents involved in the fight against AIDS.

This national policy is not yet operational. We are still waiting for a specialised programme of intervention to support the health care zones in matters relating to information, education and communication, condoms, the treatment of sexually transmitted diseases, the safety of blood, the treatment of people who live with HIV, a monitoring of the spread and behaviour of the epidemic, operational and fundamental research, follow-up and supervision, training, the provision of drugs and medicines, and the drawing up of directives, rules and regulations.

Side by side with government action we find the initiatives of 170 non-governmental organisations united in a forum in the fight against AIDS which goes under the name of 'FOSI'. Some of these NGOs are large in size – such as the religious group 'GOS' – some are medium sized (AMO-CONGO), and some are small (PAES). Their funding is provided by special backers, by the community, and by measures of self-funding which are organised within these organisations.

Because these bodies do not always have sufficient economic means, the action of members of the community is of primary importance in the field of AIDS in the Congo. The costs here are essentially born by individuals and the nuclear family.

3. Pastoral Care

Pastoral care takes place within an organised framework and a non-organised framework.

The first is characterised by activities of consciousness-raising and accompanying based upon a neutral message of hope. The ecumenical group involved in the struggle against AIDS (GOS) is the most important of the category and promotes an overall approach which includes all the aspects of the AIDS phenomenon. It has a multidisciplinary group of pastoral medical active members organised together into a special unit. The activities this group engages in are the raising of awareness (theatres, educational talks, group encounters, video forums, micro-training, slides and films and other audiovisual material, conferences and debates) and the accompanying of those with the disease (diagnostic follow-up, visits, and home-based care and treatment).

The other Christian action groups involved in the fight against AIDS have few financial resources and thus can only draw upon the resources of people of good will (medical doctors, nurses, chaplains, and the members of small churches) who work within the context of their basic professional responsibilities. Such people are not necessarily benefactors. At this level the material difficulties which are encountered often make the support which is begun at the moment of admittance to hospital ineffective.

The pastoral care which does not take place within an organised framework sees AIDS as a divine punishment and is characterised by the attribution of blame to the sick person who is thought to need purification through dangerous practices which are held to lead to a miraculous cure (prolonged fasting in the case of sick people who are already weak, being washed with poisonous liquids and materials, collective euphoria which increases the practice of forms of behaviour at risk, etc.). The religious sects are the entities which most work in this area. In this area an attempt is being made to bring them under control so as to reduce the harm that they can do.

4. Comments and Conclusion

Access to treatment and care by people suffering from AIDS, in terms of the population as a whole, can generally be reduced by 26% because of the marginalisation of the sick person, and as a result of this condition, of his community as well. It will be even lower because of the war going on in the country and all its pernicious consequences.

Given that a national policy against AIDS has not yet been implemented, assistance is essentially and symbolically provided by the individual and his close family, and this despite the great poverty which afflicts this community.

The appearance of AIDS in a family is currently experienced as a catastrophe. This will be the case for a long time to come because in addition to a good policy we need a suitable health care budget and the political will which will really enable us to fight against AIDS and reduce its impact on individuals and communities.

Efforts must still be made to promote organised pastoral care and to curb the charlatans.

Overall, the Democratic Republic of the Congo is one of the countries which is most afflicted by AIDS and in which access to care and treatment is scarce. Assistance in this field largely falls upon the individual and his family.

Dr. KAPEPELA
KAKICHA MARIE,
The Democratic Republic of the Congo.

III: South America - Brazil

– As of February 1999, there have been 162,865 cases of AIDS registered by BMH. The BMH estimates that there are over 500,000 HIV+ persons living in Brazil.

– The history of the AIDS epidemic in Brazil has quite different phases:

1. Homo and bisexual men from higher social classes in the main metropolitan areas of the country;

2. Injection drug users, mainly young subjects from different social strata (mainly disadvantaged) in the big and middle-sized cities of the country;

3. Heterosexual dissemination toward women, with interiorization and impoverishment of the epidemic.

– The first case of AIDS in Brazil was diagnosed, retrospectively, in 1980, in São Paulo city.

– Until 1987 there was no anti-retroviral treatment.

– AZT was the first drug made available by the Ministry of Health in 1991.

– DDI was available in 1993.

– In 1996 in a pioneering decision, the Brazilian government made combined therapy available to all Brazilians at no cost.

– The amount of US$ 500,000,000,00 was spent in 1996 in medicines for AIDS. Currently, some 68,000 patients receive this kind of treatment.

All patients under medical supervision are entitled to receive free of charge combined therapy (HAART).

There are specific rules to begin the treatment in symptomatic and asymptomatic subjects.

These rules are updated regularly by the Brazilian national board (at least once a year).

Currently there are 12 antiretroviral drugs available for treatment.

To receive the treatment the patient has to be enlisted in a National Databank. Using the information of this databank it is almost impossible to give the treatment twice to the same person, and BMH can follow-up the patients under HAART regimes in the different regions of the country.

The medicines are distributed under regular medical supervision and the amount of medicines delivered is enough for at least a month-long treatment. All patients are entitled to have free of charge CD4 counts and viral load tests for up to three times per year.

There has been an impressive decrease in AIDS mortality in recent years. From 1995 to 1998 the mortality decreased around 49%.

The quality of life improved substantially, with some patients returning to their "normal" life. The majority of them have returned to their jobs. After the beginning of HAART there was a decrease of up to 81% of opportunistic infections amongst AIDS patients in Brazil.

The BMH estimates that some 47,300 patients were spared being in hospital wards in 1997. That meant that some US$ 10,000,000,00 were saved in that year.

To monitor in a comprehensive way Highly Active Anti-Retroviral Therapy better laboratorial resources (tests, training, improved facilities) were made available by the Ministry of Health all around Brazil.

All patients must know and understand clearly that full adhesion to treatment is fundamental for a better quality of life and fundamental to avoid the emergence of viral resistance.

Non-adherence, besides bad consequences for individuals, has become one of the most threatening challenges for public health in the post-HAART era.

Some patients with a very low cultural background with an undetectable viral load frequently stop treatment and may transmit the virus, mainly by sexual relationships.

Constant counselling is fundamental for all patients on HAART.

There is a high incidence of tuberculosis in Brazil, and some 20% of these patients are HIV+ and cannot use different regimes of combined therapy while under treatment for tuberculosis, and ask for alternative strategies.

Some citizens believe that "a cure for AIDS" is already available and have not taken any kind of prevention in relation to HIV infection.

Some patients with an undetectable viral load begin sexual relationships with partners thinking that they have been cured.

Highly resistant viruses can be spread by some patients who have discontinued their therapeutic regimes.

Assistance is provided to AIDS patients through a complex system, comprising 338 general hospitals.

Specialized care is available in most regions of the country, including 140 outpatient facilities, 60 day-care units and 46 home-care units. The latter figures seem quite low vis-à-vis the huge Brazilian demands for medical assistance and the scale of social problems.

Another problem still to be fully addressed is the referral of patients from and to the different units of such a huge and heterogeneous country.

Our clinics and support houses care for homeless people, male and female prostitutes, ex-convicts and street kids. We have tested for HIV some X patients and Y of them were tested positive.

Our multidisciplinary team has physicians, odontologists, psychologists, social workers, and nurses.

Our population demands very special care, as the majority of them are homeless. So, we provide showers, clean clothes, meals and a day hospital. This is a complex task, seldom provided by other facilities, requiring the multidisciplinary work of different specialists, besides social support.

Most patients are heavily affected by alcohol and drug consumption, with high attrition rates unless they receive care and continuous support. A unique role is reserved to religious assistance and support, a core strategy to make their lives better and meaningful and to improve adherence to HAART and other medical and nursing protocols.

We deal with these patients in the most comprehensive and timely way possible, so that they can be assured that we do care for them!!!

Due the lack of basic education, there are barriers to communication with some of these patients. We have trained our staff to sort this problem out.

One of the most important aspects of our work is to rescue the self-esteem and dignity of these patients.

MARIA INEZ LINHARES
DE CARVALHO, MD
Archdiocese of Rio de Janeiro, Brazil

IV: Central America - Haiti

The Republic of Haiti on the western part of the island of Haiti has a population of 7,500,000 inhabitants. Over 70% of them live at the present time under the absolute poverty line with a *pro capita* of 500 gdes a year ($US 28 a year). Over 50% of children of the school age do not go to school and only 10% of children who go to school then go on to secondary school (Report of the BID, 1997).

The socio-economic conditions of the country continue to grow worse as a result of political instability and increasing insecurity. Serious health care problems afflict the population, and the hardest hit are the poor. Hunger, acute hunger, illiteracy and unemployment drive people, including many adolescents, towards prostitution and drugs. For this reason, sexually transmitted diseases (STD), and in particular AIDS, are at the present time in Haiti one of the greatest problems for public health.

Between 240,000 and 335,000 people are presently infected with HIV - about 6% of the total population of the country. However, these statistics are well below actual realities. In this country there is no legislation which governs this disease. There is no law which obliges medical doctors or the health care personnel to report diagnosed cases of HIV-AIDS. For this reason, many cases escape the knowledge and control of the health care authorities of the country.

Here are certain statistics relative to 1998:

	Total	Adults	Women	Children
People who live with AIDS	236.65 to 332.43	223.71 to 314.19	100.35 to 141.69	12.94 to 18.24
New cases of HIV infection	40.70 to 56.01	36.02 to 49.43	18.17 to 24.96	4.69 to 6.57
Number of new cases of AIDS	28.26 to 39.2	24.45 to 34.51	10.43 to 14.78	3.82 to 5.40
Total deaths since the outbreak of the infection	21.600 to 30.000			
Orphans	1.300 to 1.900			
Tubercolosis + AIDS	44.57 to 58.58			

The Catholic Church of Haiti, whose mission is to serve man in his wholeness, makes an important contribution to the reduction of the level of illness and mortality caused by pathologies of every type. In fact, concern for people with AIDS comes largely from the Catholic health care institutions amount to 190 in number - that is to say 37.9% of the health care institutions of the country. Amongst these institutions we should make a distinction between clinics, hospitals and centres for the terminally ill.

The *clinics* of the Catholic Church are to be found in the hinterland of the country, and access to them is often very difficult. Suspected cases are identified by these clinics and referred to more advanced centres for diagnosis. Once they have been diagnosed these sick people are sent back to their localities and care is provided to them by the personnel of the clinics. This care involves:

– regular consultations in order to identify early on the signs of opportunist illnesses;

– home visits in order to make the patient have an responsible approach towards the rest of the population;

– nutritional aid.

The *hospitals* are an intermediate structure between the clinics and the centres for the terminally ill:

– they carry out diagnoses;

– they treat the acute cases which are sent to them. After recovery these patients are sent to the local clinics or to the centres for the terminally ill during the last stages of their life.

The centres for the terminally ill, four in number, receive patients when they are at the advanced stage of this illness. Their treatment involves:

– physical help;
– the treatment of opportunist infections;
– accompanying these patients in order to help them live out this new reality.

In addition to taking care of people suffering from AIDS, the Catholic Church is also active in the sphere of prevention. Action consists of:
– encounters for information and training;
– education in favour of chastity amongst young people: after a period of preparation the young person freely decides to engage in chastity for a renewable period of six months. If he does not keep this promise the young person has the possibility to return to the training centre and with the help of the staff to detect and identify the causes of his failure. If he wants to he can then renew his promise.
– education in favour of faithfulness between marriage partners.

However, many obstacles make the action of the Catholic Church difficult. We may cite some of them: - lack of material;
– a shortage of qualified staff;
– certain taboos;
– a lack of co-ordination between the Catholic health care institutions (it should however be noted that for about two years an attempt has been underway to create a network made up of these health care institutions).

In conclusion, AIDS is an illness of behaviour and its prevention requires the concerted action of all the sectors of national life. The very widespread use of the condom, which has hitherto been proposed as the measure of prevention, has failed, as is borne out by the statistics published at a world-wide level over the last ten years. It is thus imperative for the Catholic Church to place emphasis upon her doctrine in relation to the dignity of the human person and to stress her guidelines with regard to the family. Furthermore, she should seek to create spaces by which to encourage and implement them.

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Episcopal Commission for Health, Haiti.

V: North-America - The United States of America

Please allow me to thank His Excellency, Archbishop Lozano, for the kind invitation which he extended to me to joint this meeting and to share some reflections on the experience of the Church in the United States in response to this pandemic which has wrought such profound effects on individual and family lives as well as on social and ecclesial structures despite the brief period of time which it has been in our consciousness.

I will begin with a brief review of the trends in the development of the pandemic as it presently has evolved in the United States. This country is joined by others in Western Europe and North America, as well as Australia and New Zealand, in which their respective populations are particularly vulnerable to the threats of denial and complacency in the face of HIV-AIDS. It is indeed true that the numbers of new cases of AIDS and of death due to AIDS-related illnesses are both falling significantly in countries where people have access to combination, antiretroviral therapy for a majority of those living with HIV. However, there is no sign that new infections are following the same downward course; it is estimated that some 1.5 million people in the above-mentioned areas were living with HIV at the end of 1999. In a study of homosexual men in San Francisco, for example, indication was given that high risk sexual behaviors are being adopted once again. The fact that people living with HIV are living longer also makes it possible that those who engage in sexual intercourse may infect others over a longer period of time. The positive effects of the antiretroviral therapy also seem to be tapering off. In the United States, for example, AIDS deaths decreased by 42% between 1996 and 1997, but by only half that proportion between 1997 and 1998.

Let us look more carefully at the effects of this pandemic in the United States. In spite of the medical and technological resources available to many residents of this country, HIV-AIDS presents itself, nevertheless, as the most critical and devastating epidemic in recent history. HIV infection and the clinical complications related to it are placing a heavy strain on medical and social services. It should be noted that not all people living with HIV-AIDS in the United States can gain access to the combination therapies. This country does not have a national system of health care. Some private insurance plans will cover the cost of these medications for HIV-infected individuals who already were enrolled in their plans. State and federal funding is available to provide such drugs to residents whose annual income is below established poverty guidelines. Others are denied the possibility of benefitting from such treatments unless they qualify for particular research protocols.

In December of 1998, the Centers for Disease Control, reported the following information related to the extent of HIV-AIDS in the USA.[1]

– AIDS is the second leading cause of death among adults in the USA aged 25-44.

– The total number of HIV-infected people in the USA is estimated between 650,000

and 900,000, and approximately 40,000 are infected each year, of which as many as 50% of these cases may be among young people under age 25.

– Although racial and ethnic minorities account for only 25% of the U.S. population, they account for more than 50% of all AIDS cases. African-Americans and Hispanics account for 58% of adolescent males with AIDS and 83% of adolescent females with HIV.

– Many at greatest risk are still not aware of the behaviors than can result in HIV infection. It is estimated that some 200,000 infected people in the USA have no idea of their infected status or of the threat which they can pose to others through sexual contact or contact with infected blood.

– The proportion of all AIDS cases reported among adult and adolescent women has nearly tripled – from 7% in 1985 to 22% in 1997.

– The incidence of AIDS is 14 times highler in state and federal prisons than in the general population of the United States.

Let us now examine how the Church in the United States has attempted to bring its ministry to those living with HIV-AIDS. The bishops of this country were among the first to appeal to all the faithful to respond to those affected by the pandemic with compassion and without fear or prejudice. In the document, issued in 1987 and entitled *The Many Faces of AIDS: A Gospel Response*, the Administrative Board of the U.S. Catholic Bishops' Conference mentioned the new services which should be considered by parishes and institutions sponsored by the Catholich Church.

Current programs and services needs to be expanded to assist the families of those with AIDS while they are alive and also to support them in their bereavement. In addition, new programs, services, and support systems need to be developed to deal with unmet and poorly met needs.

In a subsequent pastoral letter issued by all the bishops of the United States, Catholics were reminded of the Gospel-based responsibility to affirm the dignity of those living with HIV-AIDS and to care for them without hesitation.

Persons with AIDS are not distant, unfamiliar people, the objects of our pity and aversion. We must keep them present in our consciousness, as individuals and as a community, and embrace them with unconditional love. The Gospel demands reverence for life in all circumstances. Compassion – love – toward persons infected with HIV is the only authentic Gospel response.[2]

In response to the strong encouragement of the bishops and in following the excellent example of clergy, religious, and committed laypersons who heard the "cries" of those affected by this pandemic, excellent educational, medical, and social services in response to the pandemic were developed under the auspices of the Catholic Church in the United States. Here are some examples of such resources and services:

In the area of education:

– The U.S. Catholic Bishops' Conference developed a videotape entitled *Living with AIDS: An Occasion of Grace* (1990). It focuses especially on the diocesan and parish responses to HIV-AIDS.

– The National Catholic Education Associatin published a teachers' manual and curriculum for primary and secondary grade leverls; it is entitled *AIDS: A Catholic Educational Approach to HIV* (1992).

– Catholic Charities USA developed a training manual and educational program for those engaged in the social apostolate (1995).

– The National Federation of Priests' Council published a booklet on *Clergy and Religious and the AIDS Epidemic*.

– Many dioceses have produced educational manual on HIV-AIDS and their own plans for AIDS ministry within the respective diocese.

– In the Diocese of Albany, New York, and Oakland, California, and in several other dioceses, young people are educating their peers about the fact that the only "safe" way to avoid HIV-AIDS is to be abstinent before marriage and faithful within marriage.

In the area of health and social services:

In a 1995 survey, 120 hospitals, 209 outpatient health services, and 177 social service agencies identified themselves as being Catholic-sponsored and responsive to the needs of people living with HIV-AIDS.[3] The health-related services which they sponsor include inpatient and outpatient medical care, nursing home, hospice care, and in-home care. The social services which they sponsor include emergency food supplies, transportation, homemaker services, home visiting, emergency housing, transitional housing, permanent housing, counseling and mental health services, support groups for HIV-infected persons as well as for the families and loved ones, support groups for the bereaved, and support groups for those providing care. Populations served include adults, children, the incarcerated, racial and ethnic minorities, and those who are disables.

In the area of pastoral services:

Perhaps the greates demand or challenge which the pandemic places upon the Church is in the area of pastoral care. Many of those infected with HIV, even those who formerly were alienated from the faith community, urgently turn to the Church for assistance in searching out the deeper meaning and value of their lives despite, and often as a result of, the physical, psychological, and social pain they experience. At times even the Church's vital sacramental ministry is not sufficient to satisfy the hunger and thirst for God posed by people living with AIDS as they face the "dark night of the soul" through their suffering and dying. Despite the Church's unique capacity in this area of

its mission, members of the faith community have not always responded as fully as possible and as necessary to the call for pastoral ministry by persons affected by the pandemic. Some priests, religious, and laypersons are fearful to approach those living with the virus because they have the false impression that this disease could be transmitted through casual contact.

The Catholic parish is the weekly gathering place for most of the sixty million Catholics in the United States. These 19;700 parishes are focal points for education, services, social justice advocacy, and pastoral care. Conscious of demands being placed on these parishes by those affected by HIV-AIDS, the leaders of the National Catholic AIDS Network and Catholic Charities USA prepared a training manual and process to encourage the development of parish-based HIV-AIDS ministries.

In the above-mentioned training process, parishioners are encouraged to prepare themselves to respond to people affected by HIV-AIDS – not as "strangers" or "those others" but rather as brothers and sisters in the community of faith. They are asked to pay particular attention to the words of our Holy Father when he visited San Francisco in 1989:

"God loves you, without distinction, without limit... He loves those of you who are sick, those suffering from AIDS. He loves the friend and relatives of the sick and those who care for them. He loves us all with an unconditional and everlasting love".

The following questions are posed to parishioners who are preparing to serve those affected by the HIV pandemic:

– How can our parish better integrate the needs and concerns of such people into our existing apostolates?

– What resources in our parish can help us to provide care and education related to HIV, especially to members of racial and ethnic minorities?

– Is our parish a welcoming community? How can we help it to become more welcoming? How can we expand our apostolate of hospitality to include and reach our to those living with and affected by HIV?

– How can we help fellow parishioners to overcome judgment and stereotypes concerning HIV-AIDS?

This same training process offers the following guidelines to those who wish to provide pastoral care to people affected by the pandemic of HIV:

– Move out of denial – undestand that AIDS is everyone's problem. Search for the path to compassion.

– Get to know the life situations of people living with HIV-AIDS by meeting them and inquiring how this disease affects their lives.

– Understand your own responses to HIV-AIDS by acknowledging and speaking about your feelings and thoughts.

– Seek your foundation in faith by reading and reflecting on statements of the Holy Father and bishops about the pandemic, by meditating on Sacred Scripture, and by speaking with your spiritual director.

– Make a personal commitment to serve people affected by HIV-AIDS.

– Make a community commitment to seek parish support for action to bring AIDS in to the light and action of your faith.

– Assess which needs require priority action within your parish.

– Assess the resources and talents which are present among parisioners who are willing to join an HIV-AIDS apostolate in your parish.

– Plan and take action; keep the other parishioners informed about your activities so that the apostolate keeps its roots within the parish.

– Evaluate and change your activities as needed.

The pandemic of HIV-AIDS indeed has challenged and shaped humanity – and continues to do so at the present time. It has tested it with physical pain and disfigurement, with exclusion and discrimination, with emotional conflict and confusion, and with spiritual crisis and despair. This same pandemic has demanded that the Church transform itself in closer conformity with its mission as teacher, servant, and convener of the worshiping community. The members of the administrative board of the U.S. Catholic Bishops' Conference offered Catholics in the United States a "litmus test" of our ministry in response to the pandemic of HIV-AIDS, when they said:

Our response to the needs of persons with AIDS will be judged to be truly effective when we discover God in them and when they, through their encounter with us, are able to say, "In my pain, fear, and alienation, I have felt your presence, a God of strength, love, and solidarity".[4]

Rev. ROBERT J. VITILLO
Executive Director Catholic Campaign for human development USA

Notes

1 *AIDS – End the Silence*, Resource Booklet for World AIDS Day, December 1, 1999, Washington, DC: American Association for World Health, 1999.

2 National Conference of Catholic Bishops, *Called to Compassion and Responsibility: A Response to the HIV-AIDS Crisis*, as appeared in *Origins*, November 30, 1989, vol. 19, no. 26.

3 *Resourche Directory of Catholic-Sponsored HIV-AIDS Programs*, prepared by Catholic Health Association of the United States, Catholic Charities USA, and the National Catholic AIDS Network, 1996.

4 United States Catholic Conference Administrative Board, *The Many Faces of AIDS: A Gospel Response*, in *Origins*, XVII, 28 (December 24, 1987), p. 136.

VI: Europe and Poland

1. Polish society realised that the HIV epidemic had also reached Poland in 1985, the year in which a case of contagion with HIV was registered for the first time in our country. Since that year diagnostic analyses have been brought into being in Poland for the identification of HIV. The epidemiological data which have been gathered by the National Health Service demonstrate that from the beginning of the analysis – that is to say from 1985 until October 1999 – 6,050 Polish citizens were contaminated, of whom at least 3,800 were infected because of drug use. There were 826 cases of AIDS of whom 460 died. These are official data. However, it should be emphasised that given epidemiological estimates, in reality from 15,000 to 20,000 people have been infected by the virus. These data do not place Poland amongst the European nations which have a high percentage of infection, however this is not something which should comfort us because the infection is demonstrating a gradual although slow rate of increase.

The situation in Poland appears comforting in comparison with that which obtains in the other European countries, and in particular with that to be found in the Eastern European countries. The expansion of the epidemic in the countries of the former Soviet Union is much more notable, and this is something which is worrying for us. In the Ukraine, Russia and Bielorussia, the last four years have demonstrated an extremely high rate of increase in the levels of contagion. The principal carriers of the virus in these countries are drug-addicts who inject themselves with drugs intravenously. The same situation is to be found in Moscow, Minsk and Kaliningrad. A clue regarding the possible propagation of HIV in Eastern Europe through sexual contacts is provided by the results of the investigations into cases of venereal diseases. A major increase in venereal diseases has been observed in Russia, the Ukraine and Bielorussia but this is also something which has been registered in Moldavia and Kazakhstan.

The worrying epidemiological situation of AIDS in Eastern Europe has special importance for Poland, and is a source of major preoccupation, because we are the immediate neighbour of most of these countries. The development of so-called sex tourism and the phenomenon (which is becoming increasingly widespread in Poland) of prostitution practised by female immigrants from the East can bring about an increase in levels of contagion in our country. The situation is certainly serious and constitutes a challenge for the authorities of the country and the institutions established to deal with the prevention of AIDS. Strict co-operation should be engaged in, primarily in order to exchange experience in relation to preventive action and legislative and structural remedies for carriers of HIV and those afflicted by AIDS.

2. The carriers of the HIV virus and those suffering from AIDS receive guaranteed overall health care in Poland and they also have guaranteed access to therapies involving the recent anti-retroviral drugs, something which is very important for them. The responsibility for the organisation of the system is entrusted to the Minister of Health. The policy guidelines are defined by the National Plan for the Prevention of AIDS, a plan lasting a number of years which outlines the government's priorities in the sphere of the struggle against AIDS. Recently the government has established such a plan for the years 1999-2003.

In 1993 the Minister of Health created two government agencies specialised in prevention and the drawing up of standards in diagnosis and treatment: the National Co-ordination Office for the Prevention of AIDS and the Centre for the Diagnosis and Treatment of AIDS. Patients can take advantage of the services offered in twelve specialist hospital institutes located in the provincial capital cities. Following a well established practice, those suffering from AIDS are admitted to the infectious diseases wards and any form of isolation is ruled out. All the patients who need anti-retroviral treatment receive it as long as they meet the criteria laid down by the National Strategy for Anti-retroviral Treatment, which was drawn up by health care workers who were specialists in the treatment of AIDS. Before beginning the treatment the patients have to undergo a series of tests and analyses which are subsequently repeated three times a year and which permit an effective monitoring of the effects of the anti-retroviral treatment that these patients receive.

As has already been observed, the anti-retroviral drugs – the most expensive part of the treatment – are bought from a central body and paid for with funds from the Ministry of Health. At the present time anti-retroviral treatment is given to over a thousand patients and it is useful to make clear that this year seven million American dollars have been allocated to such treatment. The Minister of Health has also established a special central fund for preventive action which in 1999 amounted to four million dollars.

An important goal in the system of anti-retroviral treatment is the provision to pregnant women infected by HIV of treatment which has a high probability of minimalising the dangers of them having sieropositive children. The babies born to mothers who are carriers of HIV are from birth part of a specialised system of laboratory diagnosis which allows the rapid identification of possible infection. All sieropositive minors (in Poland there are

about fifty) are guaranteed treatment and care at the Clinic for Childhood Infectious Diseases in Warsaw. It should be observed at this point that in Poland pregnant women with the HIV virus receive strong psychological support and through specialist psychologists are encouraged to remain pregnant and to give birth to their child.

The carriers of HIV and people suffering from AIDS can avail themselves of the services of psychological consultors, of a special telephone service open night and day, and of the system of support offered by a large number of non-governmental organisations. One of these is the voluntary association 'Come to Us' in which people with HIV, their friends and supporters, offer help.

All in all the medical and social care given to carriers of HIV and those suffering from AIDS in Poland is maintained at the highest possible level and certainly we should not in the least be ashamed about it.

However, it should be observed that beyond the coherent and efficient system which operates, and the notable sums provided by the state, there is a need for an important initiative of information in order to ensure that society is increasingly informed about AIDS. This could provide for an even more suitable shaping of social attitudes towards AIDS. We are all convinced that discrimination in relation to those suffering from AIDS, which unfortunately characterised the first years of its appearance in Poland, is by now something which belongs to the past.

I would also like to discuss the health systems of the countries of the former Soviet Union. It should be observed that in general in the countries of the former Soviet Union it is rare to encounter patients with AIDS who are guaranteed health care of a good level. It is true that in the Ukraine and Russia the big cities have the so-called 'AIDS centres'. However, principally for financial reasons, they are not able to provide patients with specialised diagnoses or anti-retroviral treatment. The governments of these countries have established national AIDS prevention programmes and it is to be hoped that in the not too distant future they will manage to find funds so that these programmes can be implemented. It seems to me right to say at this point that our states are morally obliged to provide the HIV carriers and AIDS sufferers who live in the countries of the former Soviet Union with the best help possible. The high-sounding slogans which marked the celebrations of the world AIDS day in many European countries, such as 'a world of hope', 'common rights, common duties', or 'unite for equality!', seem to be mere commonplaces empty of meeting when they are considered in relation to the frightening situations to be found in Africa and the countries of Eastern Europe. Indeed, they are not even worth repeating.

3. In conclusion, I would like to stress the very important nature of the work of the Catholic Church in relation to the problems and issues connected with AIDS. We are probably the only country in which a Catholic priest and member of the Order of the Camilians is an adviser and delegate of the Minister of Health in matters connected with AIDS and drug-addiction. This fact has a marked influence on the shaping of a suitable policy of the state and the bringing about of collaboration between the government and the Church in this important area. One is dealing here in the main with educational activities and initiatives for young people, the construction of inter-human ties, and the encouragement of attitudes of solidarity towards people afflicted with this illness. In all the hospitals I have mentioned where AIDS victims are treated the hospital chaplains are fully occupied in providing spiritual care and assistance to these patients. I would like to stress the importance of co-operation with the government body the National Co-ordination Office for the Prevention of AIDS which uses funds from the Ministry of Health to implement and finance the systematic training of seminarists drawn from a large number of higher seminaries. This office also organises the publication of works for special groups of readers, for example for the clergy. It has produced books such as 'The Church and AIDS' and many others. All these publications are given out freely to those who are interested in them. The Ministry of Health also finances a conference on the questions and issues of drug-addiction and AIDS which takes place at the end of each year with the participation of numerous groups of female religious and secular students of theology. To conclude: let us remember that the Church in Poland is responsible for various centres which operate within the spheres of action of healing communities and help drug-addicts. Most of these people are young carriers of HIV. These Catholic centres are completely financed by the state as part of the collaboration with the Ministry of Health. I can affirm with great satisfaction that the presence of the Church in the field of helping people suffering from AIDS is noteworthy and that the Church's collaboration with the government works to the satisfaction of both parties.

I would like to hope that the information that I have given to you in this paper has drawn you nearer to the situation in Poland and that it has been of help to the debate. I would like to ask you once again to forgive my absence and I would like to express to you my deep regret at not being able to be with you here today.

Don ARKADIUSK NOWAK,
Adviser to the Minister of Health in matters relating to AIDS and drug-addiction, the Ministry of Health and Social Insurance of the Republic of Poland.

Conclusion

This conference led us to recognise the urgent need to follow the question of HIV-AIDS very closely, both through the standing study group and the continental study group, and with a programme organised around three key areas:
– information;
– archive material;
– education.

Work Programme for the Year 2000

1. Information

The insertion in the Pontifical Council's Internet site of:
1. The main papers given at the conference held in December 1999.
2. An information statement on the new possibilities concerning prevention with regard to transmission from the mother to the foetus.
3. An information statement on the initiative designed to help orphans.

2. Archive Material

1. The organisation of a special library on the question based on material from many sources.
2. The diffusion through Internet of the archive material of this special library.
3. The publication of the acts of the conference of December 1999 on 'The Catholic Church and the Challenge of HIV-AIDS'.

3. Education and Training Initiatives

1. The drawing up of a vademecum which will help the local Churches.
2. The preparations for the AIDS Day of 1 December 2000.
3. The meeting of the continental study group on AIDS (30 November 2000-1 December 2000).

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Seminar

The Identity of the Catholic Chaplain in Pastoral Care in Health and Health Care on the Threshold of the Third Millennium

22-23 November 1999
Nova Domus
Sanctae Marthae
Vatican City

On 22-23 November 1999 the Pontifical Council held a Study-Seminar at the Domus Nova St. Marthae on the subject of 'the identity of the Catholic chaplain in pastoral care in health and health care on the threshold of the third millennium'.

This was the first initiative of the 'programmes' which the Ministry drew up during the celebration of the IV Plenary Session of 1998, and forms a part of the third section entitled 'the ministry of communion'. Its specific objective is to 'promote, direct and co-ordinate the union of the Catholic chaplains of health centres', something required by the founding Apostolic Letter 'Dolentium Hominum'.

The participants were nominated by the respective bishops entrusted with this task by the episcopal conferences from the countries concerned, people different from those responsible for the 'National Associations of Chaplains in Health Care'.

The following are the four leading papers which constituted the platform upon which this seminar of study was based.

The Ordained Ministerial Priest, Bishop and Presbyter in the Health Care Ministry in the Light of the Apostolic Exhortation "Pastores Dabo Vobis"

At the beginning of the third millennium the health care ministry is experiencing a lack of ministerial priests. This is in part due to the lack of priestly vocations and is in part perhaps also due to the fact that this priestly ministry is often not understood. In some cases there is a limited vision of its range and it is thought that there are other priorities to be dealt with which do not allow concentration to be placed upon something which can be thought to be peripheral.

There is also the fact of hospital chaplaincies being entrusted for a variety of reasons to members of the laity. In some quarters it has come to be thought that these members of the lay faithful are sufficient for this purpose and that the presence of an ordained priest is no longer necessary, except perhaps with regard to activity of his which is strictly sacramental in character. This, however, is something which some people question given the new questions and issues which are raised by hospitals.

In this paper I will refer only to hospitals and to the health care ministry. As everybody knows, the present-day approach has undergone a complete transformation: at the centre of concern there are no longer the illness and its treatment as such, but health, forms of treatment, and the ways in which health is achieved and maintained. Furthermore, today reference is made less to hospitals and more to health care centres and institutions.

In this approach everything us seen beginning with an immanentist level which does not deny the transcendental but which in practical terms does not pay attention to it and seems not to need it to provide explanations. Everything is concentrated on health and the fundamental problems caused by the lack of health which necessarily lead to death are concealed and not dealt with other than at the level of statistical data or clinical cases.

In this paper I will seek to present certain aspects of the significance of the ministerial priest in the field of the health care ministry in the light of the Apostolic Exhortation "Pastores Dabo Vobis" which offers as an approach that of the step from Mystery to Ministry. I will then try to begin with certain fundamental aspects of this area in order to understand the Mystery of the ministerial priest and then explore its impact on that Ministry. My paper, therefore, will be divided into two parts. The first will deal with the Mystery of the ministerial priesthood and the second will examine the Ministry which springs from it. In the first part I will try to offer a reflection on pastoral charity beginning with Christ the Head, the Shepherd, the Servant and the Bridegroom of the Church. In the second I will propose some ideas about the eucharistic ministry, the ecclesial ministry, and therefore about the healing ministry of the ordained priest.

1. The Mystery

As I have already said, I will examine the Apostolic Exhortation "Pastores Dabo Vobis" and in particular numbers 21-23 of that publication where the discussion falls specifically upon 'pastoral charity' as a constituent element of the ministerial priesthood.

In the light of this we have before us a fundamental affirmation: the Holy Spirit, through ministerial ordination, shapes and moulds the priest to Christ the Head, the Shepherd, the Servant and the Bridegroom of the Church.

The previous way of existing of the priest has changed and his new form makes him a special figure who is separate from the others who reproduce Christ. Christ has a personality with many features. As a model of the ordained priest, the four which have already been mentioned emerge: Head, Shepherd, Servant, and Bridegroom. The ministerial priest has his own specific characteristics which distinguish him from the other Christians who, in their turn, are shaped in Christ, whose figure involves being the Head, Shepherd, Servant and Bridegroom of the Church. This definition makes him a being who is substantially different from other Christians, as we will see later. Let us now examine each of these features.

a. Head

Curiously enough in the 'efficientistic' approach of contemporary society we very often forget the deep meaning of efficiency. I mean efficiency in the mechanical sense of composition and recomposition. The evolutive concept of technical-scientific appreciation is common. Matter is not the real mother of contemporary progress but a source from which elements are taken which are joined or separated and which are manipulated at whim. In deciding action we allow ourselves to be guided by the agreements which are generated by a psychologically suitable repetition which presents an interminable series of products of another kind on the globalised market of supply and demand. It seems that everything can be bought and sold, even agreement within the context of a total subjectivism which is welcomed by the mass media.

The priest, shaped to Christ the Head, is not only the person who produces a series of religious agreements in presenting the product of the religious word. He produces something which is much more profound

and which goes beyond what could be called a quality leap – he produces life. And this life is the only life which in its deepest expression exists; it is the life of the Most Holy Trinity in which man takes part in a mysterious historical coexistence with the Word made Flesh in the historical experience of his life, passion, death, and resurrection. It places in a universal perspective, which is as the same time special, everything that is universal and special: the Easter of our Lord. It brings into being the so-called unique 'concrete universal' of history – full constitution of the life of humanity in Christ who manifests himself through the Spirit and projects himself into our history making it a history of salvation which walks in progressive fashion towards its consummation at the end of time. This efficiency of the priest is the efficiency of Christ, who is not merely an example to follow but the sole effective source of the whole of the life of the universe. This is his meaning as Head of his Body which is the Church, as the beginning and the end of what exists, as Alpha and Omega, as he in whom everything has substance, in heaven and on earth (cf Eph. 1:10; 1 Col. 15:20; Ap 1:8).

When this is expressed it is expressed in a word which has real contents, which works what is expressed, and this is the Sacrament, the good news of this wonder, and such is the preaching of the Church, the preaching of the priest. The Sacrament is the foundation of the Word and the Word is the explanation of the Sacrament. The Sacrament is the realisation situated within historical time of the above-mentioned concrete universal of the Easter of Christ. All this expresses the reality of Christ as Head and of the priest shaped and moulded to Christ as Head.

The ability to carry out the mystery is conferred by the Holy Spirit because this shaped conformation comes about through the infinite Love of the person of the Holy Spirit. This defines the character which the Spirit has imprinted on the ministerial priest, and which makes him essentially distinct from other Christians.

b. Shepherd

This ability to give life must conform to those to whom this life is given. This is the function of the Pastor. We could say that his essential function is inculturalisation. And not only with respect to the presence of the Gospel in the heart of every culture and its transformation through its essential rooting in that culture (cf *Redemptoris Missio*, 52), but first and foremost through its inculturalisation in every person and people, by which the priest realises his action of giving life. This is the how, the pastoral aspect of his function.

This involves the need for every priest to identify himself with the people to whom he brings the life of God. He must identify himself not in a superficial way; he should reach the centre of every person. But not merely to contemplate that person but to transform him through the priest. The divine life remains the same but receives an infinitely distinct coloration by adapting itself to the life of each person, thereby achieving the inner transformation of the cultures of peoples.

Thus does Christ the Shepherd realise himself according to chapter 10 of the Gospel of St. John: Christ knows his sheep and these know his voice. His Voice is also the Word of God and to know it means to identify oneself thereby in a Christification. In this way he feeds his sheep and also gives his life for them (cf Jn 10:1-6). The being of the pastor is not made up of a sort of religious referring of contemporary technical know-how. It is the Trinitarian divine life set in movement by the profoundest man of all times. It also involves knowing how to reach this man but only as a preface of pastoral action in the real sense of the term. The priest moulds his own personality in the being of the pastor defined to Christ and thus in the being of the effective bearer of divine life.

c. Servant

The Spirit shapes the priest to Christ. And in the final analysis the Holy Spirit is the will of God because He is the gift of this conforming and defining to Christ. The will of God, the Holy Spirit, decrees that the priest leads the whole of his life according to this conformation and definition to Christ the redeemer. In this way he is the highest servant of the Father who sent the Son so that men of all times could have life and have it in abundance (Jn 10:10). This service is the whole of the life of the priest and for this reason it is service to the point of the total giving of self because the priest has no other life than that of providing this real service. He is a servant of the Father through conformation and definition to the Son given to him by the Holy Spirit, and in this way he is the full servant of his brethren. For this reason the priest shapes himself to Christ the Servant who came to serve and to give his own life for everybody. This is his ministry, and for this reason his priesthood is called a priesthood of service or a ministerial priesthood.

d. Bridegroom

The priest is shaped to Christ, who is the Bridegroom of the Church. In this way his ministry is '*Amoris Officium*'. This is an absolute love which is total and full towards the Church, and towards all men. His ministry, his service, has no other engine than the Holy Spirit, who is the infinite Love of God. One thus understands how his office can be nothing else but full of love. Any motivation of another character would be inappropriate because his reason for being, his personality, is a spiritual personality which loves the Spirit. And it is this spirituality of his, which identifies him with Christ, that makes him transparency of the Word which is the word of God, and which also places him in full communion with the Father and the Son. This happens is such a way as to generate an understanding of why chastity is total and exclusive union with Christ and thus total fertility in order to reproduce the paschal Christ in his brethren.

With the personality of the ordained priest made specific in these four lines, we can find in them those words which are suited to describing them, that is to say pastoral charity. This

pastoral charity is the vital and inner maturation of the priest. All his activity must be the fruit and the sign of this pastoral charity; it is a gift, a duty, a grace and a responsibility. The priest is asked to make his pastoral activity real, credible and effective. It fosters his inner unity. It allows him to share the history and the experience of the Church. It reproduces the Trinitarian mystery and shapes his unity around the successor to Peter and the episcopal college.

2. From Mystery to Ministry

a. The Eucharistic Ministry

In the second chapter of the Dogmatic Constitution of Vatican Council II, *Lumen Gentium* (10), reference is made to the priesthood of all the people of God and it is made clear that there is a distinction between the ordained ministerial priesthood and the baptismal real priesthood of the whole of the people of God. It is observed that there is an essential difference between the two and not merely one of degree. The Council identifies this essential difference in the four features present only in the ordained priesthood and which lie in the fact that the ordained minister: 1. *Instructs* the people of God; 2. *Supports* the people of God; 3. *Carries out* the eucharistic sacrifice; and 4. *Offers* the eucharist in the name of the people of God.

The principal feature is the celebration of the eucharist, followed by the other three features. In the celebration of the eucharist the priests acts in the person of Christ the Head of the Church in such a way as to carry out the memory of all the salvific work of Christ whose contemporary presence in this way acquires its maximum effectiveness because Christ today achieves redemption. It makes the Word made Flesh present, born of the Virgin Mary, with his own history, his own life, his own preaching, passion, death, resurrection, ascension into heaven, and contemporary glorious presence. Given that through action one arrives at being, from this action the being of the priest, conformed to Christ, is constituted as an instrument of the Easter of the Lord.

It is obvious that in this way Christ models the whole of the people of God because he is the effective model in his historical concreteness which is realised in the eucharist. It is also obvious that in this way Christ leads the whole of humanity to the Father, and also supports it. In the eucharist the Body is given the opportunity to unite with the Head and offers itself to the Father through the Spirit, constituting by this union the total Christ. In this way, from the celebration of the eucharist, there follows the modelling of the people of God and the fact that this people is supported and offered in the sacrifice of Christ.

As a result we can say that the most profound difference between the ministerial priest and the real priest is rooted in the celebration of the eucharist. It is here that the ministerial priest in a historical and continuous way identifies in practice with Christ the Head, the Shepherd, the Servant and the Bridegroom of the Church. The culminating point of pastoral charity is realised in this way in the eucharist and from this springs the Church herself.

b. The Ecclesial Ministry

From the summons which brings about the Church, the Father send us His word which is the Paschal Christ of whom we speak in the eucharistic ministry. Christ himself is the summons to humanity, he is the call from which the people of God is born, that is to say the Church, that is to say the summonsed. As a consequence, the source of the Church is the eucharist, and Christ summons us beginning with the eucharist.

If the ministerial priest celebrates the eucharist, he therefore – because of his specific function – summons the Church beginning with the eucharist, that is to say he constitutes it. Beginning with this constitution one understands from another angle the meaning of his conformation to Christ the Head, the Shepherd, the Servant and the Bridegroom of the Church.

This summons is the vocation of humanity; through this summons the whole of humanity exists, and this is its genuine existence.

In Holy Scripture every vocation has three definite features: 1. Through the vocation the person is constituted in his own existence. Thus, through the divine call, the world is born from nothing and man, too, is born to existence (Gen 1-2). 2. Through the vocation one is led to a fulfilment of a mission for which one does not have the strength on one's own – this strength is given to one by God who makes man his partner in intimate company with him (Jer 1:8). 3. The vocation brings with it the realisation of a mission for the good of the people of God and is not reduced to an intimistic dimension closed up in its own individuality (cf the great vocations for the benefit of the people of God, judges, kings, and prophets: Ez 3:10-22; Hebrews 3:9 *et passim*). All this is realised in a special way in the call, for example, given to the Apostles, who, especially in Mk 3:13-19, are called to be with Christ, to cast out devils, and to proclaim the Gospel. The vocation of Mary in the Annunciation is the paradigm in which these three features are realised in a perfect way (Lk 1:26-38).

As a consequence, the vocation touches – to speak in a summarising way – three fundamental aspects of the whole of humanity: its being, its connection with God, and its connection with other people.

When, therefore, one says that the ministry summons humanity through the eucharist, its summoning is not merely an exhortation to follow Christ but

the foundation of the specific being with the Lord for the good of everybody. This is another way of understanding the presence of Christ in the eucharist. Through the eucharist the priest acquires a conformation to Christ the Head which means being the foundation of the existence of a renewed humanity in Christ, of the divine life which is given through an identification with Christ, as his mysterious body, and his universal mission of service to all men.

This mission is put into practice through Christ in the specific historicity which today is mysteriously realised through the signs of this alive historicity, namely the seven sacraments, and which are manifested in the communication of the Word, that is to say the proclaiming of the Gospel – something which thereby unites in solid fashion the communion of believers and constitutes the Church. The eucharistic summons is realised through the three channels of the Church – Sanctification, the Word, and Communion. In this way the vocation of humanity is defined.

The personality of the priest conformed and shaped to Christ the Head, the Shepherd, the Servant and the Bridegroom of the Church, is thus the personality of a person who, beginning with the eucharist, pronounces as an instrument in Christ the vocation of the whole of humanity.

c. A Healing Ministry

1) Health

Hitherto there has taken place a transformation in the world of illness and health. Previously the problem of its illness and its treatment were of primary importance; today health and its maintenance, or rather its recovery, take pride of place. In this way it very often happens that people do not want to refer to hospitals but rather to health care centres and institutions. The principal motivation of contemporary culture is health. It enters to the full into the assumptions about the meaning of the quality of life and the quantification of the well-being of a country. It often happens that physical health is laid stress on in the spread of this way of seeing things. But gradually the belief is spreading that the body is only one aspect of man, who indeed should be seen in his entirety, and in this way attention is also being paid to his social, mental, environmental, and even spiritual aspects.

In this context the Pontifical Council for Health Pastoral Care has produced a description of what constitutes health: *a dynamic tension towards physical, mental, social and spiritual health and not only the absence of illness, which enables man to carry out the mission entrusted to him by God according to the stage of his life in which he finds himself.*

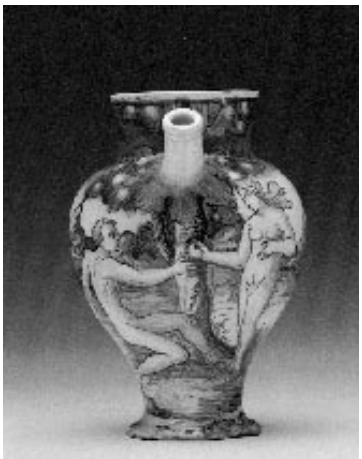
This description centres upon the vocation of man. This is a dynamic tension towards the structural harmony of man so that he accomplishes the mission which has been entrusted to him by God. The mission changes in line with the different stages of life. This structural harmony, that is to say physical, mental, social and spiritual harmony, is what constitutes the vocational being of man, and in the final analysis his fulfilment in his conformation to Christ who died and rose again. This is a conformation which is carried out by the Holy Spirit. In this way temporal health is a part of overall health, something which means, in definitive terms, eternal health. Thus health belongs to the full to the eucharistic summons of the Church. It cannot be outside the priestly action; it cannot be something which is peripheral to his pastoral action – it is rooted in its very nucleus. In this meaning of health, pain and illness are not rejected but taken on in an acceptance of the passion and death of Christ, as a good which produces the resurrection in an effective way. We oppose pain and illness because they obstruct the accomplishment of the mission which God has entrusted to us, and like the Good Samaritan we strive to fight them with all our strength. Although we know that death is inevitable we do not see the end of life as a light which goes out, but as a lamp which is turned off because the aurora of the great day has arrived.

2) Head

In some circles with reference to the health care ministry there is a desire to reduce the action of the priest to that of being a ministry of the Word which seeks through his company, his words or his silences to be an effective consolation for sick people. When lay people who are trained (for example psychologically) for this task, meet each other, it easily happens that the priest is distanced and it is not seen how his sacramental action can be integrated within a context of modernity which acts with the patient in line with the new techniques of individual or group psychological therapy.

The action of the priest as someone conformed to Christ the Head is not something which involves making purely religious suggestions, even when Christian in character, which can help or console in a psychological sense the patient afflicted by a given illness. It involves, rather, acting positively in favour of a health which is restored in reality according to the vocational divine plan, as has already been observed. All the resources of modern therapeutic sciences, medicine, and psychological and sociological approaches are not to be rejected but rather they should be subordinated in a health care ministry with a sacramental face which is strongly curative and of decisive importance in the achievement of an authentic health care ministry.

The sacramentality of other times has been contested with the assertion that it is not enough for the hospital chaplain to go around with oil in his briefcase. It is certainly true



that we need evangelisation beginning with the sacrament so that this does not become a rite which has no meaning for contemporary man but is something which always has real efficacy in line with the sacramental doctrine of all times. In the health care ministry the priest is the key because he is shaped according to the healing Christ, the resurrected Christ, and he achieves his effectiveness by achieving in the sick person the mystery of this form. This means full faith in the priestly personality and full faith in what the priest realises. His work in the health care ministry is not a compassionate complement to the works of mercy which others can carry out but the source of these same works of mercy. The Good Samaritan is Christ the Head of the Church who in this way cures through the priest. It is therefore self-evident that it is mistaken for other people who are not ministerial priests to take his place and to be in the strict sense of the term chaplains of health care centres.

3) Shepherd

The priest as Christ the Shepherd (or Pastor) must conform to contemporary man and in the health care ministry to the man who is in a condition of illness and health. This feature complements the preceding one and gives all its force to the profound meaning of the Sacrament. This last must be meaningful for practical man and thus in its administration it must be adapted to the practical circumstances experienced by the sick person. Hence the importance of the sciences of communication, of psychology, and above all else of the great humanisation of medicine which pastoral action contains. The Sacrament presents itself as the authentic Good News of salvation for man in a condition of illness and health, and as such it must be proposed to him. Hence the force of all the techniques created to bring to, and make meaningful for, the sick person the health offered to him by Christ, and to also bring it to the man in a condition of health so as to point out to him its meaning and real value. Being a pastor is to be understood beginning with the virtue of obedience as an '*ob audire*', as listening and paying attention to the salvific meaning of ministerial action. This obedience is required of the receiver of pastoral action and of the priest himself. It is an obedience which shapes pastoral charity in the form of loving obedience which listens carefully to that salvific and real Word – the Easter of Christ. And which, in this way, models the people of God in the image and likeness of Christ who died and rose again.

4) Servant

The healing ministry is healing service. As we well know, ministry is service. The service must be that of the Servant of the suffering Jehovah (Is 53) who bears within Him all our suffering and takes upon his shoulders the cross of all our woes. In this way the priest gives a *raison d'etre* to pain. Pain, which is in itself a bad thing, through the pain of the Servant of Jehovah is transformed into a source of life and resurrection and thus into a good thing. Together with the meaning of health the priest also gives meaning to pain, not as a mere theoretical explanation but as a practical explanation: doing what he says. The anointing of the sick is in particular a sacrament in which the sick person Christifies himself to take on his own pain, and his own death where this occurs, conformed to Christ, and finds in it the source of resurrection. The sacrament of the anointing of the sick redoubles in this way the sacrament of the eucharist and applies it in the 'virtuality' of a death impregnated with resurrection. The Holy Spirit ensures that the conforming to the will of God in death is the placing in a generous and total way of his own spirit in the hands of the Father so as to subsequently receive resurrection.

From the priest is required the virtue of humility in order to recognise that there is no human solution to the problem of death and that the only solution is the resurrection of Christ, God and man. It is not the consoling words of the priest which will provide 'acceptance' in the face of death but the mysterious and obscure reality of Christ who died and rose again. The priest with compassion must conform himself to the sick person who suffers not only in order to pray with him but in order to offer him the only solution possible, which is faith. As a pastor he must know how to adapt to the times of the sick man by choosing the best way to do so but he must not refrain from providing this solution with the pretext that when faced with the greatness of human pain the only thing to be done is to accompany unspeakable suffering in silence and with modesty. To do this would mean demonstrating a lack of faith, and cowardice, in relation to the definitive witness of giving at the most important and crucial moment. This is not a matter of 'consoling' and of finding only the psychological way of consoling, but of giving the effective contents of our faith when it is most needed. This is the great service which is expected of the priest and which he renders in the eucharist of the viaticum which the priest accompanies and makes doubly visible in the specific meaning applied to that sick person: the sacrament of the anointing of the sick.

5) Bridegroom

The authenticity of the priestly ministry is demonstrated in absolute and total love, in dedication to Christ himself present in the man in a state of illness and health. The motivation to exercise this pastoral care is no different from that of the ministerial priesthood, it is pastoral charity understood as full and total love. Hence one understands priestly chastity as dedication if necessary to death, as a total obligation to love, as the so-called '*Amoris Officium*' until the end, the termination of life in death in order to reach the fullness of the resurrection.

Through this love the virtue of hope has meaning and solidity. The whole of the health care ministry is rooted inescapably in the virtue of hope. Only with immovable hope in the resurrection can one acquire the joy of service and love of awaiting the bridegroom who arrives at the moment of death with all the joy of the resurrection. The whole of the Church hurries to this encounter with her Bride-

groom and lives in fullness the Word revealed through her which the Bride says to her Bridegroom at the end of time, of her time: "Come Lord Jesus" (Ap 22:20).

We have sought to outline certain ideas about the ministry of the ministerial priest and, beginning with this mystery and following the approach of the Apostolic Exhortation "Pastores Dabo Vobis", to come to the healing ministry of the ordained priest. This mysterious mystery is a ministry which in reaching the concrete, and in particular the priest, certainly means his individual mission, but it cannot be achieved without a wider and collective approach. The bishop accomplishes his mission in his local church but he does not do this alone but with his presbyter, with those who exercise their ministerial priesthood which is the foundation of his local church. This is carried out by the presbyter but he cannot do this unless he is in full union with his bishop and with his fellow presbyters. Whether the presbyter is religious or diocesan makes no difference: both belong to the presbytery of the bishop according to their different charisms in order to carry out their pastoral action. The Pope carries it out but as the visible foundation of the whole Church, that is to say as the root and foundation of Catholic unity. He does this collegially with each and all of his fellow bishops, as chiefs of their local churches, and with each and all of their presbyters, united to their own bishop and to their fellow presbyters of their local church, all of whom are open through the pontifical approach to the unity of universal Catholicism. In this way, by taking part in the same pontifical mission, it is also carried out by the Pontifical Council for Health Pastoral Care.

In order to accomplish a mission it is necessary to understand it at an ever deeper level. Perhaps these ideas will permit an advance in comprehension of the mysterious priestly and ecclesial eucharistic ministry of the healing health care ministry.

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The Identity of the Catholic Chaplain and the Health Care Ministry on the Threshold of the Third Millennium – a Theological Reflection

Introduction

The question of the identity of the Catholic chaplain in the health care ministry is of great contemporary relevance, especially in those Churches where there is a strong fall in the number of priestly vocations and where the question is raised, on the basis of an ecclesiology of communion, whether it might not be a good idea to take into consideration other models of the figure of the chaplain.[1] The present-day crisis of identity of the hospital chaplain must be placed within the vast framework of the crisis of the identity of the ministerial priesthood itself. A clarification of the nature of the identity of the chaplain requires above all else a defining approach to the question of the identity of the ministerial priesthood and its relationship with the ordinary priesthood of the faithful. It seems to me that this is the hub of the whole question.

The ecclesiology of communion places the ordained ministry within the life of the people of God, but this does not cancel out its specific nature. From the perspective of the ecclesiology of communion one cannot neglect the collaboration of the lay faithful in the carrying out of the unique mission of Jesus Christ. The day-to-day context requires a definition of the bases of this relationship between these two ministries in the light of the building of the 'family of God'.

We may take the ecclesiology of communion as the basis of this paper in order to outline certain key points of the subject which has been entrusted to me, beginning with the historical elements which have helped to shape and mould the identity of the hospital chaplain, and this so as to avoid projecting onto questions and issues of our time an interpretation which is not rooted in biblical or even historical facts. An attempt will then be made to outline the fundamental elements which have characterised the Catholic understanding of the figure of the hospital chaplain (II) and we will then ask ourselves what light can thus be gained by which to understand the questions and issues which are now raised about the figure of the priest as a hospital chaplain (III). But we should perhaps place this difficulty in delineating the identity of the chaplain within the general crisis which now characterises contemporary thinking about the priesthood (I).

In this way I will seek to provide basic theological elements and criteria which today are often neglected in the debate which is conducted with regard to this subject. In this debate on the identity of the hospital

chaplain of the third millennium we cannot construct within a vacuum. The basis was given to us in Jesus Christ once and for all. No other basis can be supplied to us and everybody should pay attention to this fact in the definition which is given to the identity of the chaplain (1 Cor 3:10ss).

1. Reflections on the Present-day Condition of the Hospital Chaplain

The need to clarify the identity of the hospital chaplain is something which makes itself felt today in a special way because the ordained ministry during the second part of our century has entered into a state of crisis in most of the Western Churches (Europe and North America).

A first fact can be found in the fall of the number of candidates for the priesthood. One cannot but worry at the further fact that a large number of priests are already well advanced in years and that many of them, as well as many of the young priests, feel that they work too much and work within a context marked by lack of success, by resignation and by frustration in a highly secularised and indifferent world. This fact may indeed have a certain impact. But it should be immediately observed that a large number of priests feel fulfilled in their ministry, and that the fall in the number of priests should be placed within a framework of a general crisis of faith and within the context of the fall in the number of members of our communities. This crisis has many causes and thus we need to avoid over-simplifications and hurried generalisations.

1.1. The Reasons for the Crisis

One of the fundamental causes which should be referred to seems to be a lack of theological clarity. From this point of view the roots of the crisis are on the one hand to be found in a unilateral and superficial acceptance of the ecclesiology of the 'people of God' and communion of Vatican Council II,[2] with a resulting unilateral interpretation of the relationship between the priesthood shared by all the baptised and ministerial priesthood.[3] On the other hand it should be said that another root is of an ideological nature and is to be found in the cultural revolution which took place at the end of the sixties and the beginnings of the seventies. This involved a transferring of democratic institutions to the Church[4] and an ideological criticism of her institutions, or rather distrust in the institutions which then characterised not only the ecclesial world but also society in general.

In this context, therefore, one can well understand that whilst Vatican Council II offered us a fine theology of the Church as the 'people of God', placing the shared priesthood of the faithful in relation with the ministerial priesthood (LG, nn. 10-11; 34-38 in particular), some theological interpretations subsequently tried to counterpose the two kinds of priesthood.[5] Or there was an attempt to bring out a certain contradiction between chapter III of the LG which deals with the hierarchical constitution of the Church and chapter II which describes the charisms within the life of the people of God and launches an appeal to take the meaning of the faith of believers seriously. Furthermore, although within the ordained priesthood itself a relationship of collaboration between priests and the priesthood of the bishop seems clear enough, the relationship with the deacon, to whom the Council refers in *Lumen Gentium* 29 and *Christus Dominus,* 15 remains rather unclear.

Very often one comes across the opinion that all these questions solve themselves in practice (in pastoral care) through the delegation of tasks which had previously been the responsibility of priests alone to the community and to members of the lay faithful.[6] It is certainly true that in practice one can solve many problems but it should also be said that solutions which seem to be merely of a practical pastoral character often have fundamental theological consequences and implications. If we want to avoid confusion and misunderstandings we must think of the world of practice in fundamental-theological terms, that is to say beginning with fundamental theological principles. We need an overall and integral approach to the priesthood and only within such an approach can one understand the figure of the hospital chaplain in a more effective way. The debate concerning that figure can then become a *kairos* within which a new figure of the hospital chaplain of the third millennium can arise. For this reason in addressing contemporary questions and issues the intention is not to work in a merely apologistic way but to engage in a constructive and creative approach.

1.2. Figures of the Priesthood who have Marked the Second Half of the Twentieth Century

The ecclesiology of communion of Vatican Council II has deep roots in the history of Christian theology. Its rediscovery, however, came about at the beginning of this century. This rediscovery was accompanied by detailed research on the part of theologians, above all else during the Second World War, which sought to capture the figure of the priest which would be nearer to the events of the Christian people.[7] The shaping of this figure of the priest was the work primarily of theologians such as Yves Congar and Marie Dominique Chenu, but support for such an approach came first and foremost from Cardinal Suhard.[8] Some radical interpretations of this perspective led to a reduction of the priestly ministry to mere presence in places where no sermon was preached and where no sacrament was celebrated, and the fine theology of the founding fathers was left only with what was called the salvific dimension of the incarnation, that is to say that salvation is to be found in the simple fact that the Saviour came in our flesh. Thus it was enough for the priest to be present where men live who did not know Jesus Christ, in the same way as he lived before his public life in Nazareth.

This radicalisation was met by the theology of Father Michel Laboudette O.P. who disputed exactly this reduction of the ministry of the priest to a mere presence: 'It will not therefore be through a mere presence

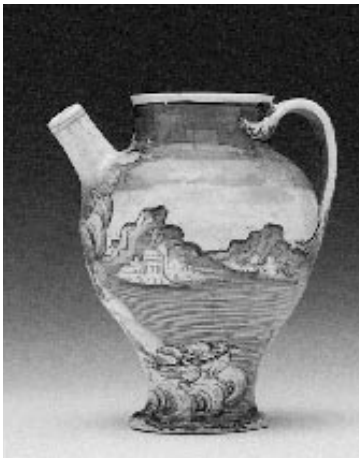
or through contact that the priest, as a priest, makes holy; it is precisely through his ministry, the preaching of the word and the celebration of the salvific cult'.[9] The question which was raised was that of the nature of the presbyterate: 'because it is a power (the order) is ordained for those acts whose object is precisely the sanctification of the people of God, the expansion and the diffusion of Christian grace within the Church'.[10] But this response left unresolved the question of whether the pastoral mission of priests owes nothing to their consecration. And it was thus in this context that the decree on the ministry and life of priests (*Presbyterorum Ordinis)* emerged on the eve of the closing of Vatican Council II on 7 December 1965.

In essential terms this document informs us that priests, because they are the collaborators of the bishops, must live out the 'apostolic life' by practising 'pastoral charity', that is to say by acting *'in persona Christi capitis'* (PO 2; LG 10). Their first task is to evangelise and this task cannot be separated from their eucaristic ministry. Furthermore, these two tasks are correlated to their third task, which is the exercise of the 'function of Christ the Head and Shepherd' *('Representatio Christi Capitis')*, that is to say to render present in a sacramental way the salvific action of Christ the Head of the Church and to act so that this is visible in the world.[11] The theme of *'Representatio Christi capitis'* brings out the theological and essential basis of the Catholic understanding of the ministry of the priest within the Catholic Church. In 2 Cor 5 14-20 the Apostle Paul stresses the unity not only of the preaching of the Gospel and the ministers of reconciliation; indeed this unity is rooted in the fact that in the ministry of the Apostolate it is Jesus Christ, risen again and raised to the right hand of the Father, who himself acts in the power of the Spirit: 'So we are ambassadors for Christ, God making his appeal through us' (2 Cor 5:20).[12] St. Augustine expressed this fact in a more effective way when he declared that *'Christus est qui paedicat', 'qui baptizat', 'qui consecrat'*.[13] It is in this sense that reference is made to Christ himself who communicates himself in the power of the Holy Spirit.

However, it should be immediately made clear that this element of *'representatio Christi'* can be said to a certain extent to belong to every Christian. Every baptised person has taken on Christ, lives in Christ, and Christ lives in him. It is therefore every Christian who must make Christ present for others in words and deeds. As has already been observed in this paper with regard to Vatican Council II, all baptised people take part in the triple ministry of Christ and are a prophetic, priestly and royal people (1 Pt 2:5-10). It is this which is understood when we refer to the shared priesthood of all baptised people. It is certainly the case that the Church as a whole is the body of Christ, the family of God, and therefore *'representatio Christi'* in the world, a sacrament, that is to say a sign and instrument of God in the world and for the world.

This insistence upon the shared responsibility of all Christians has led, as has already been observed, to the questions: 'so what remains in a specific sense of the ministerial priesthood?' What is its proprium? Is the priest not thereby reduced to a mere representative of the community or that is to say of the Church, and thus an expression of the majority which is expressed within it?[14] The paper given by His excellency Mons. Javier Lozano Barragán has brought out these issues very well by emphasising the specific character of the ordained priesthood. I would like here only to draw attention to the fact that from the theology of St. Paul one can derive a clear answer to these questions. The shared responsibility of everybody does not mean that within the Church everyone can do everything. Every charism has its specific task in the building up of the family of God (Rom 12; 1 Cor 12).

From the Letter to the Ephesians (Eph 4:12) one understands that the priestly ministry is a service for and to other services. In this way one can affirm that the ministerial priesthood is not only *'repraesentatio Christi'* in a general sense but also *'representatio Christi capitis Ecclesiae'*. In the full meaning of the word such a ministry belongs to the bishops as the successors to the apostles (LG 21). The priests, according to Vatican Council II, are described as collaborators, helpers, limbs, but also sons, brothers and friends of the bishops (LG 28, PO 2, CD 30). They represent the bishop (SC 42, LG 28). It appears that it is precisely this approach that makes up the fundamental idea of the Council's decree *Presbyterorum Ordinis.*[15]



Indeed, at PO 6 it is said that in 'exercising their function of Christ Head and Shepherd at the level of authority due to them, the presbyters, in the name of the bishop, gather together the family of God as a brotherhood animated in unity, and lead it to the Father through Christ in the Holy Spirit'.[15] With this *'repraesentatio Christi capitis'* the priestly ministry expresses at the same time the fact that the Church does not exist of itself but exists starting with Jesus Christ. This is a sign of the fact that nobody can of himself give salvific grace. It is a gift from God alone and not a human creation. Hitherto our approach has come from on high, that is to say from the mission of Christ from the Father, and sees the priestly ministry as a part of the logic of this mission. But this approach must be complemented by that which comes from below, which sees the priestly ministry as part of the action of Jesus Christ who, through the vivifying Holy Spirit, sanctifies and guides the Church towards the Father.

In the eucharistic celebration these two dimensions are brought out very well. On the one hand the minister acts *'in persona Christi'* and can proclaim the same words as Christ: 'this is my body', 'this is my blood'. On the other hand he speaks and acts in the name of the Church in bringing towards God the offerings of the community.[17] The Fathers were especially emphatic on this point. Cyprian, for example, declared that 'the Bishop is in the Church and the Church is in the Bishop'.[18] The same reality is expressed by St. Augustine in other words: 'For you I am a bishop and with you I am a Christian'.[19] This way of seeing things does not place the bishop above the community or separate from it. This is why Cyprian would say that he did not want to do anything without the advice of the clergy and the agreement of the people.[20] The priestly ministry is therefore also to be placed in service to other charisms. In this sense Vatican Council II was able to go beyond a certain clericalism and tried to sow the seeds for a trusting collaboration between pastors and members of the lay faithful in the unique ministry of Christ and invited pastors to listen to the laity (LG 37; PO 9). The Council also opened up a way by which to think about paths of responsible collaboration between the various ministries. This was not a concession to the predominant democratic mentality but of a description and realisation of the Church as the family of God and communion. But it should be said that in addition to providing an impulse to the life of many priests, the Council decree was not able to close the debate about the theology of the priesthood.[21]

Beginning with the fact that *Presbyterorum Ordinis* gave a certain priority to the preaching of the Gospel (whereas the Council of Trent made the sacrifice of the Holy Mass the first and most important task of the ministry of the priest), some people have since wanted to undervalue the sacrificial character of the priestly ministry forgetting that it was precisely the 'PO' which sees service to the Gospel as an integral part of the Christian cult, an approach indeed which is rooted in Romans 15-16.[22] The document of the International Theological Commission of 1971,[23] in the preparation of which Hans Urs von Balthsasar played an important part, helped to overcome this dichotomy between the ministry of the Word and the ministry of the eucharist. This is possible if one sees the priestly ministry as the service of active power, which is specifically eschatological, of the Word of God – Jesus Christ who died and rose again – whose discernible signs are the preaching of the Gospel message and the sacramental acts.

In response to the question of what the essential element of the ministerial priesthood really is, Padre Emile Pin S.J.[24] would find an answer in the distinction between the 'function of presiding *(praeesse* or *praesidere)* over the Christian community' and presiding over the eucharist. He did not, however, make clear what kind of relationship exists between these two kinds of presiding. But it is precisely here that we should take into account the observation of the 'PO' according to which priests, because they take part in the unique priesthood and the unique ministry of Christ,[25] are at the same time ministers of the Word of God, ministers of the eucharist, and heads of the people of God. These three functions form one single function. They cannot be separated from each other, just as the three Christological titles of Christ – priest, prophet and king – from which they are derived cannot themselves be separated from each other.[26] This rooting of the identity of the priest in Christ seeks to remind the Church that her salvific action does not spring from herself nor from a greater *'consensus fidelium'* nor from our ability to convince men of the truth of the Gospel, to gather them together in the unity of the faith and to lead them to salvation. Instead, it has its source only in Christ who remains present amongst us in the power of the Holy Spirit (LG 10-12, 20ss, 31-36).

Once these fundamental Christological and pneumatological data disappear the question emerges of the crisis of the identity of the priest. Pope John Paul II has emphasised this fact in insisting at one and the same time on the Christological identity and the ecclesial identity of the priest,[27] thereby outlining the approach involving the permanent facts by which to understand the priestly identity.

This summarising description of the questions raised by the theology of the priesthood during the contemporary period invites us to 'rediscover not only the priest but also the figure of the hospital chaplain in its originality, in its original specific character'. How can a glance at history help us to localise such originality? We will try to localise the fundamental elements of the identity of the chaplain first of all through the history of the formation of the figure of the hospital chaplain and then through a presentation of a series of key concepts. One question will guide our inquiry: what vision does the tradition of the Church have of pastoral care for the sick?

2. Looking after Sick People and the Character of the Physiognomy of the Hospital Chaplain: the Creation of his Identity as a Priest

For the Christian community, looking after sick people has formed a part of its fundamental obligations since its beginnings.[28] This task is rooted in the words of Jesus who said that the sick should be taken of (Mt 25:31-46) and this practice continues, in the same way as Jesus himself did in his behaviour towards the sick, through fighting against their marginalisation (Mt 1:40-45), and through an overall encounter with the person involving the elimination of sin and illness as a sign of a state of profound lack of salvation (as a sign of great evil).[29] It is certainly the case that from this point of view the Jewish traditions, like the vision according to which the priest exercises, as a representative of God, the power of Jehovah in relation to illness and healing,[30] and the thought of 'caring' from Greek therapeutics (to be concerned with the suffering of the other person, of the foreigner),[31] have played a certain role. But the

Christological approach has been of determining importance – in the sick person is to be found the face of the suffering Christ which is expressed to us calling for our love.[32]

In the early community education, treatment, care for the soul and preaching were not activities which were clearly separable from each other.[33] This was already to be found in the early sources where reference is made to spiritual care for the sick. It is cited in the description of Christian tasks as one of the works of compassion and is often employed in an apologistic perspective or in the context of normative rules for Christian behaviour.

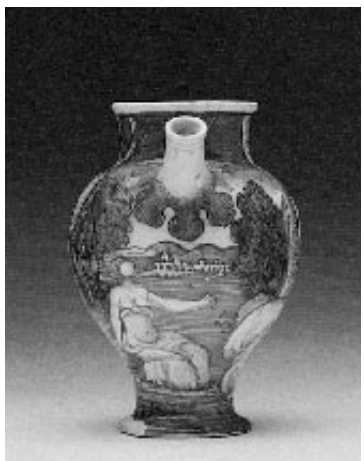
It should be said that Christian love for the sick adopted and pre-supposed a new approach, evaluation and vision of illness itself. In Greek medicine as shaped and moulded by Hippocrates there is also reference to the sick person as such and the concern of the person who takes care of him is first of all directed towards his friends and their personalities, but this is not applied to all sick people.[34] For Christian love, on the other hand, the sick person is a creature of God and a neighbour, the concrete face of Jesus Christ. Seen as an image of God made flesh and of the passion of Christ, the sick person enjoys special consideration and attention. In this way one can well understand why the letter of James lists amongst the primary tasks of the bishop and the elders those of visiting the sick and the poor (indeed these two categories are often cited together), praying for them, anointing them with oil in the name of the Lord (the anointing of the sick), and forgiving their sins (James 5:14ss).

Prayer, anointing with consecrated oil, confession and the forgiveness of sins, probably also linked with an evening meal *(agape fraterna)*, were the constituent elements of spiritual care for the sick. They refer to an understanding of illness as a complex of relations between physical fragility and spiritual weakness. This is why from the outset taking care of sick people was not the task of all Christians but primarily of well specified ministers.

In post-Apostolic literature elderly people are increasingly exhorted not to neglect sick people.[35] Precisely because it became ever more difficult for bishops and the elders to visit all the sick people, the first rules of behaviour were drawn up.[36] During the great epidemics which struck the city of Rome with great violence in the second and third centuries it was made evident with great clarity that taking care of the sick was a great expression of the followers of Christ. Dioniges of Alexandria expressed this in the following way: 'without fear they (the Christians) visited the sick, served them with joy, took care of them according to the commandments of Christ and with joy separated them from this life...This way of dying should be seen as the fruit of a profound spiritual life and solid faith which are in no way to be compared to death through martyrdom'.[37] Two tendencies are to be found in this context: one which sees illness as a test of the faith and patience of the sick person and one which asserts that the person who takes care of the sick person can hope that his free service will receive a celestial reward. At times we find bishops who are also medical doctors and base themselves upon the tradition which goes back to Mk 2:17 which refers to 'Christ the physician'.[38] Thus was developed the analogy between taking care of souls and medicine: just as the illness is seen as an expression of sin so sin itself is described as an illness. Prayer and penitence are thus understood as forms of medicine.[39]

In the fourth century hospitals were gradually established in which all those in need were received: foreigners, the poor, widows, orphans and the sick.[40] These hospitals were under the authority of the bishop. Monks in particular dedicated themselves to looking after the sick and the poor. A sanatorium was often entrusted to the monastery. Under the influence of the monks a strong link between taking care of the sick and ecclesiastical discipline emerged with the development of the anointing of the sick and rules for the monks on how to behave towards sick people. The Benedictine rule, for example, makes taking care of sick brothers a special duty of the community[41] because service to the sick was service to Christ himself in line with Mt 25. In a ninth-century commentary on the Benedictine rule it is said that the abbot must do everything to ensure that 'the sick confess their sins, receive the sacraments, listen regularly to Holy Mass, are visited, comforted and encouraged'.[42] We can understand these prescriptions and this rigour only if we take into consideration the idea of illness of this epoch that was adhered to in the monasteries – illness was seen as a disciplinary instrument for health. Care of the sick and pastoral care of the sick thus had a religious-moral character. The medical doctor was also obliged to allow the patients first of all to engage in confession and only afterwards could he treat their bodies – terrestrial medicine could act only when man was spiritually pure.[43]

As long as hospitals remained a part of the monastery it was obvious that pastoral care of the sick was a part of taking care of the sick. In the twelfth and thirteenth centuries new kinds of hospitals sprung up. In the new cities many more poor people and sick people were to be found. It was now up to the whole community to look after them. At the same time, through thinking about the crusades and the movement of poor people, a new approach to the poor and the sick came into being – they were seen as *'domini nostri pauperes'*. A papal declaration described taking care of the sick as *'pauperum Christi servituum'*.[44] In this context religious orders were born which



sought to achieve the love for Christ and one's neighbour through service to the sick. The vision according to which, through illness, the soul is tested and enlightened, remained strong. Illness was indeed seen as the spiritual medicine by which to lead the sick person to perfection (II Cor 12:9). It was also evident that every form of treatment of the patients began with confession and the celebration of the eucharist. Those who took care of the sick gained a piece of paradise; their activity was a contemplation of the suffering of Christ and through such contemplation they reached perfection.

This system of pastoral care of the sick was closely linked to confession and the authority of the priest remained unchanged until the sixteenth century.[45] With Luther, pastoral care of the sick fundamentally received the character of being accompanying, support and comfort. Confession lost its rigour and came to be seen as a joyous moment of encounter in which there was no need for a priest, merely the presence of another Christian.[46] But it should be observed that in Luther himself the ecclesial character of such care was not totally eliminated and in the Lutheran Churches of the sixteenth century there was still a strong link between pastoral care and ecclesial ministries. This was even more evident in the reformed Churches of Switzerland. However, there was great interest in pastoral care for the sick, those in prison, and the poor. Parish priests for hospitals alone were figures who were brought into being in the great cities. In the pietist tradition illness was seen primarily as a suitable time when the sick person could open himself up to the word of God and engage in conversion. Pastoral care, indeed, was in fundamental terms directed towards conversion: 'the sick person must bear suffering with patience...abandon himself to God, leave this world with joy...strive to liken himself ever more to the image of the suffering Christ...remain faithful until death'.[47] But at the same time within pietism itself there emerged an understanding of pastoral care of the sick as free conversion in which the needs of the sick person were taken seriously. It was understood as an expression of the love of God which frees and feels compassion for the suffering person. In this way new aspects were introduced, that is to say the individuality of the person and his freedom. Protestant pastoral care until Schleiermacher was to be shaped by these two principles.

Within the context of rationalism the aim of pastoral care of the sick was organised around the figure of the pastor as the friend and good companion in suffering. Illness was seen as an entirely earthly reality which had nothing to do with sin. The task of the hospital chaplain became that of comforting and of offering moral and psychological support, and thus he was required to have a good knowledge of man and his psychology. During the twentieth century this required a personal relationship with the sick person which, however, became increasingly difficult for the chaplain given the way in which modern hospitals came to be organised. In this context one can well understand the way in which the concept of chaplaincy was developed by the Conference of Italian Bishops. With the movement which was primarily born in the United States of America, in the sixties and seventies, a change in the conception of the hospital chaplain took place. Emphasis was very much placed upon 'therapeutic pastoral care', something which required a special training on the part of the chaplain and acceptance of the developments which had taken place in psychoanalytical science. In this context the 'movement for pastoral care' was born, a movement which, indeed, changed pastoral care of the sick.[48]

2.2 The Present-day Situation

Within the context of the functionalisation, specialisation and technologicalisation of hospitals, pastoral care for the sick has undergone a profound change in terms of its structural character.[49] The technologicisation of medicine goes hand in hand with an objectifying and reductive understanding of illness, seen as a provisional (transient) loss of the function of one part of the body. In this way pastoral care for the sick has the urgent need not to lose sight of the relationship which keeps together illness and life and to take seriously the emotional isolation of the sick person which takes place in modern hospitals. Care for the sick should be understood as pastoral care of the hospital. It should become pastoral care of the sick and of health care workers within the hospital institution; it is not a continuation of the pastoral care of the parish community but must, rather, develop its own aims and methods. Pastoral care for the sick should therefore be understood – by analogy with the God of Israel who walks with his people – as the accompanying of a man during the crisis of his illness with the goal of bringing together with the other his suffering and his needs so as to arrive together with him at an overall understanding of what illness and life can mean.[50] This requires sound co-operation between the hospital chaplain and the medical doctors and nurses, and in certain cases this means that the chaplain is involved as a member of the healing team. In this way pastoral care will not be seen as something supplementary but as part of global treatment and therapy which covers the whole of man. This approach requires that the chaplain has great abilities and capacities with regard to forming and maintaining relationships. It is only within the context of a relationship that he can invite the sick person to engage in prayer and proclaim the love of Christ in the concrete situation of the sick person. All this must take place within a framework of a shared journey directed towards searching for meaning. It is within this journey that the eucharist, confession and the anointing of the sick are to be placed.

The lesson to be gathered from these historical elements for the identity of the chaplain is that his ministry has first and foremost been organised down the centuries around the ministry of the Word, the eucharist, the forgiving of sins, and the solidarity of the whole of the community with its suffering member. It appears clear that

these facts conform with the meaning of canon 564 which defines the chaplain as a priest because he is a collaborator with the bishop – the figure who is primarily responsible for taking care of the sick because he represents Christ the Head and all the community. However, as has already been emphasised in this paper, this definition requires at an essential level greater co-operation between the members of the laity in the unique ministry of Christ.

Since Vatican Council II and its ecclesiology of communion we have become more sensitive to the idea of the greater involvement of deacons, members of religious orders, and members of the lay faithful in pastoral care of the sick. Given the contemporary ecclesial situation some local Churches are moving towards greater collaboration between the chaplaincy and the medical team, that is to say towards involving deacons, members of religious orders, and members of the lay faithful in the health care ministry. It seems to me that it is also in this direction that the guidelines of this Pontifical Council are also moving.[51]

3. Collaboration of the Laity in the Unique Ministry of Christ in the Health Care Ministry

It is here that we encounter the topical dimension of the pastoral question. There are not enough priests today in certain churches for them to be made available to hospitals. What should be done? It is certainly not right or sound to give increasing tasks to priests who are already heavily committed in their activities. Thus it is now debated whether it might not be possible to entrust the entire responsibility for pastoral care of the sick to a member of the laity or a group of lay members (whether paid or voluntary), or whether it might not even be possible for the deacon to be able to carry out the sacrament of anointing with oil.

On the basis of what has been said so far in this paper one can clearly answer that only an ordained minister can be a chaplain. The chaplain and the administration of the sacraments, like the celebration of the salvific minister of Christ the Head, are not separable. But Vatican Council II offers us another way forward. The Council referred to the New Testament when it dwells upon the collaborators of St. Paul (Rom 16:1-6); Phil. 2:25; 4:3; Col. 4:10-15; Phil. 1:24) and thus almost developed a theology of collaborators.

According to this theology, because of their participation (based upon baptism) in the salvific mission of the Church, the members of the laity are direct collaborators in the unique ministry of Christ.[52] On the basis of their own mission they can take on certain tasks (*munia*) which are closely bound up with the ministry (*officia*) of pastors.[53] This is possible both as regards teaching and with respect to liturgical action and pastoral care (*cura animarum*). The Council speaks more specifically about '*cooperatio*' in the carrying out of certain ministries but such '*cooperatio'* is not at the same time '*participatio*' in the ordained ministry itself (LG 33; AA 24; cf in the CIC can 228, 230, 759). The lay member remains a lay member even though he carries out a task which is closely bound up with the ordained ministry.

In essential terms we have before us the '*cooperatio*' (LG 33; CIC can 129 § 2) or participation of the laity in the tasks of the ordained ministry and thus in the guiding of the Church (LG 37: CIC can 129 § 2) and especially in the creation of synodal institutions (parish councils, and here perhaps should also be placed our discussion of the chaplaincy with the due *caveats* emphasised by His Excellency Lozano), and thus also in the carrying out of the liturgy (through the creation of readers, acolytes, the ministry of the communion, the bestowing of baptism and the animating of the liturgy (Can 230 § 2 and 3), and in the proclamation of the doctrine and the Word (LG 35; CIC can 229, 230 § 3, 759, 766). These ministries are conferred by a letter of mission by the bishop. With this the intention is to give greater emphasis to the shared responsibility of all Christians in the participation in the triple ministry of Christ.[54] And here it should be emphasised that perhaps the point of departure is more to be found in canon 785 of the CIC of 1983. Compared to canon 517 § 2 this canon has the advantage of not subordinating the collaboration of the laity to the absence of a priest but of enrolling them in the ministry with reference to the fundamental rights and duties of all the members of the people of God.

If this is the intention of the document we should not, therefore, be at all worried about the prospect of a clercalisation of the laity. A co-operative and communicative responsibility without fear would thus well express the face of the Church as the family of God with the diversity of its members and their various charisms.[54] That is to say, we are dealing here with investigating and exploiting to the full the possibilities which are offered to us by Vatican Council II which describes the lay member with reference to his character of being in the world (*Weltcharakter*: LG 31)[56] and a collaborator in the exercise of the ecclesial ministry of Christ (LG 33 and 35). It does not seem to me that such collaboration needs to be recognised as sacramental in the way it which this has been understood by Rahner and Hünnerman.[57] One runs the risk of giving rise to confusion[58] and of absolutising *ipso facto* the ordained priesthood rather than relating it to other ministries as different charisms for the building up of the family of God in march towards the encounter with the Father in the Son through the Holy Spirit.

Conclusion

We can conclude by saying that the identity of the hospital chaplain can be defined beginning with the identity of the ordained priest. This specific character of his identity does not, however, exclude an attempt to find forms of collaboration with members of the laity in order to make the presence of Christ in the world of those people who suffer in their body, turn their gaze towards Christ, and need the accompanying of the Church in this stage of their lives, more

effective and meaningful. This collaboration should not cancel out or diminish the identity of each of the members of the family of God but must work for the growth of all in mutual help.

The situation of present-day crisis which faces us can certainly be a time of rebirth for the Church, of renewal, but such rebirth cannot in any way involve fracture with tradition, Indeed, real originality is always born within tradition. With John XXII we can always remain trusting of the Lord who through the present-day crisis is preparing through the Holy Spirit a new Pentecost for his Church. Re-reading *Tertio Millennio Adveniente* I was happy to encounter the same approach of hope and trust in the presence of the Spirit of the Lord which guides, renews, and vivifies the Church.

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Notes

[1] The chaplain according to the Code is a priest: CIC can 564. The contemporary debate revolves is essential terms around this identity of the chaplain. That the subject is topically relevant and touches upon an urgent and fundamental question of the Church on the threshold of the third millennium can also be seen from the fact that a large part of the episcopal conferences have concerned themselves over recent years with the sensitive question of the relationship between the ministerial priesthood and the ordinary priesthood. I would like to refer only to two letters issued by the Dutch episcopal conference and by the French episcopal conference, and to the communication of Bishop Walter Kasper to mark the '*Internationale Deutschprachige Generalvikarkonferenz*' held at Quarten (the diocese of St.Gallen) from 21 to 26 May 1995. All three were published during the nineties: 'Au Nom di Christ. La Parole, le Sacrement, le Ministère et l'Ordination. Lettere Pastorale de la Conférence Episcopale des Pays-Bas', in *La Documentation Catholique*, 4 October 1992, n. 2057, pp. 833-846; 'Les Ministres Ordonnés dans une Eglise – Communion. Note Théologique de Bureau D'Etudes Doctrinales de la Conférence des Eveques de France', in *La Documentation Catholique*, 3 January 1993, n. 2063, pp. 420-429; W.KASPER, 'Der Leitungsdienst in der Gemeinde' (I refer here to the manuscript version).

[2] On the concept of the Church as 'Communion' in Vatican Council II: cf W.KASPER, 'L'Eglise comme Communio. Réflexions sur l'Idée Directrice de l'Ecclésiologie du Concile Vatican II', in *idem*, *La Théologie et l'Eglise* (Cerf, Paris, 1990), pp. 389-410.

[3] Padre Yves Congar described this situation in a more effective way when he wrote that 'Vatican Council II was followed by a profound socio-cultural mutation which has no parallel in thr history of the Church in terms of its breadth, radical character, speed, and cosmic nature' and that 'this crisis was not provoked by the Council' even though, according to Congar, it is necessary to recognise that its roots are to be found in it 'because of the simple fact that there was a council, a debate': Y.CONGAR, *Le Concile Vatican II, Son Eglise, Peuple de Dieu et Corps du Christ* (Beauchsne, Paris, 1984), pp. 69-70.

[4] This does not mean that the Church must not in the least feel herself the family of God where there reigns the principle of equality (LG 32) in the diversity of charisms amongst members raised by the same Spirit who concedes to all believers the supernatural meaning of the faith (*sensus fidei*), who keeps the whole of the Church in truth and is expressed in faith and custom: LG 12, 35; GS 43; AA 2s.

[5] It will be remembered for example how many reactions were provoked by the thesis of Hans Küng to the effect that two initial forms of ministry existed at the beginning of the Church: in Jerusalem the Church, he argued, had a very institutional character, while in Corinth lived solely through the spontaneous apperance of the charisms within it' (Descléè de Brouwer, Paris, 1968), pp. 554-610. We know that from a New Testament point of view this position does not hold up and has no historical foundation: cf COLLECTIF, *Le Ministère et les Ministères selon le Nouveau Testament* (Seuil, Paris, 1974).

[6] Without doubting in the least the importance of the collaboration of the members of the laity in the unique mission of Christ (cf CEI, n. 55), this paper seeks to merely emphasise the fact that the increasingly effective involvement of the laity through letters of mission has raised questions about the very identity of the priest and his mission. An indicative sign of this concern can be found in the document issued by the French Episcopal Conference: *Tous Responsables dans l'Eglise? Assemblée Plénière de l'Episcopat Français à Lourdes* (Le Centurion, Paris, 1973).

[7] We need only recall here the creation in France of the 'Séminaire de la Mission en France' in 1941 in Lisieux and in 1944 of the 'Mission de Paris' to grasp the idea of the priest who shares the conditions of life of the people and thus already realises at his place of work the missionary task. This idea is to be placed in the subsequent added part of a book by two priests, H.GODIN AND Y.DANIEL, *La France Pays de Mission? "Rencontres"*, 12 (Editions de l'Abeille, Lyon, 1943). From this idea of near presence one passes to the figure of the priest worker: E.POULAT, *Naissance des Prêtes-Ouvriers* (Castermann, Paros, 1965).

[8] See CARDINAL SUHARD, *Le Prêtes dans le Cité, Lettere Pastorale du Carême de l'An de Grâce 1949* (Paris, Editions A.Lahure, 1949).

[9] M.LABOURDETTE, *Le Sacerdote et la Mission Ouvrière, Une Etude de la Commission Théologique de la Mission Ouvrière* (Le Bonne Presse, Paris, 1959), n. 14.

[10] M.LABOURDETTE, *Le Sacerdote et la Mission Ouvrière*, n. 13.

[11] Cf G.GRESHAKE, *Priestersein. Zur Theologie und Spiritualität des Priesterlichen Amt* (Freiburg, 1982), 1991), pp. 31-80.

[12]. This idea of *reppresentatio Christi* is also present in other texts, as is borne out by Luke 10:16 'Whoever listens to you listens to me'. One can also recall here the sacramental character of the Word of God because it expresses the salvific mystery hidden since eternity in God: Rom: 16:25-7; Eph 3:9-11; Col 1:25-27. The Apostle Paul is especially filled with this idea of *representatio Christi* and sees the whole of his life and his apostolic journeys as an expression of the victory of Christ in the world: 2 Cor 2:14 and 2 Cor 4:10: 'everywhere we carry the death of Christ in our bodies so that his life too becomes manifest in our bodies'.

[13] ST. AUGUSTINE, *In Joan*, 6, 7.

[14] The studies of E.SCHILLEBEECKX have greatly contributed to the theoretical formulation of these questions: E. SCHILLEBEECKX, *Kirchliches Amt* (Dusseldorf, 1981); *idem*, *Christliche Identität und Kirchliches Amt* (Dusseldorf, 1985). 15. Cf P.J.CORDES, *Sendung zum Diest. Exegetisch – Histriche und Systematische Studien zum Konzildekret "Vom Dienst und Leben der Priester"* (Frankfurt, 1972).

[16] See also *PO*, 12.

[17] Peter Lombardus emphasised this double aspect when explaining why the priest says '*offerimus*' and not '*offero*': PETER LOMBARDUS, *Sent*. Iv d.13, 1. Cf *LG*, 10. This character of representation of the Church through the priest has left many traces in the tradition of the Church: cf Y.CONGAR, *Jalons pour une Théologie du Laicat* (Unam Sanctam 23, Cerf, Paris, 1957); *idem*, 'Le Sacerdoce du Nouveau Testament, Mission et Culte', in J.FRISQUE AND Y.CONGAR, *Les Prêtres. Décrets Presbyterum Ordinis et Optatium Totius, Textes Latin et Traductions Françaises* (Unam Sanctam, 68, Cerf, Paris, 1968), pp. 233-256.

[18] CYPRIAN, *E.p*., 66, 68.

[19] ST. AUGUSTINE, *Serm*. 340, 1 cit. *LG*, 32. Thomas D'Aquinas, for whom the minister represents the Church, argues the same: THOMAS AQUINAS, *S.Th*. III, 82, 7 ad 3; *Suppl*. 31, 1 ad 1; *S.c.g* IV, 73.

[20] CYPRIAN, *E.p*. 14, 4.

[21] One need only recall the question which is still discussed today of the distinction between ordinary priesthood and ordained priesthood. The formulation of this distinction in *LG* 10 ('the ordinary priesthood of the faithful and the ministerial priesthood...however much they may differ essentially and not only in terms of degree are however ordered to each other' requires further clarification. Of what does this essential difference which is not one only of degree consist? It seems to me that for the Fathers the intention was to avoid confusing the ministerial priesthood with the ordinary priesthood and thus to emphasise on its specific character which does not derive from the ordinary priesthood. Vice versa the ordinary

priesthood is not a derivation from the ministerial priesthood. Both have their source in the unique priesthood of Christ. The difference is found at the sacramental level ('*sacramentum tantum*'): the ministerial priesthood is the sacramental sign of what from the point of view of contents ('*res sacramenti*': communicated salvation) is given to all believers, that is to say the representation of the salvific service of Christ in the world. To be at the service of this shared mission, to make it effective from the structural point of view as well, and keep it alive is what constitutes the specific character of the priesthood in the Church: cf W. BEINHERT, 'Autorität um der Liebe Willen. Zur Theologie des Kirchlichen Amtes', in K.HILLENBRAND (ed.), *Priester Heute. Anfragen, Aufgaben, Anregungen* (Würzburg, 1990), pp.32-66, pp. 56ss; K.LEHMANN, 'Das Dogmatische Problem des Theologischen Ansatzes zum Verständis des Amtspriestertums', in F.HENRICH (ed.), *Existenzprobleme des Priesters* (Munich, 1969), pp. 121-175; P. NEUNER, *Der Laie und fas Gottesvolk* (Frankfurt, 1988), pp. 127ss; and G.GRESHAKE, *Priestersein*, pp.192ss.

[22] *PO*, n. 2.

[23] Commissione Teological Internazionale, *Le Ministère Sacerdotale* (Cogitatio Fidei, 60, Cerf, Paris, 1971).

[24] E.PIN, 'La Différenciation de la Fonction Sacerdotale, analyse Sociologique', in *Concilium*, 43, 1969, pp. 45-55. From this distinction one can understand the move achieved by Jospeh Moingt who identifies different models of priesthood: cf his articles on 'Essai sur la Mutation du Ministère Sacardotal', in *Etudes*, April 1970, and *ibidem*, July 1973; September 1973; October 1973.

[25] *PO*, n. 7.

[26] *PO*, n. 2.

[27] One need only take into consideration his apostolic exhortations, his letters to priests on Holy Thursday and homelies during ordinations to be aware of this point. He formulates the question of the identity of the priest in the following way: 'Who am I? What is expected of me? What is my identity? This is the anxious question that the priest often asks himself, and he is certainly not immune to the harsh effects of the crisis of the transformation which is shaking the world': John Paul II, 'Le Prêtre dans la Societé Contemporaine, Homélie à la Messe d'Ordination à Rio de Janeiro, le 2 juillet 1980', in *La Documentation*, 77/n.1791, 1980, pp. 751-754. See P.TOINER, *L'Ordre Sacerdotal et l'Avenir de l'Homme, "Theologie Nouvelle"* (Fac-éditions, Paris, 1981), p. 167.

[28] JOHN PAUL II, 'Motu Proprio Dolentium Hominum (11 February 1985)', n. 1 which recalls that for the Church pastoral care of the sick is 'an integral part of her mission'.

[29] Cf J.MAYER-SCHEU AND R.KAITZKY (eds.), *Vom Behendeln zum Heil. Die Vergessene Dimension im Krankenhaus* (Vienna, Freiburg, Basel, 1980), pp. 138ss.

[30] Cf H.W.WOLF, *Antropologie des At* (Munich, 1977), pp. 211ss.

[31] Cf H.SCHIPPERGES, 'Dies Entwicklung der "Cura" im Verständis der Therapeutischen Dienste', in J.Mayer-Scheu and R.KAUTZKY (eds), *Vom Behandeln zum Heil.Die Vergessene Dimension im Krankenhaus* (Vienna, Freiburg, Basel, 1980), pp. 40-55, p. 41.

[32] In the poor and the suffering the Church 'perceives...the image of her Founder, poor and suffering': *LG*, 8.

[33] Cf R.BONHOEFFER, *Ursprung und Wesen der Christl* (Seelsorge, Munich, 1985), p. 11.

[34] Cf PEDRO LAIN ENTRALGO, *Heilkunde in Gesch* (Entscheidung, Salzburg, 1950), pp. 100ss.

[35] Cf Letter of Polycarp to the Philippenses, 6, 1.

[36] Cf A.HARDELAND, *Geschichte der Speciellen Seelsorge in der Vorreformatorischen Kirchen und der Kirche der Reformation* (Berlin, 1898), p. 22.

[37] Quoted by EUSEBIO, *H.E.*, 7, 22, 7-10.

[38] Cf J.P.SCHALLER, *I Sacramenti: Farmaco di Immortalità* (Rome, 1990).

[39] Cf CYPRIAN, *De Lapsis*, 14.

[40] Cf G.UHLHORM, *Die Christlichen Liebersthätigkeit, I, Alter Kirche* (Stuttgart, 1982), pp. 316ss.

[41] Cf *Reg. Ben.*, 36.

[42] A. HARDELAND, *Geschichte der Speciellen Seelsorge in der Vorreformatorischen Kirchen*, p. 90.

[43] P.DOEPGEN, *Über den Einfluß der Autoritaven Theologie auf fie Medizin des M.A.* (Wisebaden, 1958).

[44] Cf C.PROBST, 'Das Hospitalwesen im Hohen und Späten M.A. und die Geistliche und Gesellscahftliche Stellung der Kranken', in G.BAADER AND G.KEIL (eds.), *Medizin im M.A. Abdenfland* (Stuttgart, 1932), p. 265.

[45] See for example the comment of the rule of the Order of the Holy Spirit of the fifteenth century: *Liber Regulae S.Spiritus*, edited by A.F.La Cava (Mailand, 1949), pp. 128ss.

[46] His exhortation involves saying leave us 'to confess each other, advise, help and pray..and do not doubt the Yes of God towards us': M.LUTHER, *Von der Beicht*, WA 8, 184, pp. 21-24.

[47] B.W. MARPERGER, *Getreue Anleitung zur Wharen Seelencur bey Krancken und Sterbenden* (Nurenberg, 1717), pp. 212ss.

[48] H.G.PIPER, *Klinische Seelsorge-Ausbildung* (Berling, 1972); J.SCHARFENBERG, *Seelsorge als Gespräch* (Gottingen, 1972).

[49] J.J.ROHDE, *Soziologie des Krankenhauses* (Stuttgart, 1974); J.SIEGRIST, *Arbeir und Interaktion im Krankenhaus* (Stuttgart, 1978).

[50] Cf J.MAYER-SCHEU, *Seelsorge im Krankenhaus* (Mainz, 1977); M.KLESSMAN, 'In der Krise Begleiten. Probleme und Aufgaben des Pfarrers am Krankenbett', in *EK* 16, 1983, pp. 543-547; *idem*, 'Krankenhausseelsorge Heute', in *Themenheft WZM*, 29, 1977, H.1.

[51] Cf Pontificia Commissio de Apostolatu Pro Valetudinis Administris, *Les Religieux dans le Monde de la Souffrance et de la Santé* (Rome, 1987); *Les Laics dans le Monde de la Souffrance et de la Santé* (Rome, 1987); *"Curate Infirmos" e la Vita Consacrata* (Vatican City, 1994).

[52] Cf CEI, 'Linee per la Vita dei nostri Seminari', in *Coll Documenti Locali* n. 85 (EDB, Bologna, 1999), n. 55.

[53] One can observe here how the Council itself is uncertain when setting out the difference between '*munia*' (LG, 33 with reference to the laity) and '*sacra officia*' (with reference to priests). Indeed, the tendency is towards outlining a distinction between the sacramental office and the non-sacramental ministries. But one can also note that on the one hand that in LG 18ss there is use of the term 'ministry' '*ministerium*' for priests and on the other hand that in various places the term 'office' (*munus*: *LG*, 33; *sacra officia*: *LG*, 35, 37) for the laity is used: cf W.Beinert, *Autorität um Liebe Willen*, p. 35.

[54] CF K.RAHNER, 'Über das Laienpastolat', in *Schriften zur Theologie*, II, (Einsiedeln, 1961), pp. 339-379, p. 351; *idem*, 'Sakramentale Gruddelgung des Laienstandes in de Kirche', in *Schriften zur Theologie*, VII (Einiedeln, 1966), pp. 330-350.

[55] It seems to me, indeed, that in the case of the Congolese Church it has been known since 1975 with Cardinal Joseph Malula how to apply this fine concept of Vatican Council II subsequently carried on in *Ministeria Quaedem* by Paul VI (1972) and *Evangelii Nuntiandi* (1975) and avoid this danger. I refer here to the establishment of the *Bakambi* (the plural of *Mokambi*), that is to say of a member of the laity entrusted with the leadership of a parich, that is to say in the sense of the administration of the parish and the organisation of pastoral activity. He works with a priest who is not the parish priest but has the function of representing the bishop *in sito* because the bishop is responsible for pastoral care. His function is limited here to the function of 'chairman', as he is defined by can 517 § 2. He exercises the responsibility of tasks which are specifically of the presbyter. Cf Archdiocese of Kinshasa, *Les Ministères Laics à Kinshasa* (1985); *L'Avenir des Ministères Laics. Enjeux Ecclésiologiques et Perspectives Pastorales*, edited by L.Santedi Kinpudu (Signes de Temps, Kinshasa, 1997): A. Matenkadi Finifini, *Le Statut Juridique du Catéchiste en Territoire de Mission. Structure et Signification du Canon 785 di Code du Droit Canonique* de 1983 (Ottawa, 1988); *idem*, 'L'Expérience Pastorale des Bakambi: Histoire et Perspective', in *Revue Africaine de Théologie*, 17, 1993, pp. 227-235; *Oeuvres Complètes du Cardinal Malula*, edited by L.de Saint Moulin, vol. 6; *Textes Concernant le Laicat et la Société* (Facultés Catholiques de Kinshasa, 1997). This is different from the German system of '*Pastoralreferenten* and *Pastoralreferentinnen*': cf H.J.POTTMEYER, 'Thesen zur Theologischen Konzeption der Pastoralen Dienste und ihrer Zuordnung' in *ThGl*, 55, 1976, pp. 313-337; W.KASPER, 'Die Schädlichen Nebenworkungen des Priestermangels', in *Stimmen der Zeit*, 195, 1977, pp. 129-135; K.RAHNER, 'Pastorale Dienste und Gemeindeleitung' in *Stimmen der Zeit*, 195, 1977, pp. 733-743; P.HÜNERMANN, 'Ordo un neuer Ordnung? Dogmatische Überlegungen zur Frage der Ämter und Dienste in der Kirche heute', in F.KLOSTERMANN (ed.), *Der Priestermangel und seine Konsequenzen* (Dusseldorf, 1977), pp. 58-94; G.GRESHAKE, 'Der Theologische Ort des PAstoralreferenten und sein Dienst', in *LS* 29, 1977, pp. 18-27; *idem*, *Priestersein*, p. 72; F.KLOSTERMANN, 'Zur neuen Ordnung der "Pastoralen Dienste" in der BRD', in *Diakonia* 9, 1978, pp. 129-139; H.SOCHA, 'Der Dienst der PAstoralreferented und die eine Geistliche Vollmacht', in *Archiv für Kirchenrecht* 147, 1978, pp. 377-405; W.J.HENTSCHEL, *Pastoralreferenten – Pastoralassistenten* (Eichstätt, Vienna, 1986); P.NEUNER, *Der Laie und das Gottesvolk* (Frankfurt, 1988), pp. 191-203.

[56] Of illuminatinbg value here is the document of the Pontifical Council for Pastoral Assistance to Health Care Workers, *I Laici nel Mondo della Sofferenza e della Salute* (Rome, 1987), which refers to the commitment of the lay person in the field of pastoral care in health as a ministry, a *diakonia* which springs from the very nature of the lay person as a member of the Church, as someone who is in the condition of being baptised and secular: n.8.

[57] Cf K.RAHNER, 'Pastorale Dienste und Gemeindeleitung', in *Stimmen der Zeit* 195, 1977, pp. 733-743; P.HÜNERMANN, 'Ordo in neuer Ordnung? Dogmatische Überlegungen zur Frage der Ämter und Dienste in der Kirche heute', in F.KLOSTERMANN (ed.), *Der Priestermangel und seine Konsequenzen* (Dusseldorf, 1977), pp. 58-94.

[58] See the detailed statements of G.GRESHAKE, *Priestersein*, p. 72.

The Catholic Chaplain of Pastoral Care in Health in Canon Law

1. Description of the Contemporary Regulations

a. In the CIC

Canons 564-572 do not have their equivalents in the Eastern Code. But perhaps one can find something similar in the fact that the Eastern Code recognises the personal parish in canon 280: *'si... id expedit, erigantur paroeciae personales... vel alia definita ratione determinatae'.*

a.1. Concept: Canons 564 and 568

Two key concepts: priest and pastoral care. The chaplain is the priest who is entrusted in a permanent – or at least partly permanent – way with the pastoral care of a community or a group of the faithful, and this should be carried out according to universal and particular law (564).

There are many categories of chaplains. The Code explicitly envisages the following: chaplains of the home of a secular religious institution; chaplains of hospitals or prisons; chaplains of a ship; chaplains of emigrants, travellers, or sailors; military chaplains etc. Of these, the first two categories are especially concerned with the question of health because in reality many secular religious houses are dedicated to taking care of sick people. Indeed, hospitals themselves have very often been founded by pious confraternities. The term 'chaplain' comes from 'cape' and goes back to the cape worn by St. Martin which is kept in the treasury of the basilica of St. Dioniges, which in turn became the colour blue of the French flag. This cape of the poor man from Amiens was a symbol – the chaplain became a priest taking St. Martin as his model and was entrusted with handing out the charity of the Church. Thus, also, in French, the word '*aumônier*' which is the appellation for the priest who is entrusted with alms.

Canon 568 broadens the concept: referring to the Vatican Council II vote expressed in CD 18 it is hoped that chaplains will be appointed 'for those who cannot benefit from the normal care of parish priests'. The Motu Proprio *Ecclesiae Sanctae* I, 19, in discussing the application of this decree, calls on the Conference of Bishops 'to entrust to a delegate priest or to a special committee everything to do with the study and organisation of pastoral service' for special groups of the faithful. Here reference is made above all else to migrants, but the idea is valid for all of the faithful.

Some comments: these arrangements are new and come from the Vatican Council II's decision to make the episcopal conferences study how they should meet the right of those faithful 'who cannot benefit sufficiently from the ordinary and shared pastoral ministry of the parish priests' to receive the word of God in abundance, as well as to receive the sacraments.

Here attention was primarily being paid not to the world of pastoral care in health to migrants. It is for this category that during this century the concistorial congregation has made special arrangements. But this principle holds for everybody.

It is interesting to observe that 17 of the canons of the Code which deal with this subject are concerned with chaplains of associations. Indeed, very often the institutional context and arrangements of the particular Church does not manage to meet all the rights of the faithful. Special charisms are required which are traditionally expressed through associationism. The first associations of the faithful within the Church go back to the third century AD, at a time when the Church was not yet able to bring its institutions out into the open. These associations were dedicated to care for the sick.[1] When these charisms were institutionalised by the universal Church these institutions became a gift made by the universal Church to a large number of local Churches.

a.2. Appointment and Removal

The general rule is that the appointment is made by an Ordinary of the place: 'except where the law does not provide for a different approach or where someone legitimately has special rights, the chaplain is appointed by the Ordinary of the place, who also has the responsibility of appointing who has been presented or confirm who has been chosen (565)'.

But there can be certain exceptions:

– 1. The first exception concerns the preliminary part of the process of appointment and is contained in canon 567: the Ordinary must not appoint a chaplain of a secular religious institute without having first consulted the Superior who has the right, after hearing the opinion of the community, to propose a priest (67/1).

This is an innovation: because this involves proposing and presenting, the Superior is not obliged to propose the person designated by the community and the Ordinary is not obliged to appoint the person proposed.

– 2. With regard to public associations notice should be tak-

en of canon 317, section 1, which obliges the bishop to listen – where this is appropriate – to the higher officials of the association before appointing the chaplain.

– 3. It is not made clear whether the 'spiritual adviser' envisaged for the private associations in canon 324, and whose appointment follows a special path of selection, has the character of being a chaplain. Echeverria affirms that this is in fact the case.

The Ordinary of the place, with good reason, can remove the chaplain from his office, following a wise decision (even if the chaplain had been chosen or presented by other people) as long as the provision of c.682/2 (cf 572) is obeyed. This is a principle which is valid for all the offices whose tenure is removable: the freedom of the Ordinary and the defence of the right of the Superior to be notified in good time about his subordinates.

Given that one is dealing here with a member of a religious order, this person can be removed both by the Ordinary of the place and by the religious Superior without the consent of the other party (i.e. the Ordinary or the Superior), and it is sufficient for the author of the removal to be informed of the fact by the other party.

a.3 Faculty c. 566 [2]

This is an important canon because it allows us to have a better understanding of the high idea and view that the legislation of the Church has with regard to the figure of the chaplain.

A) General principle: the chaplain must have all the faculties required for *pastoral care* which is of a virtuous and proper character.

Example: Can 911: the chaplains have the duty and the right to carry the Most Holy Eucharist with them for the purposes of the viaticum.

B) Special principle: in addition to those granted by particular right or by a special delegation because of his office, he has the faculty:

a) to listen to the confession of the faithful who are entrusted to his care; following regulation c.967, 2, this faculty, which is granted *vi officii*, is valid in all contexts except where the Ordinary of the place applies his veto;

b) to preach the word of God to them;

c) to administer the viaticum and the anointing of the sick to them;

d) to administer the sacrament of confirmation to those faithful who are threatened by death (566/1).

C) A very special principle: in hospitals, in prisons and during sea voyages the chaplain also has: the faculty, which can be exercised only in these places, to absolve people from *latae sententiae* censures which are not secret or declared, where, however, the provision to be found in c.976 (566/2) remains in force.

This faculty is not granted to parish priests or deacons and emphasises the range of the real 'pastoral care' we are dealing with. In this case the world of pastoral care in health is explicitly referred to. Given that the verb 'absolve' is employed, commentators think that this is limited to the sacramental internal forum.

– Chaplains of the armed forces are governed by special laws (569).

a.4 Tasks

1. – The famous 'pastoral care' for which his office is created.

2. – To be a rector if there is a church attached to the office.

3. – To celebrate or direct liturgical functions when he is the chaplain of a secular institute, but without interfering in the internal government of that institute (567/2).

4. In the exercise of his pastoral appointment the chaplain must maintain a suitable relationship with the parish priest (571).

For example, the chaplain cannot exonerate the community from the prescribed holy days or days of penitence, nor commute them, because these measures are the responsibility of the Superior of the institutions governed by pontifical law and of the parish in the case of secular institutions or institutions governed by diocesan law (c.1245).

The Ordinary of the place is to decide if the solemn celebrations held in non-parish church-

es damage or otherwise the parish ministry (canon 559).

b. In Interdicasteral Instruction

Article 1. *The need for an appropriate terminology*

§ 3 The non-ordained believer can acquire the general denomination of 'extraordinary minister' only if and when, and solely in a substitute capacity, he is called by the competent authorities to carry out tasks in line with canon 230 § 3 (cf Pontificia Commissione per l'Interpretazione Autentica del Codice di Diritto Canonico, *Risposta* (1 June 1988): AAS (1988), p. 1373) and canons 943 and 112.

Obviously enough, the practical term which is canonically determined for the task which has been entrusted can be used: for example, catechist, acolyte, reader etc.

The temporary delegation of liturgical actions in line with canon 230 § 2 does not confer any special denomination on the non-ordained believer at all (cf Pontificio Consiglio per l'Interpretazione dei Testi Legislativi, *Risposta* (11 July): AAS 86 (1994), pp. 541-542. When there is envisaged a function for the beginning of the entrusting of a task of co-operation of the pastoral assistants to the ministry of priests the coinciding or unifying of this function with a ceremony of sacred ordination is to be avoided, as is the case with the celebration of a similar rite for the conferring of the role of being an acolyte or a reader).

It is not legitimate, therefore, for non-ordained believers to acquire, for example, the denominations of 'pastor', 'chaplain', 'co-ordinator', 'chairman'

or other denominations which could confuse their role with that of the pastor, a role exclusive fulfilled by the bishop and the presbyter (Such an example must include all those linguistic expressions which in the idioms of different countries can be analogous or equivalent and indicative of a directive role of leadership or something which takes its form).

2. Three 'Hotter' Points

This last teaching, that of interdicasteral instruction, obliges us to take account of the present-day debate. It seems to me to be a good idea to clarify certain points in order to see whether and what, at the level of doctrine or at the level of what is positive in a pastoral sense, doors are open, taking into account the good of the Church, to guarantee a service which is more suited to sick people. These are 'openings' in harmony with the overall discipline of the Church and not exceptions erected into a system which have the goal of penetrating concepts into the Church which in themselves are extraneous to the Church. It seems to me that there are paths to be taken both in the field of the definition of new ecclesiastical offices entrusted to members of the laity – under the pastoral responsibility of a priest – both in the field of the widening of the faculties of the chaplain and in the field of the creation of new chaplaincies. But because the whole of this system depends on the conception that one has of the priestly identity and its role within the Church I will dwell above all – in order to establish a basis for the whole of the approach – on the first point.

a. The Question of the Priestly Identity of the Chaplain

The chaplain '*est sacerdos*'.

There can be other people involved in the practice of pastoral care in health but they do not have this title and they do not have these faculties. The directory for the ministry of the bishops, *Ecclesiae Imago*, section 183, in discussing the creation of special centres for the apostolate, identifies on the one hand the mission dedicated to caring for souls, and on the other the simple 'pastoral centre' where a certain form of care, specifically also of charity, can also be entrusted to deacons. Indeed, where there are no deacons, these can also be entrusted to members of religious orders or to members of the laity who exercise the functions provided for by their statute.

A Double 'Collaboration' of the Members of the Laity Envisaged by Canon Law

The principle of collaboration with the priestly ministry is set out in the contemporary canonic corpus: the Code of Latin Canon Law of 1983, first of all, refers to canon 228 § 1, which talks about a *habilitas* of the members of the laity in relation to ecclesiastical 'offices' (*officia*) and 'functions' (*munera*), and of the possibility of 'participating in the functions which are closest to the office of the pastors'. Subsequently, the Code of Canons of the Eastern Churches of 1990 reformulated this principle basing itself on Vatican Council II in order to order two levels of collaboration in a more logical way. It refers to the possibility of members of the laity 'being entrusted with ecclesiastical functions'.[3]

CDC 1983	CCEO 1990
228 § 2: members of the laity who are known for their learning, prudence and honesty, have the faculty to provide help to the Pastors of the Church as experts or advisers, in council bodies regulated by law as well.	408 § 1: members of the laity who are known for their due learning, experience and integrity are able to be heard by the ecclesiastical authorities as experts or advisers, both as individuals and as members of various councils and assemblies such as those which are parish, eparchial or patriarchal.
228 § 1: members of the laity who are suitable can be legally employed by holy Pastors in those ecclesiastical offices and in those positions which they can exercise according to the provisions of law.[4]	408 § 2: In addition to ecclesiastical positions, to which they are admitted by common law, they can be employed by the competent authority in other positions as well, except those which require the holy order or which are expressly forbidden to members of the laity by the particular right of their Church *sui iuris.*
	408 § 3: In the exercise of an ecclesiastical position, the members of the laity are fully subject to the ecclesiastical authority.

The interesting aspect of this first group of canons essentially lies in the cited references which are exclusively from Vatican Council II.

The documents of that Council are still too unexplored at the level of their real meaning because of the 'speeches' and 'ways' with, and in which, they were voted on, and they are still practically unpublished.[5] In order to gain an overall picture, but in the absence of such a synthesis – because the Church is a living body – I will principally dwell upon the parts which have in actual fact marked the view that the Church has of herself on this specific point of collaboration (not only with the 'hierarchical apostolate of the Church' which has been practised since the times of St. Paul and subsequently in innumerable fields such as the associations of the faithful, the minor orders, Catholic Action, etc.) but also with the 'pastoral ministry' as such.

The Founding Texts of Vatican Council II

At the level of recognised principles, the commission for the interpretation of the Council, which subsequently became the Commission for the Interpretation of Legislative Texts,[6] in relation to the Latin Code bases this very specific collaboration on three texts: the dogmatic constitution on the Church, *Lumen Gentium*, n. 33; the decree on the pastoral office of bishops, *Christus Dominus*, n. 24; and the decree on the apostolate of the laity, *Apostolicam Actuositatem*, n. 24. The Eastern Code orders these three references and adds others: *Lumen Gentium* 33 is cited for the two types of collaboration; *Christus Dominus* 10 only for the first, that is to say for the hierarchical apostolate; and *Apostolicam Actuositatem* 24 only for the second, that is to say for the pastoral ministry as such. In

both cases reference is also made to *Lumen Gentium* 37. For the first kind of collaboration it also cites *Christus Dominus* 27, *Apostolicam Actuositatem* 20b and 26, the decrees on missionary activity *Ad Gentes* n.30 and on the ministry and the life of priests *Presbyterorum Ordinis* n.17. For the second type it cites *Christus Dominus* 27 and *Ad Gentes* 17. With regard to submission to ecclesiastical authority in all these functions the Eastern Code refers to *Apostolicam Actuositatem* 20s.[7]

Ecclesiatical 'Functions' for the Members of the Laity

Because the question which interests us is the second type of collaboration, which may appear to be the most innovative and the nearest to the sacrament of the Order, we must quote these texts and the official clarifications provided by the drafting committees.[8] In *LG* we read the following: 'In addition to this apostolate, which is the absolute responsibility of all the faithful, the members of the laity can also be called in various ways to collaborate more immediately with the apostolate of the hierarchy (cf Pius XII, 'Alloc. Six Ans se sont Ecoulés', 5 October 1957), along the lines of those men and those women which helped the Apostle Paul in the Gospel, engaging in great trial for the Lord (cf Phil 4:3; Rom 16:3ss)[M17]. They also have the ability to be employed by the hierarchy (*ad hierarchia adsumantur*) to exercise for spiritual ends certain ecclesiatical functions (*ad qaedam numera ecclesiastica, ad finem spiritualem exercenda*) [Rel.F n.18 m.19.'.]

The drafting committees provide various clarifications through their explanations. The

only real novelty is provided by the following sentence: 'the members of the laity also have the ability to be employed by the hierarchy to exercise for spiritual ends certain ecclesiastical functions'. What are these 'ecclesiastical functions'? The draft on letter F in relation to the last text – that which could still include even substantial changes voted for by the Fathers – simply says that a 'complementary idea' has been introduced here taken from the long list of proposals made by Cardinal Suenens. But the reading of this '*propositio nova ordinatione capitum*'[9] of September 1963, which had previously been praised by the committee, does not help us to understand why the committee thought fit to keep it. The sentence in question is used as it was at the end of the section on equality and inequality amongst the members of the Church of Christ, and there are no explanations to be found in the other interventions of the Prelate. It seems, therefore, that the sentence was inserted in the constitution as a general statement thereby allowing a logical development at the heart of this section.

The *modus* 18 shows that at least for one Father this sentence lacked clarity, and he did not see whether here there was something different from the 'appeal to collaborate with the apostolate of the hierarchy', not to speak of the mandate of the associations recognised by the Church. The committee then refused to remove the text and made clear that one was dealing here with 'ecclesiastical' *munera* of which it gave two examples: the bursar of a religious institution and the catechist in a narrow sense.

If we turn to the text of *AG* 17 we can see that one is dealing not with catechists who are satisfied with leading prayers and having a mission of teaching in their community but of catechists in countries of mission which have been employed full time and who thereby have the right to be paid:

'During our time, when there are not enough members of the clergy for the evangelisation of so many multitudes and for the exercise of the pastoral ministry, the task of the catechists is of the utmost importance. For this reason, their training must be in line with cultural progress so that, as valid co-operators (*validi cooperatores*) of the priestly order, they can carry out their task (*munus)* in the best way possible, something which is becoming increasingly difficult with new and larger responsibilities. There must therefore be an increase in the number of diocesan and regional schools in which the future catechists learn both Catholic doctrine, especially with regard to biblical and liturgical matters,M1 and catechistic method and pastoral practice, and receive a Christian moral training...

In addition, those who dedicate themselves completely to this work should be guaranteed a decent standard of living and social security with just pay...[Rel.A.]

It is also to be hoped that the correctly trained catechists, where this is suitable, should receive the public conferment of the canonical mission[M3] so that they can serve the faith with great authority amongst the people.[Rel.B.]

Furthermore, once again in *AG* 17, the committee hopes that the catechists will be able to receive a canonical mission without any distinction between auxiliary catechists and catechists in a narrow sense – this fact means that it is not the canonical mission which confers the 'ecclesiastical *munus'* to which the hierarchy can call somebody. In *Modus* 3 the committee also recognises that this 'canonical mission' does not have a 'canonical' value in the strict sense! It is stated that this is merely a widespread practice and that the decree encourages this where a contribution can be made with greater authority to the service to the faith provided by the catechists.

This is most certainly an authority but it is not a '*potestas*': the possible letter of mission, which the new Code recognises no more than the old, does not confer any '*potestas*' and thus takes nothing away from the government of 'pastors proper', that is to say the parish priests and chaplains (by extension).

The text of the decree on the apostolate of the members of the laity, *Apostolicam Actuositatem* 24, is even more categorical in the matter:

'Lastly, the heirarachy entrusts the members of the laity with other tasks (*munia quaedam committit*) which are more intimately connected with the duties of pastors (*proprius cum officiis pastorum coniuncta sunt*), and in the expounding of Christian doctrine, in certain liturgical acts, and the care of souls. As a result of this mission the members of the laity, with respect to the performance of their tasks (*muneris*), are fully subject to ecclesiastical higher direction (*moderationi*).[Rel.F.]'

In order not to create confusion and to give the impression that the power of jurisdiction can be transmitted by a non-sacramental route – a subject much debated which does not belong to common doctrine and upon which it is not possible to base any discipline – the text was expurgated of every reference to the idea of 'mandate', 'canonical mission' and 'participation in the apostolate of the hierarchy'. Here one should consult the appended paper 'F'.

'Munera' et 'Officia' in a Broad Sense

Everything is based, therefore, on two particular levels of collaboration which are identified by *LG* 33 (councils and possible appointments). *LG* 37 does nothing else than go back to this distinction but this time it describes the relations between the members of the laity and the hierarchy from the point of view of the pastors:

'On the other hand the holy pastors recognise and promote the dignity and responsibility of the laity within the church. They willingly avail themselves of their wise counsel, with trust they entrust to them appointments for service to the church (*in servitium Ecclesiae officia committant*) and allow them freedom and space to act, indeed they encourage them to undertake works of their own initiative[Rel.K]. They should consider the initiatives, requests and wishes advanced by the members of the laity attentively in Christ and with paternal affection. With respect, then, the pastors will recognise that just freedom which is due to all in the earthly city.[Rel.M.]'

Today the ecclesial appointments which are spoken about here, and which a 'letter of mission' is not sufficient to confer, are in reality offices. Indeed, the Latin term employed by *LG* 37 is explicitly '*officia*', whilst *LG* 33 speaks about '*munera*' 'to be carried out with a spiritual end'. This goes back in a rather clear way to the definition of 'ecclesiastical office in a broad sense' presented in the first part of canon 145 § 1 of the Code of Canon Law of 1917 and canonised by *Presbyterorum Ordinis* 20 as the by now general meaning of an office within the Church. Paper C of the third-from-last draft of this last decree shows furthermore that on 1964 it had already been decided that one of the principles for the reorganisation of legislation would have been that in general of a broad acceptance of the meaning of ecclesiastical office and no longer the narrow definition which necessarily involved a participation in the power of order or jurisdiction. Whatever the soundness of this reform may be – indeed is it really possible to structure the institution of the Church beginning with offices which do not in the first instance take into account either the sacrament or the need for compulsory power? – this means that 'the participation in power does not belong to the concept of office',[10] and the same may be said of participation in the sacrament of the Order.

We should observe in relation to *LG* 33 that the text does not make a distinction between '*officia* and '*munera*'. In subsequent extrapolations it has been advanced that the local Church enjoys a priority in relation to the universal Church.[11] This is something which would imply an obligation to recognise the presence of spontaneous *munera* amongst the members of the laity (and in particular in parishes) and at times their erection into real and proper ecclesiastical offices. But nothing of this kind can refer back to a foundation derived from Vatican Council II: *LG* 33 does not distinguish between *munera* and *officia*; it does not see the *munera* in an ontological sense as the foundation of the *Sacra Potestas* conferred by consecration (as in canon III on the hierarchy) but sees them, rather, in a generic sense of duty or role.

'Collaborators' or 'Co-operators'?

In the organisation of the Church the members of the laity can therefore receive a very special appointment, which, indeed, is exalted, although offices are opened up to them relatively rarely, on the whole being of a full-time nature, and they are more precisely defined than is the case in numerous canonical missions, and this is something which allow ministers, including bishops, to exercise their native '*sacra potestas*'.[12] At the same time these are appointments which are rather clearly defined in character. *Christus Dominus* 27 finds it ambiguous that the title of 'collaborators' is also bestowed on members of the laity who have an office in the diocesan curia, and indeed this document limits their contribution to being the provision of 'help to a bishop':

'Both the priests and the members of the laity[M.99 M.100] who are part of the curia should be well aware of giving a hand (*adiutricem operam praestare*)[M.101] to the pastoral ministry of the bishop. The diocesan curia should be ordered in such a way as to become a suitable instrument for the bishop, not only for the administration of the diocese but also for the exercise of works of apostolate'.

The same may be said of the term 'collaborators', probably because it already indicates the element of '*sacra potestas*' conferred on priests from the moment of ordination, and thus has a sacramental foundation. *LG* says that priests are '*providi cooperatores*' of the episcopal order and not only its helpers or its instruments. The decree of Vatican Council II, the pastoral office *Christus Dominus*, never mentions the members of the laity as collaborators, not even in chapter 2-III on the co-operators of the diocesan bishop. Reference is made to a duty to co-operate which concerns parish priests but this is in relation to co-operating with other pastors – they do not have imposed upon them any duty at all to co-operate with the faithful as though this was a part of their

mission. On the contrary, parts 1, 3 and 6 in *CD* 11 explicitly excludes the members of the laity and deacons from the definition of Vatican Council II to the effect that the diocese is a 'portion of the people of God which is entrusted to a bishop who must nourish it with the co-operation of the presbyter'. When a Father asked if one could not add to this definition 'with the co-operation of the presbyter and of the members of the laity' he was forcefully told that the members of the laity are not involved in nourishing.[13]

The Members of the Laity are not 'Pastors'

Nothing therefore allows us to say that the co-operation, collaboration, or participation of the members of the laity belongs to the idea of the 'pastoral charge of pastors': in Vatican Council II only the decree *Apostolicam Actuositatem* 10 speaks about care for souls in relation to the members of the laity, and in does so in the following terms:

'the laity co-operate with dedication in communicating the word of God, especially through the teaching of the catechism; making available their skills *they make care for souls more effective*, as well as the administration of the goods of the Church'.

As we have seen, *AA* 24 speaks about the possibility of entrusting lay people with tasks which are 'more strictly linked' to the duties of the pastor, in terms of the three aspects of the single *munus*, and thus also of care for souls. But it does not speak about entrusting such care to them. From the research carried out on the basis of the '*Magistra*' data there is no official text which speaks about the laity, other than under the heading of collaboration, when one is dealing with *cura animarum*. Even less is reference made to a right held by them to collaborate in this *cura animarum* – they can collaborate with the apostolate, with the mission of the Church, and even with the transmission of the Word, but not with the care of souls, that is to say with that which is in fact the sole responsibility of the pastor. The present-day Code identifies the limits to these offices when it summarises the duties of the parish priest: 'with the co-operation also of other presbyters or deacons and contributing to the work also of the lay faithful according to law'.[14]

The Members of the Laity are able to 'Preside'

In order to conclude on the subject of the possibility of members of the laity to take on offices of great responsibility, which are at a level which is different from the sacramental responsibility in relation to souls, one should quote *modus* 2 of *AG* 17, and this because of the fact that it has been faithfully carried over into interdicasteral instruction and its traditions.[15]

'Furthermore, the Church must feel and will appreciate with gratitude the generous work of auxiliary catechists, whose help they need. In their community they must lead[M.2] prayers and provide teaching. Concern must be duly felt in relation to their doctrinal and spiritual training.'

Because the office entrusted to members of the laity does not involve any power or relationship with the sacrament of the Order, this is transferred to all their tasks of direction: the Latin does not use the term '*praesident*' in relation to them but '*praesunt*' or more strictly '*praeunt*'. This means that one can entrust these members of the laity with the task of being those who accompany the community, of being their animators, of setting an example, or even of leading the way, guiding them, and directing them. But they do not 'preside' over anything, not baptisms, not prayers, not funerals, not councils – presiding is specific to the sacramental hierarchy.

Not even the Deacons are 'Pastors'

This, indeed, has a consequence which has never been explored in relation to deacons: they are members of the sacramental hierarchy but not of the priesthood. They receive the capacity to offer in the name of the People and to distribute in the name of God, they are in front of the Church, they are the image of Christ in the dimension of service of his priesthood, but they are not the image of Christ the Head: they can thus preside and bless in front of the People but never in the presence of a priest. The common doctrine expressed in the *Catechism of the Catholic Church* or in the new *Directory for the Ministry and the Life of Permanent Deacons* begins pastoral responsibility only with the presbyterate.[16] The grace specific to deacons, who are on the first level of the 'sacrament of the ministry', does not make them pastors. For this reason they cannot receive offices which involve them in the full care of souls. The instruction recalls that they should principally be entrusted with tasks involving substitution because they exercise a real ministry. However, in the case of canon 517 § 2 as well, deacons do not take part in the 'pastoral' task but only in its exercise. All these distinctions between pastoral responsibility, ministry and ecclesiastical office can help us to understand how little power is in play in everything that concerns the armour of the institution of the Church. Precisely because one is dealing with graces proper, based upon different consecrations, the roles are not interchangeable.

Cardinal Ratzinger summarises the doctrinal question in the following way:[17]

'The Instruction well identifies the three kinds of tasks and services through which the lay faithful take part in the unique mission of the Church:

1) tasks and services involving the apostolate of the laity, that is to say their special way of making Christ present in the structures of the temporal and civil order;

2) tasks and services in the various organisational structures of the Church which are entrusted to the laity by the competent ecclesiastical authority through offices and functions;

3) tasks and services which are proper to the holy ministers but which nonetheless because of special or serious circumstances, and in practical terms because of a lack of presbyters and deacons (one hopes of a transitory character) are temporarily exercised by members of the laity, after receiving the juridical faculty or mandate from the competent ecclesiastical authority. In this case one is dealing with the already re-

ferred to *supplementary tasks* which do not describe in an intrinsic way from the character of the holy Order'.

We can recognise here the distinction made by Vatican Council II recalled further on, to which is added the distinction in cases of substitution. One cannot but realise that this doctrine immediately involves implications for the order of government. The apostolate of members of the laity is always promoted. Their co-operation in ecclesiastical offices should not be promoted. It is a possibility that in itself this will not contribute anything to the members of the laity but from which bishops can benefit in the organisation of their dioceses to the extent to which this does not introduce a confusion of identity. With regard to substitution, it is possible only as a temporary remedy in response to a situation of crisis. It is, therefore, a minor evil to be escaped from as soon as possible.

Other Canonical Aspects

The texts mentioned above show that the identification of different levels of collaboration derives from another distinction, that between the power of the order and the power of government, and from the introduction of the principle of a possible 'co-operation' into this last.

On this principle there is a second group of canons which do not reinterpret only two or three passages from Vatican Council II but which represent a rather consolidated tradition whose interpretation is not yet unanimous with regard to the form of transmission of these two powers (order and jurisdiction). However, Vatican Council II well established their sacramental origins basing the origins of collegial power in the bishops on the same ontological participation in the *munera Christi*, a participation received from a personal consecration which defines Christ according to a new way at every level of sacrament. The important edition of the Catechism summarises this teaching when it substitutes n. 879 with the following statement: 'the sacramental ministry of the Church is therefore a service performed in the name of Christ. It has a personal character and a collegial form'.

CIC 1983	CCEO 1990
274 § 1. Only priests can obtain offices whose exercise requires the power of order or the power of ecclesiastical government.[274§81]	371 § 1. Priests, with the required canonical elements, have the right to obtain from their own eparchial bishop an office (officium), ministry (ministerium) or appointment (munus) to be exercised in the service of the Church.
129 § 1. From the power of government, which exists in the Church by divine institution, also called power of jurisdiction, according to law those who belong to the holy order are able subjects in line with the canons of law. [129§1] § 2: In the exercise of such power the laity can also co-operate according to the norms of law.[129§2]	979 § 1. Those who belong to the holy order are able in power of government, which by divine institution exists within the Church, according to the norms of law.[979 § 1] § 2. In the exercise of the power of government all the other Christian faithful can co-operate according to the norms of law. [979§2]
150: An office which involves the full care of souls, whose performance requires the exercise of the priestly order, cannot be validly conferred on a person who has not yet been promoted to the priesthood.	

A 'Legalistic' Assertion

Commenting on all these texts and the tradition to which they belong would take too much time. Once again, Vatican Council II did not want to explicitly choose the form of transmission of these two powers. But one is greatly struck by the fact that the thesis of K. Rhaner of 1956[19] is periodically utilised as the final consequence of the ecclesiology of communion.[18] According to this thesis the pastoral animators would lose their secular state and would enter the clerical state through the establishment in stable fashion of an ecclesial function or office, something which would in itself make them participate in the sacramentality of the Church because their function would make them signs of the order of *sacramentum tantum*. This thesis is completely knocked out of court by the teaching of Vatican Council II on *munera* and *sacra potestas* as an ontological foundation of the ministry. Whatever may be the polemical character of these works which seem primarily concerned to break open the padlock of the celibate state, understood as a hidden motive for the distinction between priests and non-priests, they base everything upon a conception which in the end is rather 'legalistic' and a little hyptrophic of the power of jurisdiction as though this was the current usage of the Church. When they search for support from Vatican Council II these authors refer to *LG* 33 as though this text envisaged the possibility for members of the laity to exercise a jurisdiction: it has already been observed in this paper how things really are. We cannot even deny that in these desperate attempts there is a 'search if not for a theology at least for a practice which is alternative to the ministries of the Church' to employ a stock phrase, when we see these authors sign petitions after petitions and agitate around diocesan synods in order to get their theses passed. But the truth of the matter is that these are disputes amongst priests for which members of the laity are not responsible.

The Teaching of the Catechism of the Catholic Church

I would like to quote only the passage from the *Catechism of the Catholic Church* which deals with these canons, and more precisely from sections 908 onwards, on the participation of the members of the laity in the royal office of Christ:

n. 910: 'The laity can also feel called, or be in fact called, to co-operate with their pastors in the service of the ecclesial community, for the same of its growth or life. This can be done through the exercise of different kinds of ministries according to the grace and charisms which the Lord has been pleased to bestow on them' (*Evangelii Nuntiandi*, 73).

n. 911. In the Church 'lay members of the Christian faithful can co-operate in the exercise of this power (of governance) in accord with the norm of law' (CIC, can 129 § 2). And so the Church provides for the presence at particular councils, diocesan synods, pastoral councils; the exercise *in solidum* of the pastoral care of a parish, collaboration in finance committees, and participation in ecclesiastical tribunals' (cf. CIC, cann. 443 § 4; 463 §§ 1, 2; 492 § 1; 511; 517 § 2; 536; 1421 § 2).

It is to be observed that the important edition of the Catechism removes the ambiguity of an '*in solidum*' participation of the members of the laity in the exceptional exercise of pastoral care envisaged by canon 517 § 2: given that the phrase '*in solidum*' is applied to colleges whose members have equal responsibility it cannot be applied to pastoral care which belongs solely to the specific pastor of the community, even though he might be a moderator.

Ministries and Offices of the Laity in the Code of Canon Law

With regard to the ministries and offices of the members of the laity, reference should also be made to canons 224-231 which deal with the obligations and the rights of the lay faithful. These refer to a *ministry* only in canon 230 § 1 and 3 when discussing instituted ministries. They talk about *officium* in a number of meanings: in canons 225 § 2 and 226 § 1 in the general sense of *duties* linked to evangelisation of the temporal order and the family; in § 3 of canon 230 reference is made to offices of instituted ministries, and here, too, in terms of duties. In canon 228 reference is made to certain 'ecclesiastical offices', defined by law, in relation to which the laity have a *habilitas*. The meaning here is thus rather technical – one is dealing with an office according to the meanings of canon 145. We can deduce from this capacity the fact that the *munera* are said to derive from confirmation in the same way as their character derive from the sacrament of order – the order also produces the character whilst confirmation only produces a *habilitas*, something which is not valid for all offices and for all *munera* but only for those which are defined and do not involve the care of souls.

It is not a good methodology to found a theory only beginning with the vocabulary of such a contingent text as the CIC. However, the same Code does not provide any basis to seeing baptism or confirmation as giving rise to a right to office: they provide only an '*apritudo*', translated with '*habilitas* in the CIC in relation to certain offices which are 'nearer' to those of pastors.

In canon 150 the Code, beginning with a new broadened notion of office, introduced the possibility of entrusting true and real ecclesiastical offices to members of the laity, on the condition that they do not involve 'the full care of souls'. In practice the comparison with canon 228 leads to an approach where only the offices envisaged by law can be entrusted to members of the laity – those which are institutionalised by the CIC are much less numerous.[20] All the others, therefore, are created by particular law and cannot take the post of offices whose existence is obligatory. Furthermore, as we have seen, the office entrusted to members of the laity does not involve any power. It does not take the place of the pastoral responsibility for souls, and it is a basic principle of the Church to ensure that there is no community without a pastor, whether its criterion of aggregation is territorial or personal. As Monsignor Cadilhac emphasises: 'only he who is ordained can be responsible for pastoral care. A part of this exercise can certainly be delegated to members of the laity but these last can carry out their task only in dependence of whom is responsible for pastoral care'.[21] If the *Directory for the Ministry and the Life of Permanent Deacons* observes that they exercise their ministry, even in contexts which are less favoured and distant from the Church, always under the dependence of a pastor in everything to do with the care for souls, this applies *a fortiori* to members of the laity.

Being Careful with Regard to a Certain Approach, and not Saying Everything

It is important to remember canon 19 which deals with cases where there is a legal gap. The absence of a norm does not mean a licence to do everything. The Church has always recognised the validity of the '*praeter legem*' customs, but on one condition -rationality. This depends on objective criteria, the fruit of the experience of the Church, which allows her to maintain a certain coherence and consistency in her work. These criteria are those of analogy with the laws used for similar cases, the general principles of law, jurisprudence and the practice of the Roman Curia, and lastly the common and constant opinion of the Doctors of the Church.

These criteria allow, among other things, the possibility of developing the idea of '*cura animarum*'.

Article 1 of the instruction requires above all else a terminological clarification. Perhaps it would be a good idea in this sense to adhere to the classification proposed by certain teachers of the clergy.

1. *Cura animarum* is the exclusive responsibility of ordained ministers (cf canon 150).

2. Pastoral care lies in the bishop, and the presbyter takes part in it (*CD* 11). It cannot be based upon a letter of mission.

3. Pastoral care is *exercised* by the parish priest and his deputies take part in its exercise. Participation in this exercise can be entrusted to members of the laity in the exceptional case of canon 517 § 2.

b. The Question of Special Faculties

When one explores the sources of present-day legislation one discovers that many faculties have been conceded for two categories of the faithful – migrants and members of the armed forces.[22] Our sick people have had their Pontifical Council only since 1985, a body entrusted with ensuring that they receive the care of the universal Church.

The Instruction *Nemo Est* of 1969 dedicated to migrants bestows upon them a chaplain who is equivalent to a parish priest if he has a 'mission with care for souls', and the same title with the rights and obligations of the pastor proper if he is entrusted with a personal parish. Article 39 says that this personal power

is cumulative *aequo iure* with that of the parish priest. For this reason, every emigrant has the full faculty to freely turn to a chaplain and the parish priest of the place for the celebration of the sacraments, including marriage. Perhaps such an equivalence could also be used in certain cases with sick people as well.

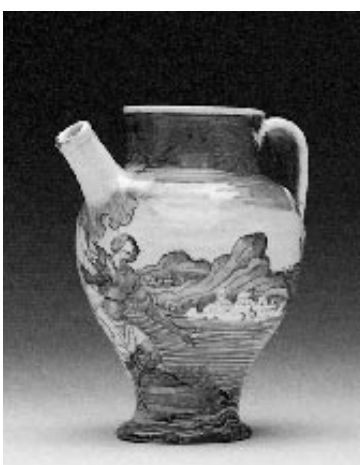
I would not like to provoke ill-founded hankerings but it seems to me that the drawing up of a new list of faculties, perhaps broadened in number after hearing what the needs of the chaplains of the universal Church really are, and perhaps furnished with new indulgences which should be asked for from the Apostolic Penitentiary, would also be a way of demonstrating two things:

– the importance for the Church of the world of suffering;

– and the special response of the Church in this world. Indeed, the Church responds to these needs not only at a humanitarian level but above all else with pastoral care, which is typically priestly in character. Pastoral care, here, is the way in which the Church responds to the right of the faithful to receive the Word and the sacraments with abundance. A priestly presence is a special presence of Christ, and the broadening of the priestly faculties means making the encounter of a special world with Christ easier.

c. The Choice of Creating New Chaplaincies

CD 18 expresses a decision of the universal Church. It is a test which applies both to the Latin Church and to the Eastern Churches. There is thus a duty on the part of the Conferences of Bishops to study the most urgent questions relating to groups of the faithful whom the ministry of parish priests reaches only with difficulty.



In this area the Church does not deaden the imagination. Indeed, it is its most solemn feature to call on everybody to engage in an examination of their consciences with regard to responding to the needs of souls.

The only reservation felt by the Church is that of the need to always act according to the virtue of prudence. In the area of 'special pastoral care' we have found only one 'restrictive' criterion in this sense: the Instruction *Solemne Semper* of 1951 recalls a principle which is always valid:

'Do not throw into the ministry inexpert priests. We exhort you, venerable brothers, to avoid, where this is possible, to throwing into full pastoral activity priests who are still inexpert, and to send them to places which are very remote from the seat of the diocese or other major centres. In such situations, indeed, isolated, inexpert, exposed to dangers, deprived of prudent teachers, they would certainly encounter harm for themselves and their ministry'.

We can also see pastoral care in health as an area which is too sensitive to be improvised – all innovations are possible with respect to entrusting souls but 'to the extent to which this is possible' the generations of priests who will be destined for innovative forms of pastoral care must be trained at the school of their brothers, who should teach them the '*sensus Ecclesiae*'to ensure that they do not 'run in vain'.

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Notes

[1] Ecclesial groupings go back to the origins of the Church. Traces of legislation in this area have been maintained relating to:

– colleges of *fossores*, with a charitable purpose, during the fourth century for burial in the catacombs;

– in the East the *parabolani* dedicated themselves to taking care of the sick from 250 AD onwards. Their number was limited by the Theodosian code to 250 for the city of Alexandria;

– once again in the East, brotherhoods of *spoudaioi* and *philoponoi*, faithful who lived in this world in a way very distinct from members of religious orders but who helped them in the search for perfection and to whom vigils which were at times too long were entrusted;

– we find the use of '*confratriae*' from 658 onwards (the Council of Nantes) to denote meetings of the faithful for the purposes of piety (cf R.Naz, *Traité de Droit Canonique*, Paris, 1955).

[2] A classification in line with the terms employed by F.D'OSTILO, *Prontuario del Codice di Diritto Canonico* (Vatican City, 1955), p. 247.

[3] The concordance of canons between CDC and CCEO is that published by E.EID AND R.METZ in *Il Codice dei Canoni delle Chiese Orientali* (Libreria Editrice Vaticana, 1997).

[4] The translation of '*munera quibus ipsi secundum iuris praescripta fungi valent*' is based here on that recognised by the Spanish Episcopal Conference.

[5] In addition to being published in the *Acta Synodalia* these texts can be found in F.Gill Hellin, *Concilii Vaticani II Synopsis in Ordinem Redigens Schemata cum Relationibus Necnon Patrum Orationes atque Animadversiones* (Libreria Editrice Vaticana). The acts of the dogmatic constitutions *Lumen Gentium* and *Dei Verbum*, as well as the decree *Presbyterorum Ordinis*, have also been published.

[6] Cf Pontificia Commissio Codici Iuris Canonici Athenticae Interpretando, *Codex Iuris Canonici, Fontium Annotatione et Indice Analytico-alphabetico Auctus* (1989), canon 228 § 1; Pontificium Consilium de Legum Textibus Interpretandis, *Codex Ecclesiarum Orientalium, Fontium Annotatione Auctus* (1995).

[7] Henceforth in this paper I will use the following acronyms: AA: *Apostolicam Actuositatem*, AD: *Ad Gentes*, CD: *Christus Dominus*, LG: *Lumen Gentium*, PO *Presbyterorum Ordinis*.

[8] The translation here is based upon that translation, which is quite close to the text, of the work *Les Conciles Oecuméniques* 2/ (Paris, 1994).

[M17] 'Two Fathers advance observations concerning this call, or what is denominated by the 'mandate' of the apostolate. Another Father asks for it to be explicity declared that: 'the *mandate* is not confined to one association only but extends to *all the associations* recognised by the Church'. R: the draft deliberately *avoids controversies relating to vocabulary*. The further definitions belong to the schema on the apostolate of the laity'.

[Rel.F] 'This complementary idea concerns the ecclesiastical *munera* to be exercised by the laity derived from the already parised *proposta* of H.E.Cardinal Suens'. The 'propositio Suenens' says as follows: – (new arrangements of the chapters) -'the laity also enjoy the ability to be called by the hierarachy to certain ecclesiatical *munera* to be exercised with a spiritual goal'.

[M.18] 'A Father proposes to eliminate the word 'also' because this coincides with the words which go before on the more immediate co-operation with the apostolate. R. this is another category, that is to say of those who exercise ecclesiatical *munera*, such as for example the bursars of a religious institution, catechists in a narrow sense, etc.'.

[M.19] 'A Father proposes to *add* at the end of this sentence a long exposition on the *various forms* by which the laity can co-operate with the hierarachy. R: such a broad development cannot be allowed'.

[9] Cf GIL HELLIN, *op. cit.*, pp. 868-871.

[M.1] 'The words 'above all in biblical and liturgical matters' should be eliminated or it should be said 'both the Catholic doctrine and the liturgy, as well as the cat-

echetic method' (1 Father). R: the renewal of pastoral action carried out by the Council, with regard to the catechesis, concerns above all else the biblical and liturgical catechesis. It is therefore suitable that the catechists are trained in such matters. The text remains'.

Rel.A 'A parenthesis was introduced so that this payment to catechists termed 'full time' could appear more clearly (2, 26 (Mons. Seitz IV, IV, 619); 5, 41 (Mons. Riobé IV, IV, 597). Indeed, it is above all about them that the first three paragraphs of this number refer. In the fifth paragraph reference is made to 'voluntary' or 'auxiliary' catechists'.

M.3 'The term 'canonical' should be eliminated, or at least it should be justified in a note; indeed this term was rejected by the decree AA on the apostolate of the laity (1 Father). R: Taking everything into consideration the *modus* is not allowed because even though presnt-day law (*ius conditum*) does not know such a canonical mission this is a practice followed in very many places and not only in missions'.

Rel.B 'Only one Father (Mons. Mazé) raises the question of confering minor orders on catechists. It seems enough for the schema to propose a special liturgical action for the institution of a catechist'.

M.34 'Thirty-four Fathers ask that in the place of 'to the offices of the hierarchy' there should be written 'to the pastors'. One Father asks for 'to the Ordinary' and another 'to the bishops'. R: let the following be written: 'to the offices of the pastors''. (*Acta Synodalia*, vol. IV, Pars VI, p. 110).

Rel.F 'The committee relies on the observations of Mons. Jubany Arnau, and in order not to enter into a question discussed by canonists withdraws the words 'mission denominated canonical' and 'they participate in their way in the apostolate itself of the hierarachy'. In the place of 'in the preaching of the word of God' it is better to say 'in the propounding of Christian doctrine'. The correction proposed by two Fathers (Mons. H.Tenhumberg and Mons I.Hoffner) to add 'some' before 'liturgical acts'. Here too the note concerning the canonical mission is eliminated for the same reasons as that used above in relation to the mandate (*Acta Synodalia*, vol. IV, pars. II, p. 355).

Rel.K After the description of the relations between the members of the laity and the heirarchy this new sentence, in opposite fashion, sees the question from *the point of view of the pastors* (cf Cardinal de Barros Camara and ninety Fathers from Brasil). The parenthesis 'dignity... add' is taken from the decree on the apostolate of the laity tit. 2 c.1. n. 21, as suggested by Mons. L.Trevor Picchy, with the agreement of the committee on the apostolate of the laity. In the place of 'advice according to their proper *responsibility*' here is placed '*prudent* advice' because 'responsibility' has already been much discussed and it would not be clear if one is dealing here with the responsibility of the laity or of the hierarchy'.

Rel.M 'What is said here about the *freedom of the laity in temporal things* meets the suggestions of Cardinal Silva Henriquez (with thirty-nine bishops), of Mons. Joseph Hoeffner, Samuel Ruiz, Marc McGrath.'

[10] J.MANZANARES, in *Code de Droit Canonique* (Paris, 1989), commentary on canon 145.

[11] There is a rejection here of the judgement expressed by the letter of the Congregation for the Doctrine of the Faith 'on some aspects of the Church as communion' in n.9. Cf DC 2055 (12-16 Auguesr 1992), p. 731.

[12] Cf *Nota Explicativa Paevia* n. 2 concerning chapter 3 of *Lumen Gentium*.

M.99 'In the place of 'the priests and laity' should be put 'all and each of the collaborators' (1 Father). R: The text of the schema is clearer: on the contrary, the terms proposed suffer from ambiguity'.

M.100 'The words 'the laity' should be omitted' (1 Father). In the place of 'is to be welcomed' (the creation of a pastoral council) the following should be said: 'where it is considered suitable' (10 Fathers). R: The laity should not be omitted because this comes from their condition in the apostolate of the Church. The other words proposed are not accepted because the institution of the pastoral council is something which is really to be recommended'.

M.101 'A request is made to add the words: 'but also with other forms of help, the laity included' (1 Father). R: This is not accepted: because the diocese is a portion of the people of God which should be nourished, one cannot add 'also with other forms of help, the laity included' because it is not for the laity to nourish the people of God'.

[14] Canon 519.

[15] Cf Art 6 § 2; 7 § 1; 12 etc. In the French translation although one uses the word 'to preside' for the priest or deacon, for the lay faithful 'to guide' or 'to animate' is considered sufficient.

M.2 'In the place of '*praesident* – president' write '*praesunt* – director' or '*praeeunt* – they set an example' because the term '*praesidere* – to preside' expresses the function of the sacramental hierarchy (1 Father): R: the *modus* is accepted because of the Latin meaning.

[16] The definitive edition of the catechism, published at the same time as the new General Directory for the Catechesis in October 1977 is even clearer on this point. Whilst article 875 could allow it to be supposed that the deacons too receive participation in the *sacra potestas* of acting *in persona Christi Capitis*, this article came to be corrected in the following way: 'From him the bishops and priests receive the faculty (the 'holy power') to act 'in the person of Christ the Head', the deacons the power to serve the people of God in the 'deaconship' of the liturgy, of the word and charity, in communion with the bishop and his presbyter'.

[17] See the interview in *30 Giorni*, December 1997.

[274§1] Canon 118 of the CIC of 1917; C.1, D.XCIV. q. 7; c.2 D.I., *de cons.*; c.2, X, 2 *de aetate etqualitate et ordine paeficiendorum*, I, 14; c. 6, X, *de transactionibus*, I, 36; c. 2, X, *de iudiciis*, UU, 1; c. 2, X, *de institutionisbus*, III, 7; c. 4, X, *de immunitate ecclesiarum, coemeterii et rerum pertinentium*, III, 49; c. 1, X, *de clerico non ordinato ministrante*, V, 28; c. 10, X, *de poenitentis et remissionibus*, V, 38; Conc. Trident., sess. VII, *de sacramentis in genere*, Can. 10; Si quis dixerit, christianos omnes in verbi et monibus sacramentis administrandis hanbere potestatem: a.s. – Sess. XIV, *de poenitentia*, c. 6, Can. 10; Si quis dixerit, sacerdotes, qui in peccato mortali sunt, potestatem ligandi et solvendi non habere; aut non solos sacredotes esse ministros asolutionis, sed ominbus et singulis chrisifidelibus esse dictum: *Quoecumque ligaverits super terram, erunt legata et in coelo*; et *Quorum remiseritis peccata, remittuntur eis, et quorum retinueritis, retenta sunt*, quorum verborum virtute quilibet absolvere possit peccate, publica quidem per correptionem dintaxat, si coreptus acquieverit, secreta vero per spontaneam confessionem: a.s. – Sess XXII, de ordine, c. 4, Can. 7; Si quis dixerit, episcopos non esse presbyteris superiores, vel non habere potestatem confirmandi et ordinandi, vel eam, quam habent, illis esse cum presbyteris communem; vel ordines ab ipsos colatos sine populi vel potestatis saecularis consensu aut vocatione irritos esse; aut eos, qui nec ab ecclesiatica et canonica potestate rite ordinati nec missi sunt, sed aliunde veniunt, legitimos esse verbi et sacramentorum ministros: a.s. – Sess. XXIV, de ref., c. 12. Innocentius III, eo. '*Eius Exemplo*', 18 Dec. 1208, Professio fidei Waldensibus praescr; Leo X (in Conc. Lateranen. C), const. 'Regimini Universalis', 4 maii 1515, § 10; const. 'Exsurge Domine', 15 iun. 1520, error 13, Martini Luther, damn; 'In sacramento paenitentiae ac remissione culpae non plus facit Papa aut episcopus, quam infimus sacerdos: immo, ubi non est sacerdos, aeque tantum quilibet Christianus, etiamsi mulier aut puer esset. 'Benedictus XIV, ep. encyclc. 'Quaemadmodum', 23 mart. 1743, § 3, 6; Pius IX, litt. ap. 'Multiplices Inter', 10 iun. 1851 = Syllabus errorum, prop. 54 'Reges et principes non solum ab Ecclesiae iurisdictione eximnuntur, verum etiam in quaestionibus iurisdictionis dirimendis superiores sunt Ecclesia.' ep. 'Exortae', 29 April 1876; S.C. Ep. et Reg., Arianen., 5 April 1593; Castellana, 22 iun. 1708, ad 3: in Causa Castellana, seu Nullius Provinciae Baren. Iurisdictionis inter Monasterium S.Benedicti Conversani Ordinis Cistercensis ex una, et nonnullos de Clero Castellanae partibus ex altera de et super infrascriptis dubbis, etc. nempe: 3. An dictae Abbatissae licear proponere ad Curam Animarutn Personas amovibiles ad nutum, easque ad libitum amovere... Sacra Cingregatio respondit: Ad 3: Negative et interim per modum provisionis usque ad exitum Causa; Cura exerceatur per Deputandum a Capitulo approbandum tantum a Vicario Abbatissae per examinatoroes sibi benevisos. – decr. I 5 uil. 1845: Sanctissimus Dominus noster Gregorius PP. XVI diu, serio ac mature perpendit relationem, quae inscribitur *Apostolic Visit by Cardinal Pignatelli Archbishop of Palermo in the venerable monastery of St.George of the Olivetan Congregation of His Majesty Ferdinand II King of the Two Sicilies in Palermo 31 March 1845*, ita subscriptam: 'I Maria Card. Pignatelli Arciv Di Palermo Regio Vistiatore Canonico Salvatore Calcara Regio Visitatore – Pietro Giuseppe Leone dei ministri degl'infermi convisatore', arque magno cum maerore cognovit omnia in ea peracta apparere nomine, iussu, et auctoritate laicae potestatis, quin mentio fiat Pontificii mandati, ac si regii iuris esset Apostolicam Visitationem indicere, et Visitatoribus peragenda praescribere. Quapropter eadem Sanctitas Sua decrevit *relationem ipsam* sub tali forma ac terminis non esset admittendam, utpote Supremae Pontificiae auctoritati summopere laesivam, et Apostolicae Sedi iniuriossimam; ed hoc decretum sionificari mandavit per me infrascriptum S.Congregationis EE. Et. RR. Praefectum eidem E.mo Archiepiscopo Panormitano in tabulario actorum Visitationis asservandum. – S.C.C., Derthonen., 19 Aug 1730. Sacra Congregatio pro Doctrina Fidei, Ep. (Prot. 151/76), 8 Feb. 1977.

[129 § 1] PIUS VI, cost. '*Auctorem Fidei*', 28 August 1874, prop. 2, Synodi Pistorien., damn.,; PIUS X, lett. enc. '*Pascendi*', 8 Sept. 1907; S.C. deProp. Fide (C.P. pro Sin.), 16 Jan. 1797, ad 2.

[129 § 2] SCConc Resol., 14 Dece. 1918 (AAS 11 (1919), 128-133); Pontificio Commissio Pro Russia, Ind., 20 Jan. 1930, SA Resp. 19 Nov. 1947; Pius PP.XII, All., 5 Oct. 1957 (AAS 49 (1957) 927); LG 33; AA 24: SA Decisio, 11 June 1968: Scris Rescr. 7 Feb. 1969; Scris Decr. Clericali Instituta, 27 Nov. 1969 (AAS 61 (1969) 739-740) Sec Facul., 1 Oct 1974; EN 73a: Scris Rescr., 26 June 1978, 3; Scris Resp., 21 Aug. 1978. Sacra Congregatio Pro Clericis, Notae directivae *Postquam Apostoli* (25 March 1980)

7, 17: La *Chiamata dei Laici*. All the laity, because of baptism and confirmation, are called by the Lord to an effective apostolate: 'The Christian vocation by its nature is also a vocation to the apostolate'. The apostolate of the laity, although it is exercised principally in the parishes, must be nonetheless extended also to an inter-parish, diocesan, national and international level. The laity, indeed, must take to their hearts 'the needs all the people of God throughout the world'. This can take place helping missionary work both with material support and with personal service.

The laity, in addition, *can be called by the hierarachy to a more direct and immediate co-operation with the apostolate*. The Church, indeed, over recent decades has discovered the rich possibilities and the vast resources which the collaboration of the laity can offer to her mission of salvation. The apostolic exhortation *Evengelii Nuntiandi* on the basis of recent experiences bestows various tasks, such as that of being a *catechist*, that of *Christians dedicated to service to the world of God* or works of charity, that of *heads of small communities* etc. This collaboration of the laity, which is useful everywhere, is useful above all else in lands of mission with respect to the foundation, fostering and development of the Church. All the members of the Church, therefore, whether they are pastors, members of the laity, or members of religious orders, participate each in his or her own way, in the missionary nature of the Church. The diversity of her members, due to the variety of ministries or charisms, as the Apostle teaches us, must be understood in the sense that 'these members do not all have the same functions', but in serving each other they form a single body of Christ (Rom 12:4) in order to carry out their mandate in a more effective way. The whole of the Church, indeed, is pushed by the Holy Spirit to co-operate so that the design of God is realised.

[979 § 1] PIUS XII, m.p. '*Cleri Sanctitati*', 2 June 1957, canon 138. Pius VI, cost. '*Auctorem Fidei*', 28 August 1794, prop. 2, Synodi Pistoriem., damn. 'The proposal which declares: 'The power is given by God to the Church so that it is communicated to the pastors who are the ministers for the salvation of souls', if understood in the sense that the power of the ecclesiatical ministry and of government derive from the community of the faithful to the pastors, (is) heretical'.

[979 § 2] LG 33 'Praeter'; AA 24 'Quaedam'; Paul VI, Lett Ap. *Cum Matrimonialuim*, 8 Sept 1973, artt. V.VI; Secret. Status, facultas data Sign. Apost., 1 Oct 1974: Ochoa V, 4347.

[18] Cf J.RIGAL, *L'Ellésiologie de Communion* (Cerf, 1997), p. 299: or the more journalistic work by B.SESBOUE, *N'ayez pas peur – Regards sur l'Eglise et les Ministères Aujourd'hui* (Desclée de Brower, 1996).

[19] Cf NRT 1 (1956); *Über das Laienapostolat: Schriften zur Theologie II* (Einsielden, 1964), pp. 339-373.

[20] Note 74 of *Christifideles Laici* would provide a list of sixteen canons which present 'different functions or tasks that the lay faithful can perform within the organic structures of the Church'.

[21] *Eglise de Nìmes*, 5 December 1997.

[22] For the members of the armed forces:

SCDS Resp., 8 Oct. 1943; SCC Inst. *Solemne Semper* 23 April 1951 (AAS 43 (1951) 564); Instructio De Vicariis Castrensibus; SCC Instr. *Divinum Persequens*, 2 June 1951 (AAS 43 (1951) 565-566); SCR Inst. *Sacrorum Administri*, 2 Feb. 1955 (AAS 47 (1955) 93-7); SCC Inst. *Per Instructionem* 20 Oct. 1956 (AAS 49 (1957), 150-163); SCC Decr. *Ad Sacra Limina*, 28 Feb, 1959 (AAS 51 (1959) 274); SCC Decr. *Sacramentum Poenitentiae*, 27 Nov. 1960 (AAS 53 (1961) 49-50).

For migrants:

SCC Ind., 31 Aug. 1953: Consistorialem benigne indulsit, ut Cappellani Apostolatus maris munere augerntur ministri extraodinarii Confirmationis pro fidelibus suae iurisdictioni obnoxiis. SCC Facul., 19 March 1954 (AAS 46 (1954) 415-418); 1. Legitime assumpti in officium Cappellani navigantium. SCC Resp., 7 July 1956: Dubia-1. Utrum durante itinere maritimo...SCE Instr. *Nemo Est*, 22 Aug. 1969, V (AAS 61 (1969) 632-633.

The Chaplains or missionaries of migrants:

SCE Decr. *Apostolatus Maris*, 24 Sept. 1977 (AAS 69 (1977) 737-746) – Second part – Faculty for priests who exercise spiritual assistance for sailors or travellers.

The Catholic Chaplain and the Health Care Ministry on the Threshold of the Third Millennium – Emerging Problems

This paper takes as given the exposition which preceded it of the theological and canonical bases of the pastoral action of the Catholic chaplain with regard to the health care ministry. My task now is to outline the guidelines of such pastoral action. In order to provide what I say with continuity, harmony and consistency I will have to make a brief reference to what has already been said. However, I will limit myself to what is strictly necessary.

In addition I will have to take into consideration the development which has taken place in the management of health care and its pastoral consequences. After the conversion into companies of institutes of care the sick person who is not in a terminal condition is kept in hospital only for as long as is necessary to define his illness and its treatment. Once the treatment has been decided he is looked after in the local area, that is to say at home or by ground-level clinics. This also involves important changes in the practice of the health care ministry. This ministry must be thought about in a new way and reorganised not only in hospitals but also within the context of parish care where it would be a very good idea to ensure the presence of parish vicars or communities of ordained religious entrusted with the specific task of spiritual and religious assistance to sick people in their homes.

Taking this new situation into account and after a number of preliminary reflections, I will proceed to speak about the active and creative presence of the Church in the world of health and health care and of certain characteristic aspects of pastoral action in relation to health care in parishes and hospital institutions.

1. General Introductory Considerations

a. A New Concept of Health and Illness

The contemporary sensibility seems to be especially concerned with the positive dimension of man's existence – health is a primary subject and interest from a social and cultural point of view. And given that all illnesses have become treatable and many have become curable, health has become a 'right', a normal and 'due' fact. In this new concept, health is not only related to physical and physiological factors – it is also linked to the mental and spiritual dimension of the person. It also involves the physical, emotional, social and moral environment in which the person lives and works; this is something which can generate a deep existential harmony between health,

quality of life, and well-being.

Health, it may be observed, is above all else a *human experience*, indeed *biographical*. It has a close relationship with the experience that the individual has of his own body and his place in the world, and with the values upon which he bases his existence. Health, therefore, is not only a fact which emerges but also an objective, a goal, a task which involves his freedom to the full. A new definition of health, after that offered by the World Health Organisation in 1946, has still not yet been formulated, but we have an idea of the clear principles upon which such a definition should be based. Trabucchi says *health is*: 'harmony between body and spirit, harmony between person and the environment, and harmony between personality and responsibility.'[1]

The idea of health or of the healthy person can be expressed in the following way: 'a person is healthy when he is habitually able to live using all the faculties and energies he possesses and which are really available to him in order to fulfil his mission, in every situation that he encounters, even when it is difficult or painful, or in other words in order to develop the highest oblative love in Christ in every situation of which he is practically capable at that moment'.[2] Like the concept of health, the concept of illness has also changed. No longer definable as a mere pathology which can be grasped through a laboratory analysis, illness is now understood as an existential ill-being, the consequence of certain life choices, of changes in values, and of a mistaken management of the human material environment' ("Note", n. 7).[3] The medicine of necessary care and treatment, after passing through the concept of preventive medicine, is now giving way to the medicine of desires. Today, much more than to health and illness, reference is made to a sick or healthy man, and illness takes the form not only of physical pathologies but also of contrasts between desires and their achievement, between promise and frustration, which in taking on the connotations of a resistant disharmony become psychological discomfort and existential ill-being.

b. The Health Care Ministry as Accompanying in Personal and Christian Growth

In saying that man is healthy when he is habitually able to *live out his situation and his concrete resources positively* means that he is healthy when is able to live in a way which favours his personal growth and development as a creature and as a son of God because of the grace which dwells within him. I emphasise the comparison between the healthy man and the man who is habitually able to live in a positive way because this capacity is a fundamental reference point in establishing the task of the health care ministry. Indeed, from a Christian point of view health seen as the habitual capacity to live one's own vocation in a positive way should also include the commitments of the baptised man, just as there should also belong to the concept of health that being in Christ of the Christian which is carried to a sufficient development of authenticity and maturity: its full realisation corresponds to holiness. Indeed, the Christian is holy when at every moment he comities himself to charity without leaving any of his resources unused. In this context we can better understand the definition which sees the health care ministry "as the presence and the action of the Church devoted to bringing the light and the grace of the Lord to those who suffer and to those who take care of them" ("Note", n.19). According to this definition the presence and action of the Church in the world of health and health care unites people in a single concern or relationship of help and of accompanying: the sick person, the relatives who need help in order to live out the illness of their dear ones without traumas and in a spirit of faith, and the health care workers who should be trained to adopt a sense of responsibility, a readiness to engage in service, and respect for the fundamental values of the suffering person.

In other words the health care ministry has the task of integrating all these forces around the sick person so as to advance him in a moral sense and to help him to accept and to have a positive evaluation of his situation of suffering; and in addition accompanying him with prayer and the grace of the sacraments so that he responds to his fundamental vocation as a man and as a baptised person.

c. Ethical Questions Raised by New Illnesses and New Forms of Treatment and Care

The increased sensitivity of public opinion and the augmented responsibility of men of government has enabled us to accelerate scientific research directed towards developing new techniques and drugs and medicines which allow the treatment and possibly the cure of new illnesses such as AIDS, drug-addiction, and in general those illnesses which so far have been considered to be incurable. But at the same time the new achievements of diagnostic, pharmacological and surgical medicine have increased the ethical questions posed to the consciences of health care workers and of society as whole. The field of bioethics is greatly expanding. Quite rightly, suitable answers and practical replies are awaited which can regulate, for example, the questions and issues connected with assisted fertilisation, pharmaceutical trials, transplants and the giving of organs, and, lastly, human cloning. Mankind urgently needs light, but it also needs uncrossable barriers with respect to research and experiments when these do not safeguard the defence of life and the dignity of the human person.

d. New Figures at the Side of the Bed of the Sick Person: Interdisciplinary Collaboration

Over recent decades there has been a marked increase in the presence at the side of the bed of the sick person of professional figures with different roles and kinds of training who in the past were not thought in the least to be needed. In addition to the classical figures of the medical doctor, the nurse and the religious helper, today one now regularly encounters such figures as the psychologist, the social worker, the philosopher, the expert in bioethics, the expert in the rights of the patient, the legal

expert, the voluntary worker, and the expert in health care management and economics. This multiplicity of presences during the time of illness on the one hand points to an increased sensitivity towards human suffering and on the other draws attention to the complexity of health care problems and concerns.

The Church is called upon to reflect on these new presences and to improve her own pastoral action so that she can dialogue in an effective fashion with other health care workers. Just as is the case in every sphere of professional work, so too in the health care world it is not possible to work alone. In scientific research, as in the routine care and daily help which is provided to the sick person, it is necessary to work together, in a harmonious way, and with the same objective.

2. The Active and Creative Presence of the Church in the World of Health and Health Care

a. The Actions of the Magisterium and of Pastoral Care

The observations which have so far been made in this paper lead us to reflect upon the initiatives of the Church in the face of the developments which have been taking place in the world of health care: they have been thoughtful, opportune, and meaningful. Certain documents of the Church have already been referred to in this paper.[4] I would like to refer here to the most recent such documents: the Apostolic Letter 'Salvifici Doloris' of 1984; the post-Synodal Apostolic Exhortation 'Christifedeles Laici' of 1989; and the Encyclical 'Evangelium Vitae' of 1995.

In his Apostolic Letter 'Salvifici Doloris', the Pope addresses himself to the Christian meaning of human suffering. This was the first document in which a Pontiff was to deal with this great question in an overall way.[5] In this letter the Pope wants to help people to look to the Crucified Christ and accept the "Gospel of suffering" with love and trust in the mysterious but always loving design of divine providence. Indeed, what for reason remains an unanswerable enigma, for faith, and thus in the light of the death and resurrection of Christ, becomes a message of hope.

In the post-Synodal Exhortation 'Christefideles Laici' the Pope is largely concerned with the mission of the lay faithful in the Church and in the world, but in sections 53 and 54 he directs a message to the sick and the suffering and in decisive fashion re-launches a *pastoral action for and with the sick* which is able to sustain and promote attention, nearness, presence, listening, dialogue, sharing and concrete help towards man during moments when, because of illness and suffering, not only his trust in life but also his own faith in God and the love of the Father are subject to major trial.(54) The Church, insists Pope John Paul II, is called upon to search for encounter with man in a special way on the way of suffering. And in this encounter man becomes the way of the Church and this is one of the most important ways.(53) In the encyclical 'Evangelium Vitae' (1995) the Pope condemns the culture of death which pervades contemporary society and stimulates the faithful to be witnesses to the gospel of life in the various opportunities which are offered to them today. In the fourth part of this encyclical (78-101) the Pope points out the steps of the Christian commitment in the service of charity and even provides a list of concrete initiatives which can be taken: family and marriage consultants, centres to know about natural methods of birth control, centres of help and of accompanying in life, communities which serve special kinds of sick people, the adoption and

the wardship of children, and bioethical committees. He also advises taking part in various kinds of voluntary work, social initiatives and political commitment.

Amongst the documents of the Church on the health care ministry we should also list the messages of the Pope for the world days of the sick; the documents of the Pontifical Council for Pastoral Assistance to Health Care Workers – for example the 'Charter for Health Care Workers'; and the declarations of the various national episcopal conferences.

b. The Creation of Structures and Organisms Dedicated to the Promotion of the Health Care Ministry

Religious institutions, groups, movements and associations involved in the health care world have always been present within the ecclesial community. Their action, which has displayed the variety and richness of the charisms presents within the Church, has been characterised hitherto by spontaneity and generosity, although at times such action has been repetitive and perhaps dispersive in effect, something which has brought out the need for structures of co-ordination, communion and programming.[6] The response to this need has only emerged recently, and has taken place at the level of the universal Church and the Church at a national, regional and parish level.

b1. At the Level of the Universal Church

At the level of the universal Church a very important event was the creation by the motu proprio *Dolentium Hominum* of 11 February 1985[7] of the Pontifical Commission for Pastoral Assistance to Health Care Workers which subsequently became the Pontifical Council for Pastoral Assistance to Health Care Workers.[8]

Amongst the tasks of this body is to be found the study of directions in terms of programmes and the practical initiatives of the world of health care policy both at an international and a national level in order to understand their relevance and their implications for the pastoral work of the Church; the

co-ordination of the activities of the various Ministries of the Roman Curia in relation to the health care world and its questions and issues; and contact with the local Churches and in particular with the Episcopal Commissions responsible for the world of health care. The Academy for Life which was created on 11 February 1994 by the motu proprio *Vitae Mysterium*[9] is closely connected to the Pontifical Council for Pastoral Assistance to Health Care Workers. This Academy has the task of studying, providing information, and instructing people in matters connected with biomedicine and law within the context of the promotion and defence of life. In this it illustrates the relationship between such matters and Christian morality and the guidelines of the Magisterium of the Church.

The Pontifical Council for Pastoral Assistance to Health Care Workers has also become responsible for certain duties which were previously the prerogative of the Pontifical Council "Cor Unum" (1971) such as the co-ordination of Catholic medical activity and support for the health and health care sector in order to secure the promotion of what is a really *human* approach.[10]

b2. At the Level of Local Churches

At a national level the structures and systems of communion and the mechanisms fostering it, although they vary from country to country, nevertheless have certain shared features. There is the presence of Episcopal Commissions which have the task of co-ordinating the health care ministry within the boundaries of their local nation through regional or interdiocesan and diocesan committees. Let us take Spain and Italy by way of example to illustrate this reality. In Spain[11] in 1970, in response to a grass-roots request, the Episcopal Commission created the "Secretariat for Pastoral Care in Health" which was a body under the supervision of the Episcopal Committee for Pastoral Care. This Secretariat is led by a bishop and organised by a director who has a special team composed of representatives of the interdiocesan secretariats, of religious orders, of the Christian brotherhoods of the sick, and the co-ordinators of the six committees established within the Secretariat. These six committees are respectively responsible for hospitals, health in the parishes, mental health, Christian health care professionals, pain killing treatment, and training.

The Secretariat has engaged in a number of initiatives and amongst them we may list the national conferences (held in Agradulce in 1975 and in Madrid in 1994), the celebration of the world day of the sick (held in 1985), the Concordat on Catholic assistance provided in public hospital structures, and the publication of the document "Religious Service in Hospitals. Pastoral Guidelines" of 1987. In every diocese there is a "delegation" which is led by a priest, a member of a religious order, or a member of the laity. Since 1977 there has been the annual celebration of the "national days of delegates" which have been an opportunity for encounter, instruction, communion, reflection, and interchange. The intediocesan secretariats are the bodies which act to link the various diocesan delegations together.

In Italy the Episcopal Conference established the "National Council for the Health Care Ministry" in 1962. After that date this latter body underwent a number of modifications until reaching its final form in 1978. It is led by three bishops who represent separate geographical areas, and one of these bishops is its president. In 1996 this Council was given a permanent office at the headquarters of the Italian Episcopal Conference.[12] The regional delegates and the representatives of the hospiteller religious orders belong to this council, as do chaplains, Catholic associations active in this area, and various experts. This council has promoted a number of initiatives. It has closely followed the health care reforms which have been implemented in the country, in which it has acted "to ensure that the presence and activity of Catholic health care service was defended and suitable space was given to the action of the religious assistant in hospital centres".[13] Three national conferences have been organised, the most recent of which (23-25 April 1995) was concerned with "pastoral planning in the world of health and health care".[14] The activity of fostering and training is gaining increasing importance through specific goals such as, for example, the preparations of the days of the sick and the training of diocesan authorities. Activity at the level of regions and dioceses is guaranteed by regional and diocesan councils and committees.

3. Pastoral Care in Health at a Local Level and in Institutions: the Parish and the Health Care Ministry in Parishes

a. The Christian Community as a Primary Subject of the Health Care Ministry

The decree *Apostolicum Actuositatem* states that "the Church was born with the goal of making – through the spread of the Kingdom of God – all men participants in the salvation achieved through redemption, and through them the direction of the whole world to Christ. All the activity of the mystical Body, directed towards this end, is called "apostolate": an apostolate which the Church carries out through all her members, naturally enough in different ways" (*AA*, 2).

It is in this context that the local Christian communities must become aware of the grace and the responsibility which they receive from the Lord with respect to the sick faithful, and they must offer them comfort, the word of God, the sacraments and brotherly concern. Christ is really present in the elderly, the sick, the suffering and the desperate. A community which does not re-

new itself through this presence, which does not perceive this presence of God in the poor, and which does not honour it with social and charitable activity ceases to be a living Church of Jesus Christ.

In this action of fostering and co-ordination the diocesan office for the health care ministry has a strategic role. It is called upon to keep in close contact with the regional office and the national office to provide the local effort with a wider vision of the questions and issues. According to the "Note" of the Italian Episcopal Conference the tasks of the diocesan council are as follows: 1. to foster and co-ordinate the health care ministry of the vicariates and parishes and promote a shared and common action amongst the various associations, groups and charitable bodies which are active in the diocese; 2. to promote the presence of sick peoples and health care workers in the diocesan ecclesial bodies; and 3. to promote forms of initiatives involving training and up-dating in this sector (see the "Note", 78).

The tasks outlined by this "Note" deserve special attention because they belong in an exceptional way to the innovations which are underway in the world of health and health care. Indeed, the general tendency of health care is by now well-known: we have before us a slow process of de-hospitalisation, that is to say the sick person spends and will increasingly spend less time in hospital and will be looked after, as has already been observed, at a local level – at home or in mobile health care structures.

As a result proposals in favour of home-based care are moving ahead gradually but inexorably. This requires a radical change in the way we think about medicine, in the mentality of health care workers, in the relationship with the patient, and in the meaning and the goals of therapeutic activity. In particular it requires greater involvement on the part of the families of the patients and the participation of the civil and ecclesial community. With regard to the health care ministry this new development involves a greater organisation at a parish level of religious help provided at home and a review of the pastoral methods used in hospital institutions where the average stay of sick people is estimated at being around five days.

b. From the Christian Community to the Parish Community

b1. The Parish and the Health Care Ministry at a Parish Level

Here it is evident that because the parish priest is a presbyter who as a special pastor takes care of the parish community (cf *CDC*,519) then it is he who has the task of providing special attention to the sick people of his parish and the promotion and fostering of the health care ministry with special reference to the sick in their homes (*CDC*, 528-529). Because of these institutional tasks the parish priest is the principal force behind the health care ministry in his own parish.

b2. The Functions and Implementation of the Health Care Ministry at a Parish Level

The three classical functions of pastoral care – evangelisation, the sacraments and service – are also the necessary steps – on a single road which leads to salvation – of the health care ministry. The sacramental moment is made meaningful by a suitable path of faith and by warm human participation. However, the specific functions of pastoral care must also include everything to do with the human, health care, and social promotion of sick people, and respect for the values of life and health (cf "Note", 6). The humanisation of care, of services and of health care institutions is recognised as a specific function of pastoral care because of its evangelising value.

c. Some Initiatives in Relation to the Health Care Ministry at a Parish Level

c1. Support and Awareness-Raising in Relation to the Family of the Sick Person

The health care ministry, which is seen as the presence and action of the Church whose aim is to bring the grace and the light of the Lord to those who suffer and to those who take care of them, as has already been observed in this paper, is not concerned only with the sick but also refers to the healthy. This should take place in particular through the generation of a culture of greater sensitivity towards, and awareness of, suffering, marginalisation, and the values of life and health. Here special attention should be paid to the family of the sick person. Indeed, the commandment of the Lord to visit the sick is first and foremost directed towards the family of the sick person. The meaning of this elementary duty must be developed from an early age.

It is also necessary for the family to be educated to look after its relatives who are in difficulty within its own confines. The warmth of the family environment has an irreplaceable therapeutic function. And in contrary fashion the abandonment of relatives to rest homes and nursing homes generates feelings of loneliness and sadness, and even at times of desperation. This is something which certainly does not work to the benefit of health. In such moments, and especially if the illness is long and serious, the members of the family, too, need support and solidarity. "Substitution" in providing care for the sick person which is offered now and then can be of great help to them.

In this context it is important to raise the awareness of the Christian community in relation to the need to create reserve health care services at a local level which can allow the most common health problems to be solved at home rather than through recourse to hospitalisation or nursing homes. There are personal, family, social and economic reasons which lead us to suggest that emphasis should be placed on home service rather on than hospital service, wherever, of course, this is possible. These services could also be provided by permanent groups organised by the parish.

c2. The Laity in the Health Care Ministry at the Parish Level

Hitherto the responsibilities of the laity in pastoral care at a parish level have been carried out in the main through the catechesis, in liturgy, in pastoral care of the young, etc., but it has been

rather limited in the case of the pastoral care of the sick. Perhaps this is because in objective terms it is more difficult or perhaps because the contemporary mentality does not give a central position to the sick person, something, however, which should take place in an authentically Christian community. This is why this sphere of pastoral care at a parish level should receive a greater level of awareness. In the pastoral programmes of parishes and dioceses greater attention on the part of the community should be paid to sick people. As long as such kinds of attention are absent the parish community will lack an important and characterising dimension.

c3. Seeing Pastoral Care as an Activity "with" the Sick and not only "for" the Sick

In his exhortation "Christifidelis Laici" (n.54) John Paul II expressed a profound instinctive perception: he spoke about a relaunching of pastoral action for and with the sick and suffering – the sick person must not only feel himself the object of attention but must also become an active subject in the ecclesial vitality of the parish community, a channel of attention on the part of Christ and the Church towards the world of suffering. At an even deeper level, the sick believer must acquire awareness of the fact that he takes part in a special and privileged way in the redemptive action of Christ in the world, being thereby able to repeat with the Apostle Paul: "in my flesh I complete what is lacking in Christ's afflictions for the sake of his body, that is, the church" (Col 1:24). The sick person must not feel marginalised from his family or the community. Despite his physical malady, his handicap or his disabilities, the sick person, as an "icon of God", is always a human being in the fullness of his dignity and his rights, and is worthy of full respect and proper treatment. If the sick person sees in the visitor not a boring consoler but a brother who has come to involve him in a useful undertaking – asking him, for example, to pray in relation to the events and problems of the parish – he will certainly manage, despite everything, to feel that he is a living member of the mystical body of Christ (today).

d. The Creation of a Parish Group of Co-operators for the Health Care Ministry

Every parish, in addition to having a priest, should have a group of co-operators dedicated to the health care ministry which is able to promote practical activity in favour of those who suffer. This group should not only lend support to the action of the parish priest but could also be a channel of penetration in areas which are resistant to the Church, a way of achieving contact with people who would otherwise remain excluded or forgotten about by the community. For these co-operators of the health care ministry we need to create effective human and spiritual training and specific grounding for this pastoral ministry. This is something which should be done through specially designed courses. The creation of a parish group for the health care ministry is justified by the need, in this area as well, to pass from spontaneous and dispersive charitable action to organised and functional community activity which has stability and a network of services which defend, safeguard and promote what is human, religious and social. The existence of such a group could avoid improvisations in service and guarantee on-going grounding and training.

The activity of the group should also be extended to the sick members of the community who are in hospital, in rest homes or nursing homes, and other health care institutions in the locality. One important aspect of this is the need for links and co-operation with other groups and bodies in the parish.

4. The Health Care Ministry in the Locality and in Institutions: the Pastoral Activity of the Hospital Chaplain[15]

a. The Hospital Chaplain

The religious assistant or chaplain in health care institutions is the priest, and to him "is entrusted in a permanent way the pastoral care of that special group of faithful made up of the sick and their family relatives and health care workers. His principal task is to preach the good news and to communicate through the administration of sacraments the redemptive love of Christ to those who suffer the consequences of the finite condition of man in body and spirit, accompanying them with solidarity-inspired love" ("Note", 38).

b. The Ministry of the Word and Communication

The faith is rooted in the Word. This explains why every form of apostolate sees evangelisation and the catechesis as being of primary importance. This also takes place through the health care ministry. One is dealing here with healing or at least reducing the fracture between the Gospel and culture, and presenting in the right way the Christian point of view about, and the Christian approach towards, pain, death, health, and the meaning of service towards those who suffer.

However, one cannot conceive of evangelising a sick person, especially if he is in a serious condition, as being the same thing as evangelising a healthy person, that is to say the health care personnel. In the first example evangelisation is carried out first and foremost by a face to face dialogue, made up of listening, silence and a word which it is felt corresponds to the needs of the sick person. In the second example there is a field where enormous possibilities are opened up for the hospital chaplain involving pastoral actions based upon the programming of pastoral care and training directed towards more human assistance for patients.

Another basic need which emerges during our epoch in relation to evangelisation is the relevance of moral questions and issues and the pastoral task of offering suitable answers to the serious problems raised by scientific and technological progress which has taken place in the world of health care. A hospital religious assistant must have a grounding which makes him able to engage in such a task. And this is true not only at a personal level but also in relation to the training of health

care workers at every level where it is necessary to promote initiatives and use structures which are already present within the structures: the teaching of professional ethics, the creation of ethical committees, advice concerning hospital pastoral care, and so forth.

c. The Ministry of Sanctification: the Celebration of the Sacraments and Prayer at the Side of the Sick Person

In parishes as in places of care and treatment the celebration of the sacraments is one of the fundamental and cardinal elements of the health care ministry. It is important, however, to bear certain pastoral guidelines in mind: the sacraments can be understandable and effective if they are placed within a path of faith. They cannot be presented and received as an isolated act within the overall life experience of the baptised sick person. Furthermore, they must freed from magical and superstitious interpretations and expectations. The sacred and ecclesial character of the sacraments must be perceived and grasped. Jesus established them by entrusting to his disciples the task of "doing in his memory" what he did for the salvation of all men.

In the health care ministry insistence is placed upon the importance of the encounter between the sick and Christ in the sacraments of reconciliation, the eucharist, and the anointing of the sick. Each of these sacraments has its own sacramental grace and thus in pastoral care provided to the sick it is a good idea to bear this grace in mind. Normally it is necessary to distinguish between the pastoral care provided to the sick and the pastoral care provided to the dying. In the case of the first the sacraments of penitence, the Eucharist and the anointing of the sick are suggested; in the case of the second the anointing of the sick, the viaticum, and the last rites are the sacraments which are called for.

The anointing of the sick is the natural and most typical form of the encounter of man with Christ in that difficult and fundamental human situation which is known as illness. From the rediscovery of this sacrament – through suitable catechesis and meaningful individual and community celebrations designed to create a new mental approach and understanding – great spiritual advantages will follow involving consolation and comfort for those whose condition of health is seriously compromised by illness or by old age. This is why it is necessary to spread the idea and principle that the "Anointing of the sick is a sacrament which should be received in full awareness in order to gain from it all the spiritual help possible, as well as physical well-being".[16]

d. The Ministry of Pastoral Care

The chaplain of the hospital could be defined as "the minister of communion" within the hospital ecclesial community. Theological reflection since Vatican Council II, indeed, has rediscovered the centrality of *communion* in the ministry of the Church and in pastoral activity. Ecclesial communion, which is above all else a gift of the Spirit and a reflection of the life of the Trinity, requires to be lived out and translated into an experience of the community. In the Church each person has his own gift from the Spirit, and each person has the grace and the task of working for the building up of the ecclesial community and its growth through faith in Christ.

The chaplain "carries out this task through a vast range of activities and initiatives: visits and meetings with the sick person, helping his family, the encouragement of groups and associations dedicated to voluntary work and/or which are professionally based, a relationship with the diocesan church and its local realities, activities directed towards humanisation etc". These activities are certainly not the exclusive task of the chaplain but he certainly has the task of ensuring that these are real ecclesial experiences. Visits to the sick are one of the most significant actions of the ministry of pastoral care of a hospital chaplain. Personal conversation must be the principal and classic arena of every expression of the health care ministry. It takes place in regular visits, in wards or individual rooms and during it there is an identification of the need for pastoral conversation with the sick, their family relatives, and the health care personnel. At the same time a presence of the Church is established.

When the illness is serious and long-lasting it is no longer a physical phenomenon but something that extends into the mental and spiritual dimension of the person, and the sick individual not only feels the need to be supported in a physical way but also expects a spiritual and psychological support: the health care worker is then called to engage in a *ministry of consolation*. The healing of the sick person to a great extent will depend upon the quality of the spiritual and psychological support which is offered to him.

The actions of the pastoral workers in these circumstances should not be of a routine character but should take as their starting point the concrete spiritual difficulties of the concrete person that they have to deal with at that particular moment. Spiritual accompanying must work to stimulate and reawaken the physical, psychological and spiritual powers of the sick person so that he can achieve the ability to reject hopelessness and receive the hope offered by faith. It is then that spiritual assistance can become religious assistance and become complete through an enlightened celebration of the sacraments.

The hospital chaplain, as a man of communion, is also called upon to be a *man of relationships*, a man who facilitates the relationships between the sick person and his family relatives, between the patient and the parish, and between the hospital institution and the local church. Indeed, the isolation of

hospital pastoral care from parish pastoral care and diocesan pastoral care should be overcome, and in the same way the distrust between the parish clergy and chaplains, and between priests belonging to religious orders and diocesan priests, should also be removed. The aim is to manage to integrate hospital pastoral care with diocesan pastoral care and at the same time make the local church more aware and conscious of the problems of the health care ministry.

e. The Fostering and Humanisation of Assistance Provided to Sick People

Amongst the important tasks of the hospital chaplain is that of fostering co-operation in achieving the humanisation of the environment of care and treatment for which he is responsible in a pastoral sense. He must promote or activate all those energies directed towards the promotion of the greater humanisation of hospital institutions. This is a task which, in line with all the respective charismatic diversities, is the responsibility of the whole of the ecclesial community which lives in such places, but it is also a special responsibility of the laity (see *LG* 31) who through their respective professional and occupational roles have a special responsibility with regard to the management of the administrative, therapeutic and technical services. The chaplain should encourage and stimulate them with advice and encouragement but he himself should not take upon himself all the tasks and responsibilities in this sphere. In the same way he should not act in a delegating fashion as though the members of the lay faithful were mere agents of the decisions taken by the members of the clergy.

The humanising initiatives to which reference is usually made are as follows: the promotion of respect for fundamental values (that is to say life-health-freedom); the defence of the rights of the sick person, also to be achieved through the creation of ethical committees or bodies whose task it is to defend the rights of the sick person; the positive evaluation and utilisation of professional associations: the creation of groups of voluntary workers; the establishment of courses, days, and meetings dedicated to professional-ethical training; the involvement of associations of sick people; and support for families of sick people who find themselves in situations of difficulty.

It should, however, be emphasised that in relation to the humanisation of the world of health care the centre of attention and concern should always be the dignity of the sick person and the quality of the relations between the patients and the staff and personnel. It is indeed at this level that tensions can arise which threaten certain fundamental values. These may be listed as follows:

– *the centrality of the sick person*. Health care service should not be seen as a means by which to meet a personal requirement. It should be seen, instead, as a response to the needs of a person for whom, at a certain point in his life, his condition of health has become a source of major concern and worry.

– *A healthy relationship between the personnel and the sick person*. The sick person should not be seen as an opportunity for work but as a being who has a dignity equal to one's own. The debilitation caused by the illness should not be an opportunity to establish a relationship with the sick person which is based on power.

– *The responsible participation of the patient in the therapeutic process*. Through more careful and detailed information the sick person should be able to pass from an approach of mere passivity to taking responsibilities in relation to his own illness and the consequences which can arise from the therapeutic process.

– *The respect of the person of the health care workers*. The world of health care becomes an inhuman environment for the personnel when health care workers are forced to endure forms of work which offend their dignity and oblige them to engage in forms of behaviour which they would willingly avoid or which are contrary to their ways of thinking about the provision of assistance to the sick.

d. Hospital Pastoral advice and the Project of a "New Form of Chaplaincy"

"One of the most effective instruments by which to express shared responsibility in the pastoral care of a health care institution is *hospital pastoral advice*. Amongst its general goals one emerges as being of especial importance: "the promotion of Christian brotherhood within hospitals" ("Note", 42). Other general goals are: the planning of evangelisation and humanisation, the promotion of the sacramental and liturgical life; and, lastly, co-operation with the local ecclesial realities.

The "Note" of the council for the health care ministry of the Italian Episcopal Conference goes beyond discussing the chaplain and also proposes a new pastoral structure – the "hospital chaplaincy". This is conceived as an "expression of the religious service of the Christian community in health care institutions". The document argues that this should be "composed of one or more priests to whom can be added deacons, members of religious orders and members of the laity" ("Note", 79-81).

The novelty of this definition lies in the fact that it opens the hospital chaplaincies to deacons, to members of religious orders who are not priests, to members of female religious orders, and to members of the laity. This is an opening which was not envisaged by the new Code of Canon Law. The words of the document make clear that this is first and foremost the fruit and outcome of a growth in the "communion mentality" which was developed in a significant way in Vatican Council II and post-Vatican Council II thought and reflection. As the chaplaincy is an "expression of the religious service of the Christian community in health care institutions" then it is important that this Christian community is represented by all its components (cf *LG*, 12; *AA*, 2; cf, 23). However in my opinion the term "chaplaincy" is not right: in order to avoid ambiguity the chaplaincy should be the prerogative of priests, of those who administer the sacraments. The other moments of the term of religious service could receive the appellation "pastoral

co-operators", or, in line with what happens at a national, regional or diocesan level where councils exist for the health care ministry, one could speak of a hospital pastoral council which has the same objectives and is composed of the same people as outlined by the "Note" for "chaplaincy" ("Note", 80-1).

The presence within the pastoral team of deacons, of members of male and female religious orders, and members of the laity, could enable the chaplain to organise pastoral work in a more effective and valuable way. He would be freed from many suppport services which do not really have a basis in the sacred order and in this way he could be left free to dedicate his energies to tasks which are more specifically priestly in character. Lastly, hospital pastoral care could gain a greater richness and variety of roles and actions from the special vision of the lay person, from the charismatic perspective of the female or male members of a religious order, and from the sensitivity characteristic of women.

Let it be well understood that the new chaplaincy can only increase the ecclesial meaning of the presence and pastoral action of the chaplain, and would allow him to foster in a stronger way the Christian forces which are present in the hospital community through groups, associations, and in a special way, the hospital pastoral council.

Conclusion

In conclusion, I would like to emphasise certain key points which emerge from what I have argued in this paper. They are as follows: 1) the continuity in the loyalty of the action of the Church carried out throughout her history on behalf of the sick – there is a radiant history of the witness of saints which should be brought back to life because of the impact that they have had and can still have through a renewed and enlightened commitment which matches the needs of our times; 2) an awareness of the changes which have taken place or which are taking place in the health care world at a cultural, structural and pastoral level: at a pastoral level we should be especially aware of the novelty of the opening towards family relatives and health care workers, the primary importance of evangelisation, the various forms of voluntary work, the new kind of chaplaincy, and the hospital pastoral councils; 3) respect for the dignity of the sick person, seen in terms of his subjectivity, as an image of God and of the suffering Christ, as a person in all his physical, mental, familial, social, spiritual and transcendental dimensions, which are also therapeutic dimensions; 4) the need for training in the face of the ethical questions and issues which have arisen because of new illnesses and advances in the techniques of medicine; 5) the promotion of voluntary work, as a sign of our time, in its most typical forms, that is to say: voluntary work which is pastoral, participatory or directed towards the provision of assistance.

I would like, finally, to bring to mind the words of Paul VI: "the techniques of evangelisation are good but not even the most perfect of them can substitute the discreet action of the Spirit. Even the most sophisticated training of the evangeliser cannot operate without the Spirit. Without the Spirit the most convincing dialectic is powerless in relation to the spirit of men. Without the Spirit the highest sociological and psychological approaches are empty and valueless. One can say that the Holy Spirit is the principal agent of the evangeliser" (*EN*, 75).

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Notes

[1] See C.TRABUCCHI, 'Benessere Fisico, Mentale and Sociale', *La Casa*, 44 (1984), pp. 151-157.

[2] See L.CICCONE, *Salute e Malattia (Questioni di Morale della Vita Fisica (II)* (Ares, Milan, 1986), p. 34.

[3] The "Nota" entitled "La Pastorale della Salute nella Chiesa Italiana" ("The Health Care Ministry in the Italian Church") of the national pastoral consultative body of the Italian Episcopal Conference (CEI) is to be praised for having outlined for the first time in an overall fashion the guidelines of the health care ministry: contexts, motivations, subjects and structures. This "Note", although it is a document produced by a local Church, has a universal value because it recognises, accepts and synthesises in a unifying way the documents of the universal Church on the subject from Vatican Council II to the date of its publication (1989). The documents to which I refer are the following: the Apostolic Constitution 'Sacram Unctionem Infirmorum' of 1972; the new 'Ordo Unctionis Infirmorum Eorumque Pastoralis Curae' of 1972; the CEI document 'Evangelizzazione e Sacramenti della Penitenza e dell'Unzione degli Infirmi' ('Evangelisation and the Sacraments of Penance and the Anointing of the Sick') once again of 1974; the Apostolic Letter 'Salvifici Doloris' of 1984; and the Apostolic Letter 'Christifideles Laici' of 1988.

[4] See note 3.

[5] See A.BRUSCO AND S.PINTOR, *Sulle Orme di Cristo Medico* (EDB, 1999), pp. 207ss.

[6] A.BRUSCO, 'La Pastorale Sanitaria nell'Attuale Contesto Sociale' in AA.VV., *Progettualità Ecclesiale nel Mondo della Salute* (Salcom, Vasere, 1995), p. 41.

[7] *EV* 9/1410-1418.

[8] *EV* 11/984-985.

[9] *EV* 14/538-563.

[10] See G.GIANNINI, 'Pontificio Consiglio "Cor Unum"', in *DTPS*, 921-922.

[11] See S.PELLICER, 'Pastorale Sanitaria in Spagna', in *DRPS*, 854-858.

[12] See S.PINTOR, 'Dite il Vangelo e Curate i Malati', *Settimana* 23 (1998), pp. 8-9.

[13] G.SANTORO, 'La Consulta della CEI per la Pastorale della Sanità', *Insieme per Servire* 2 (1988), pp. 10-13; See also R.MESSINA, 'La Consulta Nazionale e le Consulte Regionali e Diocesane della Sanità', in A.BRUSCO (ed.), *La Pastorale della Salute nella Chiesa Italiana* (Camilliane, Turin, 1992), pp. 203-202.

[14] See the acts of the conference in *Progettualità Ecclesiale nel Mondo della Salute* (Salcom, Varese, 1995).

[15] I am referring here to hospitals but I am also thinking of the other health care institutions to be found at a local level such as rest homes, nursing homes, homes for the elderly and residences for the relatives of patients, counselling centres, mobile clinics etc.

[16] For this section important reference should be made to *The Charter for Health Care Workers* (1994), and in particular the sub-sections entitled "pastoral care and the sacrament of the anointing of the sick"; "the terminally ill"; and "religious assistance for the dying".

[17] See CEI, *Evangelizzazione e Sacramenti della Penitenza e dell'Unzione degli Indermi*, nn. 137-140.

Conclusion

The twenty-five priests who attended came from twenty-two countries from four continents (only Oceania was not represented). They gave rise to a lively dialogue with the heads of the Ministry, and with those who gave papers, in describing the real state of the pastoral world of the countries where they work and in narrating the experiences now underway which work for evangelisation in the field of health.

What follows is a brief description of what emerged from the fraternal exchange which took place.

As is obvious, there were as many differentiations as there are cultures of the countries where the Church is present: pronounced secularisation in the so-called 'Western' countries, difficulties in acting in those countries where the Church in numerical terms is 'in a minority' and where it lives together with 'different' religions. Everybody, however, drew attention to the radical change which the way of providing health care has brought about: a very brief presence of the *seriously ill* in institutional structures, and thus the need and the urgency to develop a new approach, presence, and form of pastoral action. This adjustment is also required for those places of care which look after the *chronically ill* given the profound change which human society is facing with regard to the religious meaning of life. This is also the result of 'globalisation', a process to which this aspect of life is not immune.

An urgent objective was perceived in the study of how to link the action of the priest sent to places of care with the pastors on the ground, and with the parishes, where by now the '*sick person*' continues with the action of recovering and restoring his health.

One of those present described his ground-level experiences. After years of the co-ordination of the health care ministry in structures dedicated to care, and shortly after being sent by his bishop to engage in this new service, he involved the parish community in supporting a specialised group of 'visitors to the sick'. In this the medical side of things was also attended to through the financing of the work of a nurse to carry out daily visits so as to follow the implementation of treatment. Furthermore, the relations with the centres of care of the city have also been begun and intensified in order to receive information on the members of the parish.

Nearly all those speakers who gave a paper, however, observed that there is a major lack of priests in this kind of pastoral care. Hence the need to broaden matters to include a new form of 'members of the chaplaincy' – members of the faithful who, although they do not have the ministerial priesthood, are trained with specific courses and under the direct responsibility of the diocesan bishop, and are placed at the side of the priest who is sent by his bishop into the world of health care. An account of a detailed experience along these lines was presented by a delegate from a country of old Europe, and this had been studied and approved by the relevant national episcopal conference.

In absolutely clear fashion it emerged that for the priest who is sent to engage in this form of *pastoral service* there is a need, indeed a duty of conscience, for him to train himself in a suitable way and to seek out the necessary forms of periodic updating through attending courses which involve *permanent training*.

A broad exchange of information was provided by delegates who in their own countries have theological faculties which are specialised in the health care ministry, or simular study centres. This set in motion the beginning of a fraternal collaboration with those who do not have similar realities in their own countries but who declared themselves very interested in the whole idea.

The seminar, although it did not last very long, was very dense and rich in terms of the reciprocal exchange of knowledge and experiences.

An agreement was reached on achieving an immediate shared objective: the establishment of an 'International Federation' which will unite and keep in communion the already created national associations, and to help all those who were present who want to set in motion a similar experience in their own countries. In order to expedite this project the participants at the seminar accepted the proposal made by the President of the Ministry, His Excellency Mons. Javier Lozano, to entrust the task of being 'continental coordinators' to the following delegates who took part in the seminar:

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