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MEETING OF BISHOPS IN CHARGE OF PASTORAL CARE IN HEALTH
Vatican City, 23 November 2011

In this edition of *Dolentium Hominum* we publish some of the papers that were read on 23 November 2011 on the occasion of the Meeting of Bishops in Charge of Pastoral Care of Health organised in the Vatican by the Pontifical Council for Health Care Workers. A number of years have passed since that date and this is something that perhaps one can observe in some texts. In addition, some of the authors certainly do not hold the same posts that they held then. However, the topics and questions that are addressed are of notable contemporary relevance as regards the field of pastoral care in health and its organisation. We thus thought these papers could still be of interest and perhaps stimulating and helpful as well.

Address of Greetings and Introduction to the Deliberations

H.E. MSGR. ZYGMUNT ZIMOWSKI
President of the Pontifical Council for Health Care Workers

Your Most Reverend Eminences, Your Excellencies, Most Reverend Men and Women Religious, Dearest Brothers and Sisters, I am profoundly happy to welcome all of you and each one of you to this meeting organised by the Pontifical Council for Health Care Workers for bishops responsible for pastoral care in health who operate within their respective Bishops' Conferences.

The subject that will mobilise our energies during today's meeting is that of 'Cooperation between the Church and States in the Field of Health Care'. To introduce you to this complex and enormous field, two great scholars who are consultors of our Pontifical Council will dwell upon a very troubling question of the greatest contemporary relevance, that is to say 'Gender Ideology and Reproductive Health', examining its aspects at the level of doctrine, of legislation and of pastoral care. This, too, is a rather complex subject that deserves to be investigated in forums such as this given that it is calling into question – and at a deep level – the anthropological foundations of our societies and our families, as regards both their natures and their structures. To analyse the nature of the ideology of gender and reproductive health, its development, and what is at stake as regards its claims when they are compared to Christian anthropology and the treasure of the teaching of the Church in the field of sexual morality and the morality of the family, will enable our communities not to be caught unprepared and not to allow themselves to be dazzled by propagandistic speeches. Rather, they will be able to look for serious answers, based on the Gospel and on the living tradition of the Church, to the problems raised by this current of thought.

When we come to the principal topic of today's deliberations, that is to say cooperation between the Church and States in the field of health care, our minds are immediately led to those wonderful and illuminating pages of the Second Vatican Council to be found in its Pastoral Constitution on the Church in the Modern World (*Gaudium et Spes*). After referring to the principle of the legitimate autonomy of earthly realities (*GS*, n. 36), the Council Fathers affirmed in parallel the need for mutual cooperation between the Church and society 'in concerns which are in some way common to the world and the Church', and this for the good of man and humanity.[1] The world of health care, where infections, illness and suffering are combatted to achieve the recovery of health, is one of these areas. In this field the Church has always taught that real man, the person in flesh and blood who is in front of us, is, and must always be, an end of the activity of institutions, whether they belong to the Church or to the state. The Blessed John Paul II expressed this idea in the following way in his apostolic letter *Salvifici Doloris*: 'Born of the mystery of Redemption in the Cross of Christ, the Church has *to try to meet* man in a special way on the path of his suffering. In this meet-

ing man "becomes the way for the Church", and this way is one of the most important ones' (*SD*, n. 3, 1984). With the institution of a pontifical dicastery dedicated to pastoral assistance for health-care workers some twenty-six years ago, the Church sought to translate these teachings into the ordinary practice of pastoral care. And through this meeting we wish today to compare our experiences, go over the journey that has already been made, and identify the challenges that await us in order to address them with a new and vigorous pastoral dynamism.

We want once again to emphasise that the Holy Father Benedict XVI has also done a great deal for the world of health and health care. He has touched upon this subject in every encyclical of his, seeing it as a great challenge for the contemporary world.

a) In his encyclical *Deus Caritas est* he was already highlighting the '*caritas*' that exists in the health-care institutions of the Church and stressing the principle of subsidiarity-solidarity (n. 28b).

In this document Benedict XVI stresses in a very strong way that 'Love – *caritas* – will always prove necessary, even in the most just society. There is no ordering of the State so just that it can eliminate the need for a service of love. Whoever wants to eliminate love is preparing to eliminate man as such' (n. 28b). We are then reminded by the Supreme Pontiff, and with sensitivity, that 'There will always be suffering which cries out for consolation and help. There will always be loneliness. There will always be situations of material need where help in the form of concrete love of neighbour is indispensable', in short one can affirm that every man, in addition to the help of the state, needs personal loving concern (n. 28b).

It thus becomes indispensable to have a state that 'generously acknowledges and supports initiatives arising from the different social forces and combines spontaneity with closeness to those in need'. Amongst these living forces there is also the Church with her dynamic impulse of love which is generated by the Spirit of Christ. However, 'This love does not simply offer people material help, but refreshment and care for their souls, something which often is even more necessary than material support' (n. 28b).

But given that in the Catholic Church and in other Churches and ecclesial communities new forms of charitable activity have arisen, and ancient ones have reappeared which have a renewed impetus, the Pope observes that we should have before our eyes the same purpose, namely: 'a true humanism, which acknowledges that man is made in the image of God and wants to help him to live in a way consonant with that dignity' (*Deus caritas est*, n. 30b). Indeed, witness to charity is actualised through witness of life and dialogue: 'For all Christians, wherever they live, are bound to show forth, by the example of their lives and by the witness of the word, that new man put on at baptism and that power of the Holy Spirit by which they have been strengthened at Conformation. Thus other men, observing their good works, can glorify the Father (cf. Matt. ES:16) and can perceive more fully the real meaning of human life and the universal bond of the community of mankind' and this witness requires relationships through sincere and understanding dialogue (*Ad Gentes*, n. 11).

b) In his encyclical *Spe Salvi* His Holiness Benedict XVI emphasises that 'The true measure of humanity is essentially determined in relationship to suffering and to the sufferer.' I would like to quote those words of the Supreme Pontiff in this encyclical that also illustrate our behaviour in relation to the sick and the suffering that is motivated by our compassion: 'A society unable to accept its suffering members and incapable of helping to share their suffering and to bear it inwardly through "com-passion" is a cruel and inhuman society…to accept the "other" who suffers, means that I take up his suffering in such a way that it becomes mine also. Because it has now become a shared suffering, though, in which another person is present, this suffering is penetrated by the light of love. The Latin word *consolatio,* "consolation", expresses this beautifully. It suggests *being with* the other in his solitude, so that it ceases to be solitude. Furthermore, the capacity to accept suffering for the sake of goodness, truth and justice is an essential criterion of humanity' (n. 38).

c) In his most recent encyclical, *Caritas in Veritate*, Benedict XVI speaks, *inter alia*, about respect for life and the development of peoples. The encyclical *Caritas in Veritate* belongs to this tradition and specifically to the context of the dual teaching of *Populorum progressio*: the mission of the Church includes as its necessary implication the integral development of man; authentic development refers back to the totality of the person in every one of his dimensions. Benedict XVI in particular explores the link between the ethics of life and social ethics, and this link was already present in *Humanae Vitae*.

Benedict XVI identifies the question of life as being the 'social question' of our time. The question of life is considered with reference to its deep links with Christian social doctrine, in the same way as the links between evangelisation and the promotion of human welfare are themselves deep (n. 15). In this way the Magisterium of John Paul II is emphasised by Benedict XVI: '"a society lacks solid foundations when, on the one hand, it asserts values such as the dignity of the person, justice and peace, but then, on the other hand, radically acts to the contrary by allowing or tolerating a variety of ways in which human life is devalued and violated, especially where it is weak or marginalised."'[2]

The questions of human life, the proclaiming of the Gospel, and social and economic progress are fused and they underpin the inviolable dignity of the human person and the real possibility of the development of peoples and individuals at a level that goes beyond power and economics: '*authentic human development concerns the whole of the person in every single dimension*' (n. 11).

'*Development needs Christians with their arms raised towards God* in prayer, Christians moved

by the knowledge that truth-filled love, *caritas in veritate*, from which authentic development proceeds, is not produced by us, but given to us' (n. 79). The Pope calls us, as he had already done in his previous encyclicals, to that love from which authentic development comes, that same love that can, and must, inspire giving and contracts, the family and companies, the market and politics (n. 35). Development that is integral and respects human life must become an essential feature of a 'charity' that is worthy of man; a charity that today, in fact, is often defined by the synonym of 'solidarity' or even 'political charity'. Because Charity must be respected as an objective and global requirement and not placed to one side or put at the margins of economic or political relationships or relationships with the environment, the Supreme Pontiff states that: 'The book of nature is one and indivisible: it takes in not only the environment but also life, sexuality, marriage, the family…' (n. 51). It is a love that requires from those who are 'involved in the great task of upholding fully human dimension of development and peace' (n. 72) responsible forms of behaviour that should look to global justice in the long term. Such people should not seek to distance themselves in the immediate term from the risks that exist and poverty, offloading them onto other peoples or future generations (n. 50). The redistribution of wealth must not be transformed into a redistribution of poverty (n. 42).

A more human and just society is not only a society where there are more balanced agreements and ones which are more respected by the interested parties but also one where neighbours are recognised as being brothers and sisters, and this can only constitute an appeal to the moral conscience.

During the course of this assembly, in the second part of the deliberations of this meeting of ours, some experiences of cooperation between the Church and States in the field of health care in Africa, America, Europe and the world will be shared, and each time there will be a special approach. During the last part of the meeting, attention will be paid to questions and issues that relate to the organisational aspects of pastoral care in health as practised within the Church. The bishops who represent the various continents of the world will themselves illumine us as regards the realities of their respective local Churches. Lastly, after an exchange that I hope will be intense and fruitful, we will listen to a summary of this meeting before ending our special day.

My welcome to everyone and may your deliberations be successful and fruitful! ■

Notes

[1] 'the Church, at once "a visible association and a spiritual community," goes forward together with humanity and experiences the same earthly lot which the world does. She serves as a leaven and as a kind of soul for human society as it is to be renewed in Christ and transformed into God's family. That the earthly and the heavenly city penetrate each other is a fact accessible to faith alone; it remains a mystery of human history, which sin will keep in great disarray until the splendour of God's sons, is fully revealed'(*GS*, n. 40). After referring to the injurious role of sin in the history of humanity, the healing work of the Church, and the contribution of other Christian Churches or ecclesial communities, the Council Fathers went on to state how much the Church 'is convinced that she can be abundantly and variously helped by the world in the matter of preparing the ground for the Gospel. This help she gains from the talents and industry of individuals and from human society as a whole. The council now sets forth certain general principles for the proper fostering of this mutual exchange and assistance in concerns which are in some way common to the world and the Church' (*GS*, n. 40). The Council Fathers then sought to identify the general principles designed to guide such cooperation.

[2] *Evangelium vitae*, n. 93.

THE IDEOLOGY OF GENDER AND REPRODUCTIVE HEALTH: DOCTRINAL, LEGISLATIVE AND PASTORAL ASPECTS

1. The Ideology of Gender and Reproductive Health: Doctrinal and Pastoral Aspects*

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'A society is truly human when without reservations it protects and respects the dignity of every person from conception until the moment of his or her natural death. However, should it decide to "get rid" of its members in the greatest need of protection…it would be behaving in a profoundly inhuman and also distorted manner with regard to the equality — obvious to every person of good will — of the dignity of all people, in all the stages of life'. Benedict XVI, *Speech to the Ambassador of Germany to the Holy See*, 7 November 2011

Introduction

The ideology of gender and the notion of 'reproductive health' are two concepts that we must clarify in order to understand the challenges that they pose. They involve a change in various paradigms that transforms the meaning of relationships between men and women, the meaning of sexuality, and the meaning itself of the family and of procreation. They thus have repercussions in the field of health that are directed principally towards a certain exaggerated approach to limiting births, to placing men and women in opposition in the name of a book-keeping vision of parity, to disassociating sexuality from procreation (which involves an insignificant and immature vision of the sexual act), and encouraging the institutionalisation of sexual orientations. This idealist conception of sexuality poses a problem for public health and will pose it in the future as well.

Chapter One: the Notion of 'Gender'

The concept of 'gender' has numerous definitions. Specialists of the human sciences have widely argued that it does not depend on definitions connected with nature and the destiny of each sex and the intention is to understand better the relationships between the sexes and the types of femininity, masculinity and sexuality that are constructed by society.

In choosing the word 'gender', rather than the terms 'man' and 'woman' which, according to the theoreticians of gender, depend too much on the notion of nature, three concepts are used in this approach: the social *construction* of sexuality through what is male and female that does not necessarily correspond to *biological sex*; *sexual orientations*, starting from which it is possible to define oneself; and *power* relationships between men and women and the *roles* that are prescribed for each of them.[1] These relationships are often analysed in terms of the subjection of women by men. This is a situation that has often been confirmed by acts of injustice and ill-treatment but which does not take into account relationships between men and women as a whole and, without a doubt, the mental questions and issues of women in relation to men. Despite this, women are called to emancipate themselves from the social vision of their portryal which begins, amongst other things, with their roles as wives and mothers. They should assert themselves through autonomy and independence in relation to men and liberate themselves from the unjust restraints of motherhood. This last point explains, amongst other things, the promotion of contraception and abortion through the contemporary notion of 'reproductive health' which is not neutral be-

* This text was read on 23 November 2011 on the occasion of the meeting of bishops in charge of pastoral care in health organised in the Vatican City by the Pontifical Council for Health Care Workers.

cause it is restricted to methods of contraception and abortion.

Let us be clear on the matter, *gender studies* that tend to highlight injustices and forms of discrimination between men and women continue to be relatively instructive and pertinent. But the problem arises when sociologists draw anthropological conclusions from them both to institute specific realities such as homosexuality and to modify the meaning of human sexuality starting from the technical restriction of births and to change the meaning of what a couple and the family are, starting with sexual orientations.

However, we have before us a dilemma: on the one hand, what is experienced at a practical level by men and women, and, on the other, a system of analysis of the conceptual portrayal and understanding of their situation codified by gender theory that does not always correspond to the way things really are. Yet this ideological current has ended up, despite everything, by being the basis of political decisions in developed countries and in other countries as well, in particular in Africa and in Asia, where a colonialism of Western thought is imposed (pressure being exercised to this end by international institutions) to the point of destabilising society in a way similar to what happened with Marxism. It is at the least strange to observe the activity of the chancelleries of Western countries as they seek to impose homosexuality on African nations and use various financial arguments to encourage them to revise their legislation in this field.

For her part, the Church invites people to respect homosexual people when it comes to their dignity and their civil rights. But this does not mean that she approves sexual practices that diverge from the dignity of human sexuality or accepts 'couples' made up of people of the same sex, their marriage, and their ability to adopt children. It is an abuse of language here to speak about a 'couple' or a 'family' because both of these always, and solely involve, a meaning of otherness constituted by sexual difference and a couple that is able to generate children.

Hitherto we have had a unified vision of the human person with a realistic *recognition that it is sex that decides gender, whereas now the intention is to assert that gender decides sex*. This is an unrealistic and idealist idea.

It is true that a distinction exists between how a person subjectively lives their sexuality, their own sexed body, on the one hand, and social models of men and women, on the other. The influence of society on the development of a person's personality cannot be denied, even if the personality is not solely the result of social inductions as the concepts of 'gender' claim. In this sense, personality as the mental face of the human person loses its personal, autonomous, and thus also free, character.

According to Freudian psychoanalysis, in every personality we find biological, mental and social elements that are to be inscribed in spiritual and moral elements. A human being is a sexed person, male and female, who is fulfilled in the masculine and the feminine. A correspondence exists between the sexed body and its identification through 'gender' that belongs to it because mental life develops '*in extenso*' towards the integration and internalisation of each person's sexed body.

The approach that is imposed on us through the concepts of 'gender theory' breaks up sexuality and derives from an ingenuous, puerile and idealist argument. We find this argument in the texts of a certain number of writers whose thought principally amounts to a manipulation and deviation of the meaning of notions that should refer to actual realities.[2] For this reason, it is not sufficient to affirm that 'sex is a social category'[3] with the implication that it is structurally modifiable according to the desires of an individual and dependent on the 'construction' of social models.

The question that is often raised is to know what the creators of 'gender theory' really want to achieve. The objective that is pursued involves reorganising society so as to consolidate in a better way the parity of civil rights that all people are recognised as having. Expressed in these terms, we can only approve this legitimate aspiration. But when we look in a careful way at the contents of this request, things become less evident. The need to oppose men and women in the name of a bookkeeping parity is contrary to the meaning of equality. The wish to extend marriage to people of the same sex in the name of parity is, at the same time, a contradiction in terms and an anthropological transgression because only a man and a woman can ally with each other, although some people would like us to believe, demonstrating a 'deficit' of thought, that marriage can be achieved on the basis of sexual orientation. Now, male and female identities are based on the very being of the person, whereas sexual orientation depends on partial impulses and primary identifications. From an epistemological point of view, those sociologists who propound 'gender theory' do not see that their concept is a source of conflicts when they are confused about what depends on ontology and what depends on psychology.

In the outlook of gender theory, therefore, one has to 'denature' sexual difference in order to give greater justice to the *equality* of men and women, and this to the point of making them similar, and legitimate *sexual orientations*. Sexual difference will be replaced by difference at the level of sexuality and thus we will live in a better world. In reality, the world will be a part of a delirious and deleterious universe.

Chapter Two: Reproductive Health

Is the notion of 'reproductive health' pertinent? When this concept is utilised the idea is deduced from it that society will take care of women who are, or will become, mothers, and that they will be helped to prepare for their own motherhood. In reality, this formulation indicates a reduced field of action for women because one is dealing above all else with promoting contraception and abor-

tion given that the dominant ideas channelled by agencies such as the United Nations and the World Health Organisation and imposed on States, and in particular on the poorest populations of the world, have as their sole objective the reduction of births.

2.1 A semantic problem

The concept of 'reproductive health' also poses a problem in that human beings do not reproduce themselves – they procreate. Thus they are not reproducers, otherwise they would manufacture clones. In other terms, you have to have two sexed beings who are fundamentally different in order for a third human being, another, to be born from them.

The use of the concept of 'reproduction' when speaking about human fertility means that man is aligned with animals. He is called in the same way an 'individual' as animals are, in the sense that he cannot be shared or divided without losing his own characteristics. But if this denomination is relatively pertinent in its truest sense and can have various meanings, it is insufficient because a human being is a person.

The semantic changes that have been produced in recent years are not inoffensive. The study of living things has sought to establish correspondences and likenesses between the vegetable kingdom, the animal kingdom and man. Language was adapted to this new vision of things when, thanks to the new instruments of scientific research, the biology of living things was increasingly examined with reference to its particular components and its infinitely small reality. The risk that is run is that of establishing definitions starting with *elementary particles*, with the loss of the meaning of the overall character of each species and going beyond the boundaries that differentiate them. But this frontier today has been crossed by taking animals as a reference point to codify human biology and behaviour. Starting at the point when society no longer knows how to reflect sexual difference, it loses the meaning of the truth of things, the meaning of male and female, the meaning of the difference of generations and the difference of species. Today some people are in favour of sexual activity with animals.[4]

2.2 Women liberated from the so-called 'traditional' family

The establishment of parity between men and women constitutes a notable advance in the world, in particular where cultures see women as inferior and despise them, starting with baby girls (cf. the anti-birth policy of some countries which require the abortion of babies who are female, something that in the long term provokes an important demographic imbalance). The policy of quotas imposed in Western countries in all the fields of social, professional, political and family life in the name of parity between men and women, fostered by the conclusions based upon 'gender theory', will lead to yet other aberrations.

According to the logic of the Conference of Peking (1995), women are to be privileged in relation to men because it is argued that they should benefit from special support after social, economic and cultural restraints have been diminished with the passing of history. This is an approach to be implemented in a voluntaristic way through 'gender studies' that demonstrate the historical and social character of the construction of the male and female sexes, and also that of the family. For this reason, the notion of 'parity' is here falsified because one is dealing first and foremost with levelling men and women into a lack of distinction between them, and their fundamental separation, in the name of reproductive health which is located solely within the context of the primacy of women.

Article 16 of the Universal Declaration of Human Rights of 1948, however, declares that 'The family is the natural and fundamental group unit of society and is entitled to protection by society and the State'. *One is dealing here with a family based solely on a monogamous couple made up of a man and a woman and involved in a tie of matrimony*. There are no cases that exist whereby the family can be defined differently. These are decisions that are taken without the democratic approval of the population, whose political leaders have acquired the habit of governing without asking their populations for their opinion.

After the Conference of Peking the very term 'family' was deviated from its meaning with the attribution to it of 'consensual relations' which do not have the same value: so-called homosexual families, lesbian families, reassembled families, single-(male or female) parent families, adoptive families, and traditional families, as has been curiously emphasised.

The term 'family' has become a polysemic concept which refers to polymorphic realities. This is a shift that can be understood in the context of the individualistic or subjectivist anthropology that at the present time dominates men's minds. Thus, again in the name of 'gender theory', it is argued that one single definition of the family does not exist because the family has become multiform (the biological family, the adopted family, the single-parent family, the reassembled family, the nuclear family, the wider family, and the homo-parental family). Here particular and problematical situations are confused with the very meaning of the family based upon the conjugal life of a man and a woman. Now, such particular situations that do not belong to the definition of the family are often presented in sociological discourse as possible cases with a 'family' profile although they do not, in fact, have the structure of the family.

For this reason, *we should not speak about 'families' but about the family*, inasmuch as it has its own internal logic and structural characteristics which, at times, can be forgotten about because of the customs and practices of an epoch. The specialists of these sociological studies tend to conclude their works by wanting to legitimate all *de facto* situations of this kind without any other analysis than that of opinion poll percentages that are said to validate them.

Pastoral care that relies upon these dominant ideas of this area, demonstrating complicity with them, with the pretext of compassion, runs the risk of getting bogged down in pastoral care for 'families' rather than being based on the meaning of the family and promoting families based upon the matrimonial alliance, even though they are, it may be recognised, attentive to particular situations. Otherwise, people will have a vision that diverges from the meaning of the family expounded by the Church and they will not see what it can contribute that is original and liberating in the face of these sociological impasses.

At the present time we tend to value the blind points of society to the detriment of what constitutes it, and in this way pastoral thought and action have taken part in the alteration of the meaning of the family and of social ties. In France the newspaper *La Croix* (27 September 2011) and *Pèlerin Magazine* (4 October 2011) published an opinion poll which *indicated that very few Catholics believe that the Church can help them in their conjugal relationships*. This is an attitude that does not surprise us in a context of pastoral confusion if people do not know how to locate the discourse of the Church and if the question of conjugal life is not addressed in homilies, catechesis and pastoral activities of a certain level: Catholics do not know how the Church can help them and accompany them whereas, in fact, she has available to her a treasure of concepts to do this. It is for this reason that the family must be the privileged terrain for the new evangelisation.

2.3 Women dissociated from men

In the history of ideas, conjugal and family life has at times been portrayed as a place of *oppression* (Friedrich Engels) and of *class struggle* (Marx) that is a burden for women; their liberation passes by way of the destruction of the family.

Christian thought is that thought that has best explored and valued sexual difference, the equality of men and women, the conjugal relationship created by them in the name of freedom, and family life that comes from the commitment to marriage. These are principles that took time to prevail with their logic; indeed some twenty centuries were needed for free marriage, for mutual consent and for an irrevocable commitment to be recognised as an institution – the institution of marriage which seals the alliance of one man and one woman.

As the Delegation of the Holy See to the Conference of Peking (1995) made clear, the Church disassociates herself from the 'notion of biological determinism according to which all the functions and relationships of the two sexes are established in a single and static model'. The Blessed John Paul II laid stress at the time on the fact that men and women are distinct and complementary (*Letter to Women*, 1995, published before the Conference of Peking, but also *Mulieris dignitatem* 1988, *The Dignity and the Vocation of Women*), recognising at the same time that in the past mentalities and institutions had not always known how to recognise the dignity and the riches of the contribution of women (n. 3). John Paul II observed that a great deal remained to be done to 'achieve *real equality* in every area: equal pay for equal work, protection for working mothers, fairness in career advancements, equality of spouses with regard to family rights… This is a matter of justice but also of necessity' (n. 4). It was only through the duality of the 'masculine' and the 'feminine' that the human finds full realisation. 'Womanhood expresses the "human" as much as manhood does, but in a different and complementary way' (n. 7) Thus Pope John Paul II was happy about the fact that women were taking on new roles and thought that cultural conditioning had been an obstacle to the advance of women.

As early as the Conference of Cairo (1994) which was on the subject of *population* and *development*, the notion of 'reproductive health' was adopted as 'health in the field of sexuality' and 'rights in the field of reproduction' in relation to women. Although it was right to protect women and girls against sexual violence and aggression in order to denounce, rightly, 'forced pregnancies' connected with armed conflicts (rape), it was more questionable to refer to these subjects in order to reduce 'reproductive health' in general to contraception and abortion: it would have been more precise to have spoken about the 'health of women' or even the 'health of the family' in which the health of men, women and children, but also their sexual health, were included. The same applies to the term 'family planning' in order to promote techniques of contraception and abortion: it would have been more pertinent to speak about the limitation of births by having recourse to morally acceptable instruments which respect the dignity of the human person.

The Conference of Peking (1995) took up these notions and created the concept of the 'absolute control of sexuality and fertility' which is an equivocal term that can justify sexual acts outside sealed marriage between a man and a woman, with the approval of abortion and homosexuality. In stating that 'women's rights are fundamental rights of the person', should one understand them as new rights, even though the mission of this conference was not to establish them, or should one understand them in the logic of human rights and fundamental freedoms which are shared by men and women? The way in which they were presented leads one to suppose that they were different to those relating to men as well, with an accentuation of the distance between men and women.

The term 'sex' was no longer understood in the sense in which it was habitually understood because of sexual difference but was above all interpreted, within the framework of the conceptualisation of *gender theory*, as a *sex constructed* culturally, independently of its biological reality, allowing a belief in the mobility of sexual identity in the search of new interests. This is a vision of things that encourages a defi-

nition of so-called intimate sexuality (outside the social field) in terms of *sexual orientations*, which is unrealistic.

After the Conference of Peking, the agencies of the United Nations and their allies went well beyond this in their mission to banalise the limitation of births solely to contraceptive pills and abortion, to impose the homosexual model, and to disseminate the concepts of *gender theory*. These are all intentions that took practical form in Western countries with the financing by health-care insurance of instruments of contraception and abortion, although these have nothing to do with illness, in order to facilitate their free distribution amongst teenagers without their parents being informed about this. Parents have thus found themselves dispossessed of their educational responsibilities and placed under the power of the state, as with totalitarian countries, in order to restrict the sexual education of young people to contraception and abortion.

Procreation has become an illness that international organisation and countries try to neutralise by disassociating it from human sexuality. An unborn child is not welcome. With the publication in 1968 of *Humanae vitae,* Pope Paul VI engaged in a prophetic act envisaging – despite the denials expressed at the time by the proponents of contraception and abortion – that these practices were not only *morally illicit* but would also involve the separation of the meaning of procreation from human sexuality.

In the contemporary context, we have observed a decrease in births that will intensify in the years to come and an increasing rise of ageing populations without young people and thus without a source of renewal. In order to limit the danger represented by unborn children, some sociologists come to use the argument of their *carbon impact* on the ecology of the planet whereas the real problem is the way of living of market societies with its multiplication of the possession of objects which are far from being necessary. Agencies of the United Nations have recently announced the birth of the seven billionth child without us really knowing to what this more than contestable figure corresponds. Above all given that we know that in numerous countries registries for births and deaths are not kept with the greatest rigour (25% of birth and deaths in some countries are not registered). Is this not a way of troubling the population with the centuries-old worry that the planet will not have sufficient resources to feed everyone? This is a doubtful statement. The 'demographic winter' we are now going through is one of the most important facts, amongst others, of the economic crisis. It is not due to an increase in the birth rate, which is falling, but to an increase in life expectancy. For this reason, Russia, a country where the population has steadily and dangerously decreased, has decided to relaunch the birth rate.[5]

Indeed, the structural crisis of the economy and finance is due not only to the excessive debts of States but also to the fall in the birth rate, and the consequences that follow from this, as well as the increasingly expensive ageing of the population.[6] The future and the wealth of a country are its children who, far from impoverishing it, enrich it in many ways.

Chapter Three: the Aspects of Pastoral Care

The Church is always called upon when political practices in the field of health and birth rates call into question the dignity of the human person. She cannot be indifferent and her pastors have the duty not only to remember this but also to mobilise Catholics so that they engage themselves politically, at least with their votes, and enable those people who ask for the votes of the electorate to know about the requirements of life, which are those of the common good of mankind.

The primacy of respect for the dignity, the integrity and the life of man is essential. The so-called techniques to help procreation, abortion and research on embryos, raise very grave problems and are not morally licit. Contraceptives are not without consequences for people's health and the environment. It is not admissible for public authorities to distribute them free amongst minors without informing their parents. These last are thus deprived, in the name of 'reproductive health', of their right to bring up their children. The notion of a 'parental project' is equally a concept that ill-treats the embryo where parents are led to believe that its existence is nothing else but a mass of cells until the twelfth week of pregnancy and that their relationship with this child of theirs depends on their wish to create it or otherwise at the beginning of life. Adults are thus said to have a right to life and death through abortion practised on a human being at his or her beginning in the name of subjective interests whereas, in fact, an embryo exists objectively. Lastly, the experiences with stem cells derived from the destruction of embryos constitutes another transgression whereas current scientific research with adult cells leads on to real therapies and must be privileged. For this reason Benedict XVI observed that the Church adjudges resort to stem cells as acceptable when they 'are taken from the tissues of an adult organism, from the blood of the umbilical cord at the moment of birth, or from fetuses who have died of natural causes'.[7] There are non-negotiable points, as Benedict XVI himself stated.[8]

3.1 The non-negotiable aspects and the role of Catholics in politics

'As far as the Catholic Church is concerned', Benedict XVI observed, 'the principal focus of her interventions in the public arena is the protection and promotion of the dignity of the person, and she is thereby consciously drawing particular attention to principles which are not negotiable. Among these the following emerge clearly today:

– protection of life in all its stages, from the first moment of conception until natural death;

– recognition and promotion of

the natural structure of the family – as a union between a man and a woman based on marriage – and its defence from attempts to make it juridically equivalent to radically different forms of union which in reality harm it and contribute to its destabilization, obscuring its particular character and its irreplaceable social role;

– the protection of the right of parents to educate their children.

These principles are not truths of faith, even though they receive further light and confirmation from faith; they are inscribed in human nature itself and therefore they are common to all humanity'.

The Supreme Pontiff referred to these principles in his apostolic exhortation *Sacramentum Caritatis* (22 February 2007). They are the principles that form the basis of social life. 'Democracy must be based on the true and solid foundation of non-negotiable ethical principles, which are the underpinning of life in society'. One may also refer to the *Doctrinal Note on some Questions Regarding the Participation of Catholics in Political Life* (24 November 2002) of the Congregation for the Doctrine of the Faith signed by Cardinal Ratzinger. We can read in that document: 'The Christian faith is an integral unity, and thus it is incoherent to isolate some particular element to the detriment of the whole of Catholic doctrine. A political commitment to a single isolated aspect of the Church's social doctrine does not exhaust one's responsibility towards the common good'.

Let us remember that the common good depends objectively on a higher interest for individuals and society. The natural law derives from universal principles, starting with which humanity is constructed. There are, therefore, practices and actions that are contrary to the dignity and development of humanity.

Some citizens and political leaders declare that they are Catholics even though they are in contradiction with the Magisterium of the Church. From the needs that spring from natural morality illuminated by faith in Christ, they select the aspects that are convenient for them so as not to be in opposition to the fashionable ideas of the epoch. With a purely propagandistic vision and with a paradoxical approach, some of them argue that in this way they are against marriage for people of the same sex yet they approve the idea of adoption in such a context. Others are favourable to this marriage in the name of the meaning of 'love' (this is very badly understood inasmuch as between these people conjugal love does not exist) but they oppose the adoption of children for such a couple. Others give their support to marriage and adoption in this context. And yet others are favourable to contraception, abortion, euthanasia or research with embryos. The pastors of the Church must know how to make these Catholics active in politics know that they are contradiction with the principles of natural morality and run the risk of no longer being in communion with the Church and no longer being morally suited to receiving the Eucharist.

A society that promotes contraception, abortion, euthanasia and assisted suicide contributes to the devaluing of life by proposing as the only way of getting out of certain painful problems the solutions of death. A Catholic in politics cannot be an accomplice of what destroys life. Man does not have the right to attribute to himself this power over life and death, and to attack the meaning of the family as constituted by a couple made up of one man and one woman and engaged in marriage.

3.2 Options that pose problems in relation to which Catholics must mobilise

I will base myself now on the Interdicasterial Note *The Reproductive Health of Refugees* – a text that is always of contemporary relevance – which was published on 14 September 2001 by the Pontifical Council for Pastoral Assistance to Health Care Workers, the Pontifical Council for Pastoral Care of Migrants and Itinerant People, and the Pontifical Council for the Family. This was a document in response to the *Inter-agency Field Manual on Reproductive Health in Refugee Situations* published in 1991 by the United Nations High Commissariat for Refugees (UNHCR). We find in this *Note* of these Pontifical Councils a certain number of principles for action on which Catholics should base themselves when reference is made to reproductive health.

We have laid emphasis on the problems raised by the notion of 'reproductive health'. The Holy See cannot refrain from expressing its own numerous reservations about this practice which involves imposing on women and adolescents forms of health-care behaviour that range from contraception to abortion, involving at times, despite their will, their sterilisation. These are all practices that attack the dignity of people, the exercise of conjugal sexuality and the family.

In the *Field Manual* of the agency of the United Nations, which contains some positive aspects, we find the summary of a disquieting vision of human sexuality and a compendium of the principal problems raised by the Church.

1. There is a fundamental difference between the utilitarian and pragmatic conception of human sexuality, associated with the concept of 'reproductive health', and the perspective offered by the Church in her respect for dignity of man and his sexuality. 'Man and woman have been created… by God… equal as persons… and complementary… One should, therefore, respect the dual meaning of the mutual giving of the man and the woman, open to life, in marriage, which the contraception promoted by so-called 'reproductive health' contradicts'.

2. Forms of scientific knowledge allow us to affirm that human life begins at the moment of fertilisation. Most of the time a woman is aware of this and is already thinking of the child that she bears within her. Despite this objective observation and the subjectivisation that the woman experiences by internalising it, she is made to understand that this is only a bunch of cells. But human

life is already present at its initial stage. The Church, therefore, reminds people of the obligation 'to respect and to protect the right to life of every human embryo and rejects as immoral every action which brings about its abortion or manipulation'.

3. Often after forced or non-protected sexual relations resort is proposed to what is called 'emergency contraception' or the 'morning-after-pill'. This is presented as a contraceptive whereas, when fertilisation has taken place, it is above all abortive. The World Health Organisation relativises the biological status of the embryo during the first days by calling it a 'pre-embryo', which means, once again, that it is reduced to being a bunch of cells. The Church denounces here a 'sophism' that does not correspond to a precise biological basis. 'Emergency contraception' is not morally acceptable. The situation can be worse when sterilisation is presented as a simple 'contraception' whereas one is dealing with the radical elimination of the procreative function. In poor countries, adolescents and women are not informed about what constitutes a real manipulation of individuals and the mutilation of women, and, at times, of men through masked sterilisation.

4. The separation between sexuality and procreation is amply confirmed and requires that extra-marital relations as well as homosexual relations are not judged. Rather than being educated in the meaning of love, looking towards a marriage and a future family, girls and boys are introduced into mere immediate, irresponsible and individualistic sexual pleasure which increases the risks of the transmission of sexual infections and AIDS. Here the *Field Manual* limits itself to proposing and even imposing the condom whereas, instead, the question is one of educating people to have responsible sexual behaviour for a lasting prevention against infections and precarious and transient relationships connected with the mere search for sexual pleasure.

5. The limitation of births is reasonable and legitimate when individuals use natural methods which have been demonstrated to be valid on the basis of a real education and are morally licit. They respect the body and the relationships of the couple, and foster dialogue and a responsible approach by the spouses.

6. In numerous cases, abortion becomes an instrument of contraception, particularly in developed countries where, instead, the use of contraceptives is notable. Rather than paying attention to, and reflecting upon, this situation, public authorities commit themselves to offering every instrument to encourage the elimination of embryo and unborn children with the sole pretext 'of the freedom of women to dispose of their bodies'. As we have said, this vision of things, which in the name of freedom inscribes death in the heart of procreation, has consequences and burdens society with that deleterious feeling of guilt which is so present in the depressive society.

In France recent studies[9] have demonstrated the lack of interest of young people in teaching about contraception in schools and what it implies as regards abortion as well. We have so linked sexuality, contraception and abortion that this trio provokes strong disquiet in young people. Indeed, at a time when they are involved in their own sexual development, the first question that they ask themselves is knowing if they will be less fertile or if they are normal in all respects. As a response, the public authorities and over-represented organisations such as those for family planning make them understand that they have to distrust procreation and not seek to integrate it into their sexuality. This is an approach that goes against the subjectivisation effected by them to internalise their sexed bodies. It is not in this way that they can become responsible.

Conclusion

1. Although *gender studies* had the merit of highlighting social disparities and injustices in relation to women, very soon these sociological studies were transformed into an ideological movement and a movement involving a struggle between men and women. The class struggle was transformed into a struggle of the sexes with the view that women not only had to emancipate themselves from men but also to search for their own autonomy outside conjugal and family life. But the relationship between men and women cannot be based upon a conflict of power – it must be based upon equality, their interdependence, and their complementarity.

2. In order to emphasise in a better way the autonomy of women, the theoreticians of gender theory wanted to liberate them from their vocations as wives and mothers, neutralising motherhood thanks to contraception and abortion. In separating the sexual expression of spouses from procreation, one makes men and women lose the *unitive* character that nourishes and strengthens the conjugal bond and at times also the *procreative* character of their conjugal sexuality, as well as their capacity to project themselves into the future. A society that discredits the meaning of a child ends up by losing the meaning of its history. It becomes individualistic, it closes itself up in the magnificence of the king-baby, and transforms the sexual act into a ludic gesture that searches for egocentric personal pleasure.

3. The notion of 'reproductive health' masks the negative tendencies of human sexuality, the precariousness of the family after divorce, and the exaggerated efforts of the organisations of the United Nations and of NGOs to define, amongst young people, sexuality in terms of contraception, abortion and the liberality of practices protected solely by technical instruments, without any rational discernment of what it is advisable to do.

In excluding procreation from sexuality, society prepares young people for irresponsibility in their sexual activity sexual behaviour. The mutilation of the meaning of sexuality in its dual dimension – the unitive and the procreative – does not always foster the mentalisation of the relationship of the couple, and this leads to dif-

ficulties in being a couple together and knowing how to overcome all its stages, that is to say crises, in order to develop.

With the absence of a true mentalisation of the relationship of the couple, the situation is changed to the point of regulating the mental difficulties of the couple at the level of separation and break-up in divorce. We should understand this point clearly: the Church has always recognised the necessary limitation of births, but using methods that are morally licit and that respect the dignity of the person and human sexuality as a setting for communion of self-giving within the marital relationship.

4. The concept of reproductive health should not be used as such. It requires a critical analysis and should be called into question, as has been shown in this paper, as regards what it implies and involves. For this reason, we should prefer to speak about the 'health of the family' as the same way as a *Family Handbook* exists which includes a father, a mother, and children. The family is a common good of humanity which is based upon the marital union of a man and a woman because they alone are in the logic of otherness and thus of love, and a couple able to generate life. The family constitutes the fundamental cell of society and it is the setting to the utmost for the socialisation of children. In supporting 'family health', the set of social ties is strengthened and opened to the sharing of life and the future.

Pope John Paul II rightly wrote in his apostolic exhortation *Familiaris Consortio* (1981) that 'the future of humanity passes by way of the family' (n. 86). ■

Monsignor Tony Anatrella, Author on the same subject of *Differenza vietata*, Flammarion; *Époux, heureux époux*, Flammarion; *Le règne de Narcisse*, Presses della Renaissance; *La tentation de Capoue*, Cujas; and the recently published Pontificio Consiglio per la Famiglia *Le gender, la controverse*; preface by Tony Anatrella, Téqui.

Notes

[1] Florence Rochefort, *Le pouvoir du genre, laïcités et religions* (PUM, Toulouse, France).

[2] Authors who are familiar with this shift in meaming are: Judith Butler, *Le trouble dans le genre* (La découverte, Paris) and Éric Fassin and Véronique Margron, *Homme, femme, quelle différence?* (Salvator, Paris).

[3] *Op. cit.*

[4] Marcela Iacub, 'Le sexe, comme des bêtes', *Journal Libération* (France) 29-30 November 2011.

[5] 'La Russie veut limiter l'avortement pour relancer sa démographie', Benjamin Quénelle, *La Croix*, p. 5, Friday 18 November 2011.

[6] Ettore Gotti-Tedeschi, 'Editoriale', in *L'Osservatore Romano* of 4 November 2011, Vatican City: 'For the economy to grow in a stable and balanced way, the population must grow in an equally harmonious and balanced way. We have denied births and we have replaced the necessary growth with a consumerist and debt-driven growth'.

[7] Speech of Benedict XVI, Saturday 12 November 2011, to those taking part in the international conference on the subject 'Adult Stem Cells: Science and the Future of Man and Culture', organised in Rome by the Pontifical Council for Culture in 9-11 November 2011.

[8] Speech of Benedict XVI to those taking part in the Congress of the European People's Party, 30 March 2006.

[9] *Le Monde*, 25 October 2011, '*Contraception à l'école: le désintérêt des lycéens*', article by Sylvie Kerviel.

2. Gender and Reproductive Rights: the Legal Aspects*

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To speak about gender and reproductive health, placing these two terms in the broader context of human rights, means understanding a fundamental aspect of the current international debate not only about subjects connected with procreation and medical questions inherent in the sexual and reproductive sphere but also about education, psychology, and more in general, lifestyles. The interest – but also the perplexities which cannot be overcome easily – of a jurist is evident; indeed I would say necessary.

An example? 'The child's name is Storm, fourth months' old, blonde hair and sea blue eyes. An adorable baby who will grow up 'without a sex': the parents, Kathy Witterick and David Stocker, decided not to announce to the world whether storm was a boy or a girl. Because of their decision, which is decidedly unconventional, this Canadian couple has already been called 'the most politically correct in the world'. For these parents, the sex of a child should not determine its place in the world'.

A jurist has two immediate reactions to this news which appeared in *The Times* of London

* This text was read on 23 November 2011 on the occasion of the meeting of bishops in charge of pastoral care in health organised in the Vatican City by the Pontifical Council for Health Care Workers.

on 24 May last. At the registry of births, how was Storm registered? Can legal systems not envisage rules that involve and impose, quite rightly, the making of a distinction between a woman and a man?

In other terms, a jurist cannot fail to consider the immediate consequences for a legal system of behaviour dictated by 'political correctness' that is based upon an approach that seeks to go beyond the basic (and it should be said – natural) difference between a man and a woman. Indeed, the political, ideological and cultural foundation of the decision taken by these Canadian parents is important in understanding which rules should be applied not to protect the parents but to protect Storm. Looking at the international dimension of law, our minds go immediately to the great advances in law expressed by Conventions that defend women workers and prohibit the employment of women in forced labour and envisage the principle of parity (same pay for the same work). These examples are taken from the first tracts drawn up by the International Labour Organisation which were greeted as goals of civilisation. But one could continue to ask oneself why in some areas of the world the abolition of polygamy, or the abolition of customary rules that impose the paternal line in the educational process or in decisions in the religious field, is greeted as a positive goal.

On what juridical foundations is the choice of this Canadian couple based? Certainly, a first reference is the meaning acquired by the term 'gender' in the legislative and normative processes that have developed over recent decades and which was adopted by international language in the year 1993 (the debate at the UN conference on human rights). These processes have always seen difference by gender as a factor to replace, or be an alternative to, the traditional difference by sex, so as to allow every person to attribute to themselves their own 'gender' in a free and thus changing way – male, female, or even so-called other conditions (as in the case of 'transgender').

1. Some Observations on Roots and Meanings

International language leads us to read words and phrases such as 'gender', 'gender equality' or 'gender identity' and to draw from them meanings and possible applications that are increasingly broad and above all capable of having an impact at the level of law and thus of behaviour as well. Indeed, it is evident that in this case the use in legal measures (in the case as well of 'soft-law' in, for example, the final documents ('Declarations' or 'Action Plans') adopted by UN conferences in the 1990s on human rights, population, and women) of these terms has led to projects and lifestyles and thus to collective and individual forms of behaviour. And not the contrary, according to the adage *ius sequitur vitam*, thereby overturning hermeneutics based upon the relational tandem 'life-rules' which is specific to jurisprudence.

A reading of terms with the language of international law highlights the following. a). Male 'gender' and 'female' gender are expressed in the formula 'man and woman', and is thus an *identity perspective*, whereas 'gender' does not relate to being a man or a woman but, rather, to their relationships. b) Society assigns to men and women role differences, relationships, character traits, forms of behaviour, and the power and capacity to influence situations and decisions. c) The term 'gender' goes side by side with, and does not replace, 'sex', as in the case of the principle of non-discrimination adopted by the Treaties of the European Union since 1997 with the revision of Amsterdam. A distinction is fundamental in this approach: whereas sex is determined by genetic and anatomical (and no longer biological!) characteristics, 'gender' is an 'acquired identity' which is learnt, which evolves with the epoch, and which varies notably from one culture to another, as it does within a culture.

To dwell upon the *relativistic* dimension of this approach is obligatory, but it is equally essential in order to understand its impact at a juridical level. The fragmentation of the subject, to which fundamental rights are connected, is practised through a decomposition of his or her identity between the element of sex, which is the traditional component, and that of 'gender', which constitutes a new one. To this last rights are then attached.

Initially, 'gender' was connected to equality and to fairness in treatment, as is demonstrated by the first interpretation of the *Convention on the Elimination of Discrimination against Women* as regards statistical data on women (cf. Convention on the Elimination of Discrimination against Women, http://www.un.org/womenwatch/daw/cedaw/reporting.htm,*General Recommendation n. 9, 1989*, on same pay for the same work; *General Recommendation n. 13, 1989*, where there is the phrase 'gender-neutral criteria" (para. 2); and on domestic work (*General Recommendation n. 17, 1991*).

The question of violence against women led to a modification of this approach, which had been followed hitherto (*ibidem*, *General Recommendation n. 19, 1992*), with the introduction of the phrase 'gender-based violence which impairs or nullifies the enjoyment by women of human rights and fundamental freedoms under general international law or under human rights conventions, is discrimination'.

The same approach is to be found at the Cairo Conference on Population and Development (ICPD) of 1994 which referred to: a). 'gender' linked to the prevention of violence and to the control of fertility (ICPD, Declaration, Principle 4), thereby placing it in a direct relationship with the dimension of individual rights; and b) the right of couples and *individuals* to decide the number, spacing and time of births (ICPD, *Declaration*, Principle 7). On 5 December 1992, John Paul II, when inaugurating the *International Conference on Nutrition*, stated the same principle, but it was anchored in family life, in the man-woman couple, and not in the individual dimension. This, for that matter, was in

line with what had been developed in international language and law.

In a more specific way the *Peking Conference on Women* (1995) added: a). the idea of distinction and protection in relation to 'gender' as a part of the exercise of the right to become a mother; and b). empowerment understood as the conferring of power on women who through the protection of their 'gender' can acquire control of their lives, capacities, and confidence in themselves, solve their own problems, and become autonomous in relation to their traditional complementariness with men as indicated, for example, in article 6 of the *Universal Declaration of Human Rights*: '(1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution'.

The effects of this approach in the field of human rights have been direct because it has been possible to place them in that so-termed 'conceptual framework' according to which the process of *human development* should be based upon international standards of human rights and has as its objective the promotion and the defence of fundamental rights. This is a framework which in relation to this field seeks to analyse those inequalities – of gender – that form the basis of the problem of development, and also addresses discriminatory practices and an unequal distribution of power (a lack of gender empowerment) which impedes effective human development.

What have been the consequences in national laws of this approach since the establishment of the concept of 'gender' in the policies and legislative directions of States? Initially, the term appeared to emphasise equality. It then replaced difference by sex and subsequently flanked this difference. Even in the absence of full incorporation into law, this has been a process that has affected the legislative plain in the fields of health care, education and humanitarian action. Today it is possible to assess the implications for men and women of all actions planned through legislation, policies or programmes in every area and at all institutional levels (local or national powers). This is an authentic strategy that covers the concerns and experiences of women and men in the planning, implementation, monitoring and assessment of operational directions and programmes in all economic and social policies so that women can benefit from them to the same extent as man, with a consequent disappearance of inequality. *Gender* equality is proposed not as a means or instrument but as a final objective.

2. Questions Opened up by the Gender Perspective: Produced and Producible Effects

Juridical norms are an instrument for social cohesion and they act to assure legality and living together in society. In this function of theirs, they act to assure the certainty of rules and their application without forms of discrimination. Instead, in the gender approach they become *stereotypes*, especially when they circumscribe the range of rights or the application of the principle of non-discrimination, as is clearly visible not only in acts of soft-law but also in the meaning given to binding norms. Such was the case with the Convention on the Elimination of Discrimination Against Women, whose interpretation indicates the stereotypes of a normative kind in the case of violence against women (Committee on the Elimination of Discrimination against Women, http://www.un.org/womenwatch/daw/cedaw/reporting.htm *General Recommendation n. 19*, 1992, with reference to articles 2, 5 and 10 of the Convention) and the participation of women in public and political life (cf. *General Recommendation n. 23*, 1997, with reference to art. 7), thereby opening up the road to the establishment of the assumption that what is not prohibited is allowed. This is an approach expressed in a spasmodic attempt to match fundamental needs and rights and to pay greater attention not to the weak subject but to the vulnerable subject, who is no longer a woman. So-termed 'affirmative action' also loses its coherence – that positive discrimination which is called upon to protect rights for a subject or a category through the apparent denial of the rights of others. In concrete terms, a new way of reading and regulating the following is imposed. a). *Equality of the sexes*: all human beings, men and women, are free to develop their own personal capacities and make choices without being bound by stereotypes, rigid roles or prejudices. This means that despite the differences between them, the attitudes, aspirations and needs of men and women deserve the same consideration, have the same value, and should be equally favoured. This does not mean that there are no differences between men and women (that they are identical). It means, rather, that the rights, the responsibilities and the opportunities that they possess do not depend on their sex at birth. In juridical and legal terms, protection and the subjects themselves are defined in expanded terms. b). *Equality of treatment*: men and women should be treated in a fair (not differentiated) way on the basis of their own needs and a way that is equivalent in terms of rights, advantages, obligations and opportunities. The objective of the fair treatment of both sexes requires the use of measures designed to correct imbalances that are derived from historical, social and religious developments that go against women. c) *Cultural sensitivity* (this belongs to the approach based on human rights). This is a planning strategy that helps political figures and development workers to analyse, understand and use positive cultural values, resources and structures when they work to eliminate all resistance to the implementation of international guidelines (final Declaration of Cairo, the Peking Action Plan, and the Millennium Goals adopted in 2000). The objective of this sensitivity is to

create the conditions for the continuous implementation of development programmes and to allow change 'from within', above all in terms of the empowerment of women and the promotion of reproductive health and rights (a phrase which with a meaning of a mechanistic kind replaces that of procreation).

In substantial terms, legal systems and political orientations are placed in a dimension which, although it remains at the level of human rights, is no longer connected with the relationship between subjects but, rather, with their opposition because of different and diverse individualities, above all in recognising other subjective statuses as compared to traditional ones which are anchored in the difference between men and women.

3. Reproductive Health/ Reproductive Rights: New Law or a Category of Rights?

In August 1994, when preparing for the Conference of Cairo, the World Health Organisation inserted into its work document drawn up for that meeting the phrase 'rights of reproductive health' by which the individual dimension of procreation (or reproduction) was identified, with its separation from the couple. In substantial terms, at the level of formulations of a juridical kind, sexuality was separated from procreation in juridical terms. And this notwithstanding the lack of a precise definition of reproductive health. In fact in the belief that subsequent practice would propose a precise definition (today we could say that precision was understood as effective and efficacious implementation of this objective: 'reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents' (ICPD, *Programme for Action*, para. 7.3)

Whereas the original context linked the rights of reproductive health to the question of demography, subsequent developments connected them to sexuality. If we look deeply, it emerges that reproductive rights include some human rights that had already been recognised in national laws, international documents on human rights, and some documents adopted by consensus. This includes the recognition of the fundamental right of all couples and individuals to decide freely and responsibly the number, the spacing and the time of births and to have the information and the means by which to do this, as well as the right to attain the highest standards of sexual and reproductive health. These are aspects to which are added decisions concerning the right to reproduction without forms of discrimination, coercion and violence, as is expressed by documents on human rights or programmes adopted in inter-governmental areas.

The difficult elaboration of the concept started from the assumption that decisions concerning reproduction must be free from discrimination, coercion and violence. The World Health Organisation in 1994 placed this in its classic concept of health, defined in terms of physical and mental wellbeing, but with specific reference to the mechanisms of reproduction and the functioning of the reproductive system at all the stages of life, this last being a recommendation incorporated in subsequent practice as is demonstrated by the application that took place in the field of rights of the child (cf. Committee on the Rights of the Child, General Comment n. 4 (2003) *Adolescent health and development in the context of the Convention on the Rights of the Child*) and the debate that was opened on the rights of elderly people.

The concept of reproductive health implies the possibility of responsible, satisfactory and safe sexuality, and the freedom of people to choose to have children if they wish to have them and when they wish to have them. This is an approach anchored in autonomous standards as regards ethical choices or broader reference points of a moral kind which involve for women and men the possibility (in terms of 'right to') choosing methods for the regulation of fertility that are safe, effective, accessible and acceptable. In addition, it requires domestic systems (through health-care services) to allow individuals and couples to have access to adequate health-care services, especially for expectant women, so that everyone is assured the possibility of having a healthy child. The final objective becomes a sort of guarantee for sexual activity and thus for decisions connected with procreation – what would later be defined as 'reproductive safety'.

What are the implications of this at a directly juridical and normative level? Three aspects become examples: family planning, abortion, and health-care services. A study carried out by the UNFPA and published in 2011 (*Gender at the Heart of ICPD: The UNFPA Strategic Framework on Gender Mainstreaming and Women's Empowerment*) indicates that from the above-mentioned concept of reproductive health, from a juridical point of view, there derive the following. a) A guarantee for married and non-married people, adolescents and young people. b) The placing of treatment in primary health. c). Seeing, as regards abortion, the impact of unsafe abortion on the health of women as an important problem of public health care, indicating as a goal the activation of measures to reduce resort to abortion through services involving extended and improved family planning. In other terms, one is dealing here with recommendations addressed to state legislation, with or without provisions regarding abortion, both through specific domestic norms and through the incorporation of international norms (the case of the transfer of article 14 of the *Protocol of Maputo* of 2004 to the *African Charter on Human and Peoples' Rights*). A further extension of the range of this approach is the recommendation that where abortion is not prohibited by law, health-care systems should train health-care workers and provide them with the means by which to take other measures by which to assure that abortion is *safe and accessible*.

The consequences of this approach are also evident in relation to the allocation of resources in the health-care field, as was made clear by the World Health Organisation (*Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality,* 2007),[5] which for that matter had already been recommended by the Programme for Action of the Cairo Conference (paragraph 7.6), in relation to a number of objectives: a). family planning; b). treatment at the pre-natal stage, birth stage and post-birth stage; c). the appropriate prevention and treatment of infertility; d). the prevention of abortion and management of the consequences of abortion; e) the treatment of infections of the reproductive tract; f). the prevention and treatment of sexually transmissible infections and HIV/AIDS; g). information, education and specific assistance in relation to human sexuality and reproductive health; h). the prevention and surveillance of violence against women, post-violence care and other actions to eliminate traditional prejudices and practices such as female genital mutilation; and i). appropriate reference points for early diagnosis and the management of preceding situations.

4. Gender in International Law and Action

The question of the strictly juridical profile was extended to a consideration of other situations as well which are connected essentially to the profile of non-discrimination, in particular in relation to women, and to an increasing involvement of more inter-governmental institutions in increasingly sectorial aspects. Such is the case with prenatal sex selection – already indicated as a discriminatory practice at the Conference of Cairo (*Programme for Action*, 4.16) – which became a subject for joint action by WHO, UNFPA, UNICEF, UN WOMEN and the High Commissioner for Human Rights, with reference not only to the use of technologies for selection on the basis of the sex of unborn children but also to selective abortion (WHO, *Preventing Gender-biased Sex Selection*, 2011); or to specific provisions regarding the right to contraception (UNFPA, *The Rights to Contraceptive Information and Services for Women and Adolescents*, 2010), which confirmed the introduction of such a right in the context of the practice as regards interpretation of the Committee for the Rights of the Child (CRC, *General Comment no 4: Adolescent health and development in the context of the Convention on the Rights of the Child*: 'States parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases' (para. 28).

The adoption in the year 2000 by the general assembly of the *Declaration of the Millennium Development Goals* gave a further connotation of soft law to gender. This can be demonstrated, lastly, if we refer rapidly to the recent *World Development Report 2012: Gender Equality and Development* published by the World Bank where it is possible to identify the kind of pathway that the idea (or ideology?) of 'gender' has followed in international practice. In our specific case, the World Bank offers it as a specific indicator of the question of development and makes it a catalysing element for the obtaining of resources, activities and goals of forms of funding for development to whose framework belongs not only the inter-governmental dimension expressed by the World Bank or other institutions but also the approach of States. These last, indeed, are called upon to direct in terms of 'gender' every initiative for the development and growth of populations and local areas. For that matter, the reading offered by the *World Development Report 2012* presents the gender perspective as an explanation – or rather as a criterion of interpretation – of the health of women as found in the 'Fifth' of the *Millennium Goals*, a guideline document around which revolves the whole of the action of the United Nations system as regards activities involving cooperation to promote development.

One can say, therefore, that in the field of human rights the *gender perspective* has brought out a direction in understanding and therefore also in defending rights based upon diversity rather than upon difference and the existence of a right to non-discrimination, in place of the traditional defence against non-discrimination. This is what is demonstrated, for example, by the debate about the right to privacy that should be assured in the field of reproductive health to young women in contrast to the right of parents.

5. References to the Meaning of these Terms in National Legislation

What are the realities of the domestic legislative profile of States that have been shaped by this approach?

The identity of gender has placed inside this legislative profile the category of LGBT (lesbian, gay, bisexual, transsexual and transgender) people as a category of people in itself that requires a protection of their own rights. These rights do not belong to the framework of recognised international rights and thus subject to court action within States and at an international level. Examples are the so-called 'right' to *rectification of one's own sex and change of one's name in official documents*, through access to treatment and a legal recognition with a consequent parity of treatment in most of the spheres of social life. By now there are many laws on so-called 're-assignment' that also establish suitable structures. Then there is the right to *juridical protection of a transgender individual*, not as a person but as regards their condition, with consequent indications for cases of 'transphobia' and connected sanctions. Then there is *the right to the international protection of asylum seekers*, which is in gen-

eral a situation motivated by political, ethnic or religious causes. Today there is also a request for extension to sexual orientation or gender identity for those people who cannot live in their own countries for these reasons. In twenty-three States this is already present with LGBT people being indicated as a 'special social group'. We also encounter the right to *freedom of assembly and expression* in relation to events and situations that involve gender identity or sexual orientation. In addition there is the right to *protection against incitement to hatred or hate crimes* against LGBT people which in some cases are put on the same level as racial discrimination (the European Union), with the request to envisage specific cases of crime and related punishments or even to consider such forms of behaviour as aggravating aspects for other crimes. Furthermore, there is the right to *protection against unequal and degrading treatment or more general discrimination*, an aspect that relates in particular to transgender people in the work, education and social fields. Then there is the right to *free circulation and the right to join family relatives*, with the recognition of relations between people of the same sex and unisexual marriages, with the inclusion, that is to say, of couples of the same sex – whether they are registered as being married or are *de facto* couples – in the definition of 'family relatives'. This has already been the subject of legislation in Austria, Canada, France, Hungary, Ireland, Luxembourg, Portugal and Spain. Lastly, there is the right to *impartial information about the condition of a LGBT person and their relationships, with particular reference to young LGBT people*, connected with the question of privacy in the field of reproductive health and with recommendations for the drawing up of laws that envisage suitable forms of education and formation (Estonia, France, the United Kingdom, Germany, Spain, Holland). ■

Cooperation between African Countries and the Church in the Field of Health Care: the Contribution of the Regional WHO*

DR. LUIS GOMES SAMBO
Regional Director for Africa, the World Health Organisation

It gives me great pleasure, and it is an honour, to address this meeting of bishops in charge of pastoral care in health. It was with a deep sense of humility and moral sensitivity that I accepted the invitation of His *Excellency Monsignor Zygmunt Zimowski,* the President of the Pontifical Council for Health Care Workers, to address such a distinguished audience of bishops from all over the world, gathered here on the occasion of the meeting organised by the Pontifical Council for Health Care Workers.

To speak about cooperation between African countries and the Catholic Church in the field of health care and the contribution that the World Health Organisation could make to fostering State-Church partnerships is a challenge. In the space of time allotted to me, I would like, first and foremost, to highlight the main features of the health situation in Africa and their key determinants. *Second*, I will refer to the values and principles, the ethos, underpinning health systems ideology in both Church and State health-care facilities. *Third*, I will explore the complementarities of the sub-systems and outline their added value in improving health care delivery and health outcomes. *Fourth*, I will propose some approaches to improving dialogue and partnership between the health-care services of the Church and those of the State. Finally, I will suggest programmatic priority areas that you may wish to consider and the role that the WHO could play in the context of fostering State-Church partnerships and accelerating progress towards achieving national and internationally agreed health goals.

The Main Features of the Health Situation in Africa and their Key Determinants

The health-care systems are weak and the region still faces a very high burden of communicable and non-communicable diseases; high child and maternal mortality levels; recurrent epidemics; and humanitarian crises aggravated by factors such as climate change, the global financial crisis, and the food crisis. The majority of African countries are not on track to reach the 2015 targets for child health, maternal mortality reduction, and control of major diseases such as HIV/AIDS, tuberculosis and malaria. In addition, most of the countries will not achieve the other health-related Millennium Development Goals on improving access to water and sanitation and alleviating poverty and hunger. In spite of various constraints, tangible progress has been made by governments, communities and partners – amongst which the Catholic Church – in making concerted efforts to address the many development challenges facing the region, in particular those related to equity and sustainability. Time will not allow a more detailed description of these challenges today. I described them in some detail in the paper I gave last year at the twenty-fifth international conference organised here in the Vatican by the Pontifical Council for Health Care Workers.

The Values and Principles (the Ethos) Underpinning Health-care Systems

The ultimate goal of the health sectors of both the Church and the State is to achieve universal access to health care and improve the health of people. The Church's values and principles such as compassion, equity, solidarity and participation are also shared by States that have adopted the 'primary health care' approach to strengthening their health-care systems. The strong service ethos, concern for quality, and staff-patient relationships, which are the hallmarks of the Church's health-care services, are also at the core of the 'primary health care' strategy. It is, therefore, to be expected, logically, that the shared values and the theoretical underpinnings of the design of State and Church health-care services would facilitate complementarity at methodological and operational levels. In terms of social benefits, such partnerships should enhance synergies and leverage both the structural capacity of health-care systems and their ability to deliver quality health care.

About the Complementarities of the Two Sub-systems

The usual location of the Church's health-care facilities

***** This text was read on 23 November 2011 on the occasion of the meeting of bishops in charge of pastoral care in health organised in the Vatican City by the Pontifical Council for Health Care Workers.

– often in remote rural areas – and of State health-care services – often in metropolitan areas – provide opportunities for complementarity in health-care coverage. Likewise, the two sub-systems complement one another in terms of the extent of emphasis on curative or preventive health care. The approach adopted towards specialised care versus holistic care is another aspect that could be further explored. Moreover, the health workers' training facilities (e.g. for the training of nurses and auxiliary health personnel) run by the Church complement the State sector's effort to improve the size and mix of the national health workforce. Church and State services can also match one another in the area of health financing, in particular social protection measures that facilitate universal access to health care and protect the poor and vulnerable segments of the population against catastrophic health expenditure.

As regards the provision of medicines and vaccines, the different procurement and logistic systems could be better synchronised to reduce the cost of medicines to help prevent stock-outs, ensure the rational use of quality medicines, and apply common standards and norms of treatment.

Approaches to Improving Dialogue and Partnership

The dialogue should first commence at the highest level between representatives of the Church and of governments. It is to be expected that such discussions would enable exchange, the identification of common ground, and arrangements leading to formal agreements that would guide collaboration at the operational level.

There is a need to map *policy* and *structure* and *process* issues that could reflect the strengths or weaknesses of one side or the other. This mapping should also include an overview of the outcomes and results obtained by both sides. For example, policy issues could *first* appreciate the commonalities and differences in values, principles, perceptions, meanings and beliefs; *second*, analyse different perceptions and rationalities, including aspects related to civil law and ecclesiastic law; *third,* assess alternative conceptualisations and constructions; and, finally, build consensus and accommodate different views whenever possible.

There is no single methodology for developing State-Church partnerships. However, I am convinced that interpretive social science offers relevant epistemological grounds and tools that we could further explore to address in a more effective manner the complex and pluralistic nature of health-care systems.

Depending on each country's specific health context, the WHO could be a convener or just a facilitator of dialogue between governments and the Church. In this regard, it could foster partnerships in support of national health policies, strategic plans and their implementation. It is important to recall that every system of health care is purposeful and has a historical background. A health-care system exists within a political, social and economic context, and as the context keeps changing, so also does the health-care system, thereby adapting itself to new situations. Being subject to strong human control, health-care systems dynamics are inevitably influenced by philosophical, cultural and religious factors. All these are factors that have an impact upon the performance and outcomes of health services.

In my opinion, enhanced partnerships between the Church and the State not only would boost the structural capacity of national health-care systems but would also identify the parameters of the engagement, for example priority areas of intervention, and even address contentious issues such as methods relating to human reproduction and the prevention of HIV/AIDS.

Priority Programmatic Areas that could be Considered

Priority areas in which Church-State partnerships can be built in Africa are: *the strengthening of health systems* based on the primary health care approach, including human resources capacity building, health financing, and the provision of essential medicines and vaccines. Special attention should be given to boosting the numerical strength of community health workers, particularly in remote areas: this could help increase the coverage of routine immunisation and contribute to achieving the poliomyelitis eradication goal. Other key priorities include *maternal and child health*, in particular cost-effective and proven intervention to reduce the still-very-high levels of maternal and infant mortality. *HIV/AIDS*, *malaria and tuberculosis* are diseases that affect sub-Saharan Africa more than any other part of the world. The prevention and control of *non-communicable diseases, including mental health*, injuries and violence are emerging matters of concern. All these are priority areas that could be considered in the process of fostering State-Church partnerships in Africa.

What Could be the Role of the WHO?

The WHO's contribution in fostering State-Church partnerships could be envisaged in accordance with its core activity, namely: convening for better health; generating evidence on health trends and determinants; providing advice for norms and standards relating to health and development; coordinating health security; and strengthening health systems and institutions. For example, the WHO can convene multi-stakeholder platforms for dialogue on risk factors affecting public health, such as alcohol abuse, tobacco use, unhealthy foods, and behavioural risk-factors.

The WHO's advocacy role has been extended to health research and development institutions, including pharmaceutical companies, to promote the discovery of new tools and negotiate the price of medicines and vaccines to make them more accessible to people, particularly the poor. Just to mention a few examples.

In conclusion, the significant role of the Church with its long history of pastoral care in health in Africa could be leveraged through enhanced partnerships with States. The WHO is willing to contribute substantially to fostering such partnerships with the Catholic Church and other faith-based institutions with a view to strengthening health-care systems and improving the health and living conditions of people in Africa.

Distinguished members of the audience, I would like to express my modest recognition of the noble sacrificial role that bishops in charge of pastoral care play in health-care delivery, particularly for the underserved populations in Africa. May I use this opportunity to convey to you my best wishes of good health and success in your endeavours!

THE ORGANISATION OF PASTORAL CARE IN HEALTH IN THE CHURCH

1. General Character*

H.E. MSGR. JOSÉ L. REDRADO, OH
Secretary Emeritus of the Pontifical Council for Health Care Workers

TWO FUNDAMENTAL IDEAS

I. *Evangelising the health-care field: contents*
II. *The organisation of pastoral care in health: pastoral practice*

I. The Evangelisation of the Health-Care Field

1. Starting from the model of Jesus of Nazareth:

A) He proclaimed his evangelising project in the synagogue of Nazareth: 'The Spirit of the Lord is upon me, because he has anointed m to preach good news to the poor' (cf. Lk 4:18-19).

B) He corroborated this with his *works* (Mt 11:4-6); he used *words*: 'I will; be clean' (Mt 8:3). Also *gestures and silences*: he sees, he waits, he stays (Jn 8:1-11; 9:1 -40).

C) The Gospel tells us that Jesus went throughout Galilee *teaching and healing* every infirmity and suffering…People admired him and exclaimed: 'He has done all things well: he even makes the deaf hear and the dumb speak' (Mk 7:37

D) Jesus instituted a *team for pastoral care* and did not carry out his mission alone: he called the apostles (Lk 6:12-16; Mt 10:1-4), he taught them (Lk 11:1-3; Mk 4:1-20), and he sent them out (Mt 28:16-20; Lk 9:6; Mk 6:13).

The mandate of Christ takes shape in the health-care field in the following terms: 'And he called to him his twelve disciples and gave them authority over unclean spirits, to cast them out, and to heal every disease and every infirmity' (Mt 10:1).

2. The Church has received an explicit mandate from Christ: Go forth. Preach. Heal.

A) The Church *exists to evangelise*, to communicate the Good News; she continues the words and deeds of Jesus. To evangelise is the reason for her existence (Mt 28; *EN* 13,14).

B) Through the mandate of Christ, the sick as well are entrusted to the Church. This attention paid to *caring for the sick is inseparable from evangelisation*. The tradition itself of the Church teaches us that service to the sick is an integral part of her mission (cf. *Dolentium hominum*, 1). The Church searches for encounter with man, in particular on the way of suffering. 'Man becomes the way of the Church' (*Salvifici doloris*, 3). Care for the sick is an ecclesial '*diaconia*' (*LG*, 1).

C) *The care and concern of the Church for the sick*. After *Jesus and the apostles, the whole of the history of the Church is full of Good Samaritans*, men and women, saints and non-saints, but all of them saw on their life journeys the wounded, people in need of health, of attention, of welcome, of hospitality and of healing, and they helped them with a great deal of love. There has been an army of merciful people, starting in the early centuries of Christianity, beginning with synods and bishops, passing by way of the monastic Orders, and on to the great saints of charity of the sixteenth century – John of God, Camillus de Lellis, Vincent de Paul – and then on again to the nineteenth century when new men and women saints flourished, revivifying the flame of charity: Benito Menni, Don Guanella, Giuseppe B. Cottolengo, John Bosco, Luigi Orione, Teresa of Calcutta, John Paul II. 'The saints are the true bearers of light within history' (*Deus caritas est*, 40).

D) This care and concern for the sick which has been *great in its range* – today there are 20,000 Catholic health-care institutions in the world – and *great in its witness* and dedicated lives, has been emphasised in recent years. Pius XII *illumined medical science* with innumerable speeches which today are important points of reference. The Second Vatican Council, starting with its Message to the Sick, recommended both to bishops and to priests to have special care for the 'sick and the dying, visiting them and comforting them in the Lord' (*PO*, 6, 8; *LG*, 38). *Canon law* itself (Can. 529, par. 1) reminds parish priests of their duty to help the sick and the dying and to do this with generous charity.

E) *The Magisterium of Pope John Paul II*. The care and concern of the Church for the sick was very important in the Magisterium of John Paul II, both because of his numerous speeches at meetings with sick people and professionals of the medical world and because of his documents of great significance – the Code of Canon Law,

* This text was read on 23 November 2011 on the occasion of the meeting of bishops in charge of pastoral care in health organised in the Vatican City by the Pontifical Council for Health Care Workers.

the new Catechism, encyclical letters and apostolic exhortations. In all of these we find various passages which directly or indirectly allude to pastoral care in health. The review *Dolentium hominum*, the organ of our dicastery, brought these together and commented upon them in a number of editions (cf. *Dolentium hominum*, nn. 5, 11, 12, 17, 21, 23, 29, 32, 36, 41).

This care and concern of Pope John Paul II for the sick was marked by *three important dates* for pastoral care in health – three dates with three important documents: *11 February 1984*, the apostolic letter *Salvifici doloris* on the Christian meaning of humaan suffering; *11 February 1985*, the apostolic letter *Motu Proprio Dolentium hominum* by which he instituted the Pontifical Commission for Pastoral Assistance to Health Care Workers. With the reform of the Roman Curia (the apostolic constitution '*Pastor bonus*, 28 June 1988), this Commission became a Pontifical Council); and *13 May 1992*, the date which witnessed the creation of the World Day of the Sick (Letter of Pope John Paul II to Cardinal Angelini in which he indicated its establishment and purpose).

Starting with these dates, a movement was created that aimed at the animation of pastoral care in health in all the Churches. Bishops were appointed to be responsible for this area within bishops' conferences; national and diocesan commissions were created, as well as groups for animation; the Camillianum came into existence – an institute for pastoral care in health which awards licences and doctorates in the theology of pastoral care in health; national and diocesan centres were created for the formation of workers in the field of pastoral care for the sick: priests, men religious, women religious and lay people. Congresses, publications and other initiatives increased in number…The very celebration of the World Day of the Sick contributed in an effective way to this reawakening at the level of nations, dioceses, hospitals and parishes.

An important leap forward has taken place and a great deal has been achieved but much remains to be done. There will be an ongoing challenge to achieve a constant development of pastoral care in this field.

From John Paul II we inherited an exceptional heritage with his writings and visits to the sick but it was his life that struck the whole world, from the assassination attempt to his death, as an example of fortitude, vigour and love in suffering. For everyone he was a magnificent teaching chair.

F) *The Magisterium of Pope Benedict XVI*. This heritage was continued by Pope Benedict XVI. We can see this in a precise way in very many circumstances, whether they were the general audiences held on Wednesday or his various visits to Churches or the World Days of the Sick; the encyclicals *Deus caritas est*, *Spes salvi* and *Caritas in veritate*; or his visits to health-care centres: the Child Jesus Hospital in Rome, and hospitals in Spain – the Del Nens Hospital in Barcelona, on 6 November 2010, and the San José Hospital, Madrid, on 20 August 2011.

II. ORGANISATION: PASTORAL PRACTICE

1. General observations

I wanted to strengthen this second idea – that of 'organisation' – which I will now address in a brief way, with my previous observations, calling attention to the preaching of Jesus about sick people and his style towards them, and how starting with him and then following the apostles, the Church has always been sensitive to sick people and with loving care and concern has written a great history of love which has been emphasised at certain points by the great men and women saints of charity through the example of their lives and the heritage of their institutions at the service of sick people. We thus came to a privileged stage for pastoral care in health with the figure of John Paul II, his life, and the works that he bequeathed to us, in particular the institution of a dicastery whose purpose is *animation* and which now has a – brief but fertile – history behind it of twenty-five years' duration because in the whole of the Church there has been a strong reawakening as regards pastoral care in health, a singular movement offered to the Pontifical Council. The past is past and now we have to continue along our path; the future still has to be built and this will not be easy: it will be demanding because the health-care panorama is complex and changing. A great deal of courage, a great deal of enthusiasm, many great and practical ideas, a great deal of mediation, and a great deal of organisation and animation will be necessary.

The local Churches are walking forwards; some more than others, some less than others. But thought is being engaged in and one notices that pastoral care in health is more alive, more organised, and there is a greater tendency to be more present and to train pastoral workers who will motivate and accompany sick people and health-care professionals. In relation to this idea, the Pontifical Council has its own room for action and it has the responsibility to engage in animation and to help bishops' conferences. This is very important and at times decisive because one is dealing here with extending animation, encouraging above all the *animators* of bishops' conferences, that is to say you: bishops who are responsible for pastoral care in health in your respective nations. For the Pontifical Council you are our right hand. Without you, the animation of pastoral care in health would be incomplete. For this reason, we encourage you to embrace, in a serious way, the task, the missions, that your bishops' conference assign to you when it comes to pastoral care for sick people.

All of the doctrinal riches of the Church in this field must be translated into pastoral organisation at a national, diocesan, hospital and parish level so that pastoral care in this field of health multiplies, reaches all sectors, and is implemented in an effective way.

A magic model does not exist. All this will depend upon many circumstances: culture, contexts, dioceses, parishes, health-care institutions, the availability of peo-

ple, training, vocation, creativity…but nobody can deny the need for basic organisation; no agent of pastoral care should think and evangelise alone – he should do this in a group.

Pastoral activity requires pathways that give it greater breadth, efficacy and permanence. These pathways are called by us pastoral structures for the carrying out of Mission; they are functional, necessary – some of them have to be – and contingent, because all of them are interchangeable, they are not an end in themselves, they must serve life and be renewed with it.

In order to facilitate and make effective our work I will make a number of suggestions that may be applicable and practical.

2. The criteria that a bishop must take into account

A) *What he must be*: a Teacher, a Liturgist, a Pastor (cf. *LG*, 20, 25, 26 and *CD*, 11) An '*example* for the believers in your speech, your conduct, your love, faith, and purity'(I Tim 4:12); 'they should care in particular for the sick and the dying, visiting them and comforting them in the Lord' (*PO*, 6, 8; *LG*, 38); a bishop is an '*innkeeper*' to whom a sick person is given so that he can take care of him.

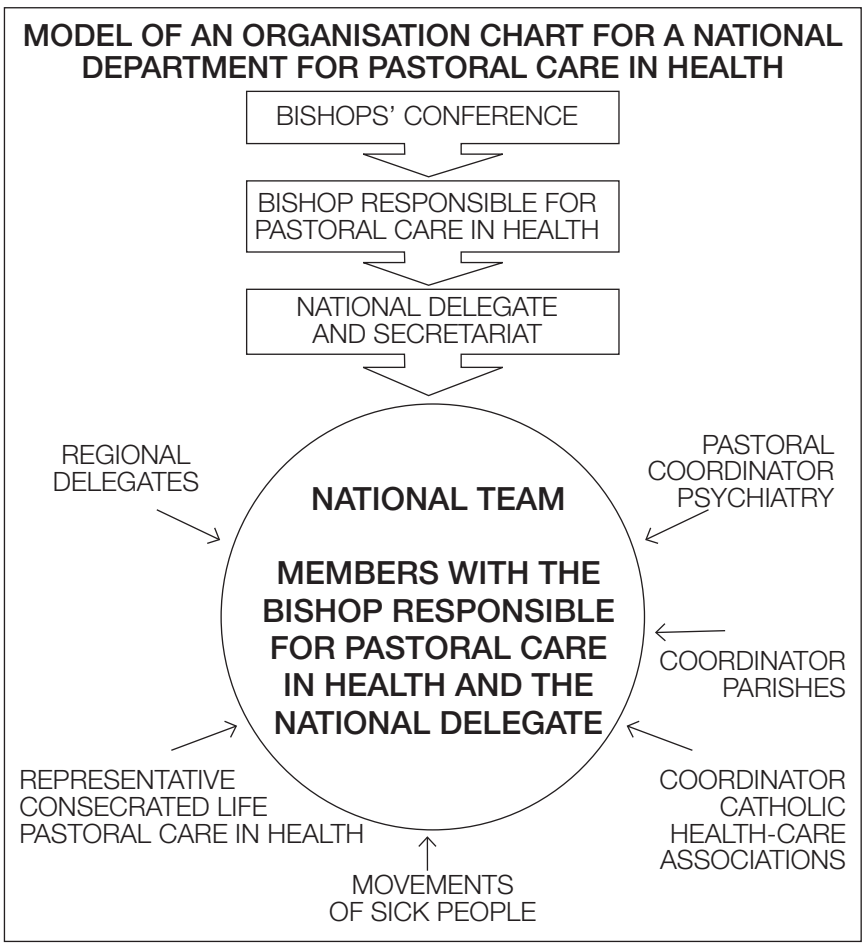
When commenting on the parable of the Good Samaritan, St. Charles Borromeo pointed out the obligation that a bishop has towards sick people and if he is a successor of the Apostles the Lord sends him out to preach and to heal. For this reason, a bishop is the first person to be responsible for pastoral care in health and comes before those religious institutions that engage in service to the sick.

B) *What he has to do*. He has to '*create a community*' that is sensitive to sick people so as to achieve complete care for them; '*illumine*' the complex world of health care – the subjects of life, of health, of illness and of death; '*accompany*' both patients and their family relatives and health-care professionals; and '*create, give an impulse to, and organise*' the diocesan delegation for pastoral care in health.

C) *In 'particular'*, a bishop responsible for pastoral care in health within a bishops' conference *must be*: a *memory* who remembers and continually revivifies this commitment with the bishops' conference, and this must be a commitment of each bishop in his Church of the bishops' conference as such; a *stimulus* that helps bishops to discover new fields for this form of pastoral care; he must present new experiences of other places, support bishops in exploring this task, and help them to review this pastoral activity (cf. Javier Osés, in *Dolentium hominum*, n. 38/1988); and *a bond of union* between the Pontifical Council and his bishops' conference. To this end, mutual knowledge and a reciprocal relationship must be established which helps both parties. It should help the Pontifical Council to have more direct knowledge of the activities of the bishops' conference as regards the world of sick people, and it should help the bishop responsible for pastoral care in health to know about the objectives and the activities of the Pontifical Council and other bishops' conferences.

3. Concrete actions of the bishop responsible for pastoral care in health

Creating a department or a secretariat at a national level; appointing a national director or secretary; forming a national team and planning activities at a national level; encouraging dioceses to create a diocesan secretariat; promoting the training of workers in pastoral care in health; promoting Catholic health-care associations; studying the presence and the working of pastoral service in health-care institutions; preparing and celebrating the World Day of the Sick; paying attention to national legislation that attacks health and its repercussions for pastoral care and ethics; sending to the Pontifical Council an annual report on the development of pastoral care in health at a national level; drawing up a five-year report for the '*ad limina* visit' and during that event visiting the Pontifical Council; and stimulating participation in congresses or study meetings that are organised by the Pontifical Council. ■



2. The Organisation of Pastoral Care in Health in Argentina*

H.E. MSGR. LUIS TEODORICO STÖCKLER
Bishop Emeritus of Quilmes, Argentina

1. ARGENTINA: the Episcopal Commission for Pastoral Care in Health

In 1991, the Bishops' Conference of Argentina established the Episcopal Commission for Pastoral Care in Health. It is made up of at least three bishops, one of whom is its chairman, and by a priest who acts as its executive secretary. The chairman of this commission is H.E. Msgr. Luis Teodorico Stöckler, the Bishop Emeritus of Quilmes. Its members are H.E. Msgr. Fabriciano Sigampa, the Archbishop of Resistencia; H.E Msgr. Pedro María, the Bishop Prelate of Humahuaca; and H.E. Msgr. Horacio Benites Astoul, the Auxiliary Bishop of Buenos Aires. The executive secretary is Fr. Andrés Tello Cornejo.

In 2006, this Episcopal Commission created the Pastoral Care Support Team and this team is made up of the regional delegates for pastoral care in health.

2. Pastoral and Spiritual Care for the Sick

In Argentina, pastoral care in health is provided in state and private hospitals, in nursing homes and geriatric centres, in medium-term admission centres, in hospices (centres for the terminally ill), and in family homes.

Many hospitals and nursing homes can rely upon assistance provided by a chaplain who is appointed by the diocesan bishop and by women religious who live in these centres.

In dioceses where there are not enough priests, it is the members of parishes who deal with this kind of pastoral care. They also assist patients who have been admitted to geriatric centres and also help sick people in their own homes.

In Argentina there are various health-care centres that belong to the Church: the St. Camillus Nursing Home (Buenos Aires); the Mater Dei Nursing Home (Buenos Aires); and the Austral Hospital (Del Viso, the Province of Buenos Aires).

There are also houses of charity, Congregations and private associations of faithful for sick people who have been discharged from hospital. These are: the Casa Belén (Buenos Aires); the Casa Efetá (Buenos Aires); the Casa la Posada (for men with HIV-AIDS) (San Miguel, the Province of Buenos Aires); the Casa La Posada (for women with HIV-AIDS) (José C. Paz, the Province of Buenos Aires); the House of the Missionary Sisters of Charity (for men with HIV-AIDS) in Benavidez (the Province of Buenos Aires), in Zárate, for men (the Province of Buenos Aires), and in Mar del Plata, for women (the Province of Buenos Aires).

In addition, for some time hospices have been created to provide care to the terminally ill, who for the most part are cancer patients: the St. Camillus Hospice (Martinez, the Province of Buenos Aires) and the Mother Teresa of Calcutta Hospice (Luján, the Province of Buenos Aires).

Many geriatric centres also exist that belong to religious Congregations and provide care and assistance to elderly people.

3. The Pastoral Accompanying of Health-Care Workers. Moral and Spiritual Formation

In Argentina, a specific form of pastoral care for health-care workers does not exist, but the participation of these workers in 'pastoral care in health meetings' is envisaged. These meetings are organised by various dioceses or regions. Health-care workers are invited to take part in them and medical doctors, nurses and other health-care workers give papers at these meetings and make their contributions.

These meetings, which are organised together with the Episcopal Commission for Pastoral Care in Health, have the purpose of providing pastoral, bioethical and spiritual formation imparted in the communion of a fraternal meeting.

In Argentina there are various organisations that take part in the life of the Church and are addressed in particular to health-care workers:

1. 'The Network of Health-Care Workers' which is under the Department for the Laity (DEPLAI) of the Bishops' Conference of Argentina. This network, to which health-care workers belong, has as its goal the exchange of services between all the participants in order to be able in this way to overcome the interminable waiting times that people experience for visits, examinations, etc. This network periodically holds meetings during which criteria for work and for formation in the spiritual and bioethical field are shared by those taking part.

* This text was read on 23 November 2011 on the occasion of the meeting of bishops in charge of pastoral care in health organised in the Vatican City by the Pontifical Council for Health Care Workers.

2. Professional associations. These associations are for, and are made up of, health-care workers who meet to share their experiences in the spiritual field and offer formation in the spiritual and bioethical field.

3. Networks for pastoral accompanying in the field of mental health. In various dioceses networks of health-care workers active in the field of mental health (psychiatrists, psychologists, psychotherapists) have been created, in the majority of cases under the guidance of a priest, to accompany people who come to parishes because they need psychotherapeutic assistance in line with Christian values which they do not find in public/private care or because they encounter delays in the public health-care system.

3. Associations of Professionals and Volunteers

As I have already observed, these associations that bring together health-care workers who work in the same fields deal with the spiritual and bioethical formation of their members, organise annual spiritual retreats, and celebrate the day dedicated to their profession with a Holy Mass.

In controversial cases that bear upon the public interest, they express the thought of the Catholic Church with declarations that are disseminated in the mass media.

Belonging to these associations we may cite the 'Consortium of Catholic Physicians', the 'Association of Catholic Women Nurses', the 'Consortium of Catholic Psychologists', and the 'Consortium of Catholic Dentists'.

Many of the volunteers who visit sick people belong to parish groups dedicated to pastoral care in health. In Argentina, however, they also come together in organisations. Amongst these we may cite the 'Volunteers of Caritas', the 'Women Volunteers of Mary' (of the Apostolate of Schoenstatt), the 'Volunteers of St. Vincent de Pail', and the 'Volunteers of St. Francis'.

Emphasis should be laid upon the 'priest emergency service' which is present in sixteen dioceses and can rely upon the presence of a priest and one of two lay people, from nine o'clock in the evening until six o'clock in the morning, to minister the sacraments during the night, principally to people who are dying.

In the majority of the dioceses these 'priest emergency services' have existed for more than twenty-five years. They have their own statutes, a governing committee, and a priest who acts as a consultant with the approval of the diocesan bishop.

There is also a 'National Federation of Priest Emergency Services' whose statutes, governing committee and ecclesiastical consultant are appointed with the approval of the Episcopal Commission for Pastoral Care in Health of the Bishops' Conference of Argentina.

This Federation holds its annual assembly every November and the members of the various governing committees take part in this assembly. Pastoral experiences and challenges, moments of prayer and theological and bioethical formation are shared in a meeting of a fraternal character.

4. Catholic Chaplains

In dioceses that have a larger number of religious, hospitals and nursing homes can have a Catholic chaplain who is appointed by the diocesan bishop. For the most part, these priests dedicate themselves exclusively to pastoral care and in addition they are nominated by the state or by a private health-care institution.

Special reference here may be made to the Archdiocese of Buenos Aires which has forty-five chaplains who meet every Thursday of the month to share ongoing formation, shared criteria for pastoral care, and fraternal communion.

In the year 1998 the 'National Fraternity of Catholic Chaplains of Hospitals and Care Centres' was established. Its statutes, which were approved by the Bishops' Conference of Argentina and the relevant state authorities can be renewed every three years. This Fraternity operates according to a mandate approved by the Episcopal Commission for Pastoral Care in Health.

The mission of this Fraternity is to bring chaplains together and to engage in their ongoing formation. It aims, in particular, at the participation of those chaplains who belong to dioceses where few priests engage in this form of pastoral care and are unable to share with other chaplains this priestly mission.

5. Private Catholic Health-Care Institutions

In Argentina there are not very many Catholic nursing homes and health-care institutions. They are to be found above all else in the Archdiocese of Buenos Aires and its supporting dioceses: the St. Camillus Nursing Home (Daughters of St. Camillus), Buenos Aires; the Mater Dei Nursing Home (Schöenstad), Buenos Aires; the San José Nursing Home (Club of Catholic Workers), Buenos Aires; the Austral Hospital (Opus Dei), Del Viso, the Province of Buenos Aires; the Cottolengo di Don Orione – Temperley, the Province of Buenos Aires; the Cottolengo di Don Orione, San Miguel, the Province di Buenos Aires; and the Casa Bagués (St. Camillus), Bagués, the Province of Buenos Aires.

Catholic nursing homes and hospitals have not created a network but they defend the need for health-care workers to have the right to conscientious objection and for these institutions to have the right to conscientious objection in the face of the advance of new regulations and laws that have the tendency to include in the 'Obligatory Medical Programme' practices that belong to 'Programmes for Sexual and Reproductive Health' and others which at the present time are being studied, such as the 'Projects for Laws for a Worthy Death', the 'Project for Law for Abortion that in not Punishable', and the 'Project for Law for Abortion'.

Another challenge as regards evangelisation is pastoral care and formation for the consciences of health-care workers and prior-

ity spiritual care for sick people and their family relatives.

6. Bioethical Committees

The majority of public hospitals and many private hospitals have a clinical bioethics committee which in some cases is distinct from the ethical committee for clinical research.

Catholic chaplains are invited to take part in these committees inasmuch as their presence is qualified by their theological, philosophical and bioethical formation, as well as by the pastoral work that they perform in their hospitals.

The bioethical committees of Catholic nursing homes and hospitals adhere to 'ontologically founded personalist bioethics'; the recommendations of the Pontifical Academy for Life; and the Magisterium of the Church.

At the level of public hospitals, in the city of Buenos Aires a network of bioethical committees exists. This is not the case, however, as regards private nursing homes and hospitals.

The Institute of Bioethics of the Catholic University of Argentina organises courses and master's degrees in bioethics, and health-care workers, lawyers and priests take part in them in large numbers.

This Institute also organises the International Congress of Bioethics to which Catholic hospitals and nursing homes are invited as members of the audience and also as speakers.

In Latin America a 'Latin American Network of Bioethics' exists. It has a strong expression of '*Principialista*' thought and the 'bioethics of human rights'

7. Challenges and Future Prospects

A. Pastoral care for the sick

The ongoing challenges are two in number: ongoing formation and the involvement of new chaplains. Over recent years the number of pastoral workers who visit the sick has decreased. This is a form of pastoral care where more people, and more younger people, should be involved.

Another challenge is to ensure that in the various dioceses of the country pastoral care in health also involves ministers of the Eucharist.

B. Health-care workers

Pastoral and spiritual care for health-care workers is a constant challenge, even though the greatest challenge is the formation of their consciences in line with the humanisation of health, respect for the dignity of a sick person, and the practice of their profession in line with bioethical principles.

C. Professional associations

One goal is the formation of a network of associations in order to share the challenges of the profession in line with the bioethical principles of the Church.

Another goal that should be achieved is the evangelisation of professionals by each other and their evangelisation of their patients. We have often noticed that a professional attends to his or her own spiritual life but does not have the goal of evangelisation in the context of the health-care institution in which he or she works.

D. Voluntary work

At the present time a strong need exists to create large-scale pastoral care for vocations so as to generate amongst lay people, in particular young people and adult men, vocations at the service of sick people

Another task is the ongoing formation of people who engage in the provision of pastoral care.

F. Catholic chaplains

Another great challenge is to ensure that everyone in hospitals and nursing homes can count upon the presence of a Catholic chaplain. However, the lack of priests in many dioceses makes it difficult to meet this need.

As a Church, efforts are currently being made to achieve the formation of seminarians in hospital pastoral care so that when they are ordained they can have a grounding that will enable them to work in this field of pastoral care.

Another challenge is the ongoing training in the pastoral, bioethical and spiritual fields of priests in hospitals.

Yet another challenge is the formation of volunteers by chaplains in hospitals.

G. Bioethical committees

Another challenge in this field is the establishment of a network of bioethical committees in Catholic hospitals and nursing homes and the formation of professional workers in the institutions where they work.

Another great objective to be achieved is ensuring that Catholic health-care workers can belong to the bioethical committees of public hospitals.

E. Other challenges

At the present time in Argentina a debate is underway about certain regulations and parliamentary Bills that may constitute an attack on the dignity of life. We may refer, for example, to the following topics and issues: 'abortion that is not punishable', 'abortion', 'assisted and artificial fertilisation', 'biomedical research', 'gender identity', and a 'worthy death'. To what extent as a Church can we ensure that legislators are aware of respect for the dignity of life when it comes to these regulations and parliamentary Bills?

Another challenge, in relation to poverty, is the lack of access to health-care systems that is experienced by many people, that is to say social exclusion. As a Church we ask ourselves in what way we can influence public policies that bear upon health and health care.

3. Pastoral Care in Health in North America*

H.E. MSGR. KEVIN C. RHOADES
Bishop of Fort Wayne-South Bend, USA

Thank you for the opportunity to participate in this Round Table and to share the organization of pastoral care in health in the Church in North America.

I speak as the Chair of the Task Force on Health Care of the United States Conference of Catholic Bishops, a group of bishops of our Episcopal Conference which, for the past three years, has had the responsibility of coordinating the activities of the Conference as they are carried out by the various committees that have health care in their mandates. Members of our task force include bishop representatives from the Committees on Doctrine, Domestic Justice and Human Development, Pro-Life Activities, and Canonical Affairs, since health care issues and concerns arise within each of these respective areas. The task force includes consultants from the National Catholic Bioethics Center, the Catholic Health Association, the National Catholic Partnership on Disabilities, and the Catholic Medical Association. Just last week, our Episcopal Conference decided that the Task Force will now become a permanent subcommittee under the Committee on Doctrine since much of our work has focused on moral and ethical concerns in health care. The new subcommittee, like the Task Force, will include bishop representatives from the other above-mentioned committees since domestic justice, pro-life, and canonical issues continue to arise in the area of health care.

One in six hospitalized patients in the United States is cared for in a Catholic health care facility. In fact, there are 636 Catholic hospitals in the United States, almost 13% of the total number of hospitals in the nation. In addition, there are over 1400 other Catholic health care facilities in the United States, including nursing homes and other long-term care institutions. The Catholic health ministry is the largest group of non-profit health care providers in the nation. In Canada, Catholic health care is comprised of approximately 100 hospitals, long-term care facilities, nursing homes and community health centers. This is a significant component of the overall health care system in Canada.

A large majority of Catholic health care facilities in the United States are members of the Catholic Health Association of the United States. Its sister organization in Canada is the Catholic Health Alliance. These associations bring together leaders in Catholic health care to share ideas, to work collectively on issues, and to advocate for the values and priorities of the Church in the public square. They provide consultation services, educational programs, publication and Web-based tools addressing strategic areas of mission, ethics, leadership formation, sponsorship, and advocacy. Bishops often write in CHA journals. The president of the Catholic Health Association is a consultant to the USCCB Task Force on Health Care. The Episcopal Conference also has a Bishop who serves as the liaison between the Conference and the Catholic Health Association. In Canada, a bishop, appointed by the Canadian Conference of Catholic Bishops, serves as a member of the Governing Council of the Catholic Health Alliance.

All Catholic health care facilities in the United States are guided by the *Ethical and Religious Directives for Catholic Health Care Services* of the United States Conference of Catholic Bishops. These Directives affirm "the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person" and "provide authoritative guidance on certain moral issues that face Catholic health care today." "The directives promote and protect the truths of the Catholic faith as those truths are brought to bear on concrete issues in health care" (*Preamble of Ethical and Religious Directives*). The Directives are organized in six parts: the Social Responsibility of Catholic Health Care Services; the Pastoral and Spiritual Responsibility of Catholic Health Care; the Professional-Patient Relationship; Issues in Care for the Beginning of Life; Issues in Care for the Seriously Ill and Dying; and Forming New Partnerships with Health Care Organizations and Providers. Through these directives, the Bishops exercise their teaching and governing role in relation to Catholic health care institutions and services.

Similar in importance to the *Ethical and Religious Directives* in the United States is the *Health Ethics Guide* in Canada. It is used by all Catholic health care organizations in Canada. The *Health Ethics Guide* is developed by the Catholic Health Alliance of Canada, in collaboration with the Canadian Episcopal Conference. The Canadian Episcopal Conference reviews the *Guide* and issues the *nihil obstat* and *imprimatur.* There is a close working relationship between the Alliance and the Commission for Doctrine of the Canadian Conference of Catholic Bishops.

The *Ethical and Religious Directives* in the United States and the *Health Ethics Guide* in Cana-

* This text was read on 23 November 2011 on the occasion of the meeting of bishops in charge of pastoral care in health organised in the Vatican City by the Pontifical Council for Health Care Workers.

da both provide direction concerning the spiritual and pastoral care of patients or residents in Catholic health care facilities. Pastoral care is considered integral to the mission of Catholic health care and the ministry of healing.

Bishops also have the duty of ensuring spiritual and pastoral care for Catholics in non-Catholic health care facilities. In the United States, the National Association of Catholic Chaplains is an organization that educates, certifies, and supports chaplains and pastoral health care workers in health care ministry in the United States. This association has an Episcopal Advisory Council comprised of bishops representing each of the regions of the United States Conference of Catholic Bishops. It also has a bishop who serves as the official episcopal liaison between the USCCB and the National Association of Catholic chaplains. In the past twenty years in the United States, we have seen a large increase in the number of lay people serving as pastoral health care workers. In fact, today nearly half of the members of the National Association of Catholic Chaplains are lay men and women. These lay ecclesial health care ministers must be formally approved and endorsed by their respective bishops. They are trained for this ministry and must adhere to the *Ethical and Religious Directives* of the USCCB. Though there is not an association of Catholic chaplains in Canada, the Catholic Health Alliance of Canada works closely with the Canadian Association for Spiritual Care, a multifaith organization responsible for the professional education, certification and support of people engaged in pastoral care.

The increase of lay ecclesial ministry has not lessened or diminished the importance of the priests' ministry in health care. In the United States and Canada, there are still hundreds of priests who serve as chaplains in health care facilities. Pastors are also responsible for the spiritual and pastoral care of their parishioners who are hospitalized, homebound, or living in long-term care facilities. Most parishes have well-organized health care ministry which includes sacramental care by the priests, especially the Anointing of the Sick, as well as the bringing of Holy Communion to the sick and homebound by priests, deacons, and extraordinary ministers of Holy Communion. In a growing number of parishes in the United States and Canada, the development of "parish nursing" is also an important dimension of the health and healing ministry within the parish. Many dioceses provide continuing formation for health care chaplains and pastoral workers through diocesan associations.

The pastoral care of health care workers, including their moral and spiritual formation, takes place in a variety of ways in North America. In the United States and Canada, there is an organization of Catholic physicians, the Catholic Medical Association, which supports physicians, nurses, and other health care workers in their personal spiritual and professional lives. This association, with local guilds throughout the United States and Canada, assists Catholic physicians and others health care professionals in "upholding the principles of the Catholic faith in the science and practice of medicine." Many of the guilds sponsor seminars, retreats, and annual Masses. The Catholic Medical Association also hosts an annual educational conference and publishes an official journal dedicated to medical ethics.

The Church in North America faces many challenges as we look to the future. These challenges arise from the increasing secularism of society. The Church and Catholic health care ministry continues to witness to the sanctity of life from the moment of conception until natural death in a culture where there has been an erosion in the past several decades of respect for the life of the unborn and increasing threats to the life and dignity of the terminally ill and dying. The Church in North America is a strong voice in promoting and defending the sacredness of all human life and also in seeking conscience protection for Catholic health care in the face of growing threats to our religious liberty, our freedom to provide health care in conformity with the Church's moral teaching.

The Church has also been a strong advocate in society for the right to quality, affordable and accessible health care for all people, especially the poor, the uninsured and underinsured, immigrants, and other vulnerable populations. In the midst of heated and often very contentious political debate in the United States concerning health care policy, the Church has been consistent in its defense of the sanctity of life and for a just health care system that works for everyone. Internally, the Church continues to face the challenge of maintaining Catholic health care in a challenging economic environment. Partnerships with non-Catholic health care institutions and services have become necessary in many places. Besides economic benefits from such partnerships, we have also seen the benefit of non-Catholic hospitals ceasing to do abortions and other immoral practices that are prohibited if they partner with a Catholic hospital. At the same time, these partnerships can present significant challenges for preserving the Catholic identity of our Catholic health care institutions and services and in ensuring that no illicit cooperation with evil results. This is an area that requires ongoing vigilance to ensure that such partnerships preserve the required adherence to the *Ethical and Religious Directives* of the United States Conference of Catholic Bishops.

Thank you for your attention. ■

4. The Organisation of Pastoral Care in Health in Burkina Faso*

H.E. MSGR. JUSTIN KIENTEGA
Bishop of Ouahigouya and Bishop Responsible for Pastoral Care in Health in Burkina Faso

Introduction

The indicators of health-care policies demonstrate that sub-Saharan African countries are experiencing grave problems. The lamentations of the psalmist seem to be on the lips of our sick people: 'From whence does my help come?' (Psalm 121:1).

Very quickly, by vocation and by mission, the Family-Church of Burkina-Niger became involved because it was a question of Man. Indeed, the arrival of the Missionaries of Africa (the White Fathers) witnessed the birth of the first health-care services and schools. They integrated social promotion with overall pastoral care. The evangelisers tried more to save in human, social and religious terms than to form communities or found a Church.[1]

In this short paper, I wish simply to answer the following question: what kind of organisation has the the Family-Church of God of Burkina instituted to meet the health-care needs of the men and women of this country?

1. The Reality in the Field

Following the wishes of the bishops, in the year 2002 an episcopal commission was instituted with the goal of coordinating activity in this field: training personnel, improving the quality of services, and above all assuring witness to Christian faith through care for the sick. Four sub-committees were then created:

The sub-committee on Catholic private health-care institutions

The Catholic Church manages ninety-six health-care institutions distributed amongst the thirteen dioceses of the country. These are brought together in an association ('The Association of Catholic Private Health-Care institutions of Burkina Faso') which is recognised by the state. These health-care institutions are in the poorest regions of the country.

The typology of Catholic health-care institutions varies: places for primary care and treatment, centres for nutritional assistance to children, medical centres with an operating theatre, centres for rehabilitation for people with handicaps, orphanages, centres for medical products, and admission centres for people in need and people with AIDS.

In the table that follows, we find the distribution of these institutions by diocese and typology:

908 people work in these centres, of whom 107 are men or women religious and priests (12% are consecrated people). Every month about 53,000 patients pass through these institutions and this corresponds to about 640,000 sick people every year, that is to say 7% of the total population of Burkina Faso.

The sub-committee for hospital chaplaincies for multiform assistance to the sick.

Most of the dioceses have committed themselves to appointing chaplains for spiritual assistance to the sick and for the accompanying of family relatives and health-care personnel. Faced with the challenge of the formation of chaplains, we implemented a system of formation by correspondence. Given the distances and a lack of financial resources on the part of the episcopal commission that we animate, the secretary of this subcommittee draws up and sends out the formation modules and at the end of the year we assess the level of learning of their contents.

	Cma	Cm	Csps	Cren	Handic.	Orph.	Depôt	Acc.	Opht.	Total
Ouaga	1	1	10		1	1	1	3		18
Manga				1			1			2
Koudoug.	1		4	10	1		1			17
Ouahig.		1	1							2
Koupela		1			4	1			1	7
Fada		1	2	2	2		2			9
Dori					1					1
Kaya			1	3	1		1			6
Dedoug.			1	3	1					5
Nouna			1		2		1		1	5
Bobo			3		3		3			9
Banfora					1			1		2
Diebougou			1	2	4	1	5			13
Total	2	4	24	21	21	3	15	4	2	96

* This text was read on 23 November 2011 on the occasion of the meeting of bishops in charge of pastoral care in health organised in the Vatican City by the Pontifical Council for Health Care Workers.

The Catholic sub-committee for the fight against AIDS

This sub-committee is very well organised from the national level to the grassroots of the parishes and basic Church communities. It is animated by the Catholic National Committee for the Fight against AIDS (CNCLS). It is this association that organises and animates through its various branches the International Day for the Fight against AIDS of 1 December of every year.

At the present time it is a member of the Union of Religious and Village Chiefs of Burkina Faso (URCB) which works for the taking of responsibility for AIDS patients and for the fight against tuberculosis and against malaria. The Catholic Church, like other religious confessions (Muslims, Protestants, and village chiefs), has its representatives at the level of national and regional coordination of the administration of Burkina Faso. As a partner of the state, the Union receives part of the funds of the World Fund for the Fight against AIDS, tuberculosis and malaria.

The ethical sub-committee

This was created thanks to the efforts of Professor Jacques Simpore MI, a Camillian religious, and it organises congresses on subjects of sensitisation linked to the challenges posed by the ethical problems of the society of Burkina Faso. It is now at its second congress (this took place on 4-6 October 2007) and produces articles to ensure that the general public becomes increasingly aware of what is at stake in an ethical sense and to communicate to it the vision of the Catholic Church.

The women religious in the health-care service have their own organisation (the Fraternity of Professional Health-Care Women Religious of Burkina Faso: FREPSAB) which functions rather well at a national regional and diocesan level. It seeks to promote formation and the sharing of experiences between its members.

One organisation that has begun slowly is that of Catholic medical doctors and pharmacists. A conference that took place in 2008 laid the foundations and provoked great interest amongst those taking part. We hope that its creation at a diocesan and national level will be a force for witness for Christian personnel who provide care and treatment.

On the occasion of the celebration of the seventy-fifth anniversary of evangelisation, the bishops wanted to encourage the missionary role of lay people, helping them to organise themselves in a better way.[2] This appeal found a favourable echo at a health-care level. Indeed, to such an extent that we witnessed the birth of a certain number of associations of a social-health-care character which have channelled the missionary zeal of many Christians: the Legion of Mary, the CPAM (Parish Councils for the Accompanying of the Sick), the Friends of the Sick, the Torch of Charity, the Toby Association, and so forth. They cooperate with hospital chaplaincies and health-care institutions in visiting the sick both in their homes and in health-care institutions.

2. The Challenges

We are aware that nowadays we are called to take other organisational steps and steps connected with formation if we want the Word of Christ, the Physician of Souls and Bodies, to be expressed in the Family-Church of Burkina-Niger: 'I came so that they may have life, and life in abundance (Jn 10:10).

In this area we are happy that Pope Benedict XVI, during his first voyage in Africa on 17-21 March 2009, found the right words to ask us to deal with the question of health care. Indeed, when praising the work of the Church, the Pope hoped that her action would be even more visible in education in basic health.[3]

This means that as regards the organisation of pastoral care in health-care services, Burkina Faso has important challenges that it has to address. I would like to refer briefly to five of these challenges:

The first challenge: pastoral care in health and the cultural realities of the country

Despite some defects, health in Burkina Faso has some notable aspects in terms of treatment and care for patients.[4] For this reason, people should not stop at the services that are provided because the social-health-care services offered by the Church do not aim only at achieving a practical objective – people should also try to change their mentality about health, suffering, life and death. The question of the choice between modern medicine and traditional pharmacopeia relegates modern medicine to a secondary level.

The second challenge: pastoral care in health that is attentive to the signs of the times

It is the poor classes of society that go to our health-care institutions. This requires us to offer high-quality health care to poor people, asking from them a modest contribution without forgetting the difficulties that some of them encounter in paying for the costs of a consultation or a biomedical examination. Thus AIDS continues to create poor people, orphans, widows, and abandoned people. Institutions for the treatment of the mentally ill are absent in a crucial way.

The words of St. Paul could echo this challenge: 'For the Spirit that God has given us does not make us timid; instead his Spirit fills us with power, love and self-control' (2 Tim 1:7).

The third challenge: cooperation with the state

Considering, on the one hand, that the mission of the Church is to be at the service of man and of every man, and, on the other, given the pioneering role of the Church in the supply of health treatment in our country, the state accepts that it should support the activity of the Church and assigns its workers to Catholic health-care institutions and also assures that they are paid for.

Pope John Paul observed that: 'Catholic social works…are not a mere substitution for provisional failings of the state, nor even less are they competition for it – they are an original and creative expression of the fertility of Christian love'.[5] In practice, the road to follow today to achieve this goal still has numerous difficulties: conflicts

at the level of medical ethics; conflicts at the level of the application of the agreements that some religious institutes have with the state; conflicts in the formation of our workers in state medical schools; the role of the workers assigned by the state to our health-care institutions, according to our vision of the sick person and his or her service in abnegation, etc.

The fourth challenge: the lack of adequate formation in pastoral care in health

One should doubt the success of any form of pastoral care when the formation of the people of Christ and its leaders is marked by shortcomings.[6] For this reason, we count on meeting this failing through the centre for formation of the Camillian Fathers of Ouagadougou. We praise the efforts of dioceses that have already sent, or are about to send, priests to obtain a specialisation in the theology of pastoral care in health at the Camillianum of Rome.

The fifth challenge: pastoral care in health and economic realities

We may note first of all that the economic challenges are immense. The poverty of the States of sub-Saharan Africa, to which Burkina Faso belongs; the difficulties that are encountered in maintaining the existing institutions, in particular when it comes to the buildings; the difficulties that are encountered as regards payment at the level of Catholic health-care institutions whose employees are lay people; the high cost of work material; the lack of Western benefactors; and the decreased generosity of NGOs and international organisations are all serious economic challenges. We thus need to rediscover a financial equilibrium at the level of Catholic health-care institutions in order to be able to finance ourselves, because, as a proverb of the savannah says, 'he who is lying on the carpet of someone else is lying on the ground'.

Conclusion

Our young Church of Burkina Faso, which received the Good News of the Gospel in the nineteenth century, has known how to read the signs of the times to respond to the health need of the population ever since the arrival of the first missionaries. She has always been aware of the fact that multiple ways have to be created and that efforts have to be made beyond those that I have discussed in this paper. The Church of Burkina Faso could not do this if she could not rely upon each one of her sons and daughters and lacked the support of people or institutions of good will. The framework of consultation in which we live today will open up for us new and fruitful pathways for our mission of compassion. We thank the Pontifical Council for this fine initiative and we hope that there will be others so that, both pastor and flock, we can be a Church that receives the life of her Teacher and Physician to the utmost in order to offer it in abundance. ■

Notes

[1] A. Sanon, *Préface*, E. Sandwidé, C., *Histoire de l'Église au Burkina Faso, traditio, receptio et re-expressio*: *1899-1979* (N. Domenici-Pécheux, Rome, 1999), p. VI.

[2] Cf. ÉVÊQUES DE HAUTE-VOLTA, 'Option pour un nouveau départ', in *Fidélité et Renouveau* (July 1977) n. 104, p.3; ARCHEVÊCHÉ DE OUAGADOUGOU, *Enseignement socio-politique du cardinal Paul Zoungrana*, (Archevêché, Ouagadougou, 2004), p. 135.

[3] Cf. L. Badilla and L. Mainoldi, 'Benedetto XVI. XI° pellegrinaggio apostolico internazionale 2009 (Camerun-Angola)', in *SeDoc – Agenzia Fides n.sp.* (17-23 March 2009), p. 69.

[4] J. Ki Zerbo, 'Charisme camillien et culture africaine', in *Fidélité et Renouveau* (1982) n. 122, pp. 25-37.

[5] Speech at Loreto, 11 April 1985.

[6] L.S. Kinkupu, *Les défis de l'évangélisation dans l'Afrique contemporaine* (Karthala, Paris, 2005), p. 76.

5. The Organisation of Pastoral Care in Health in Africa: the Case of Burundi*

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Introduction

When he sent out his apostles to proclaim that the Kingdom of Heaven was near, as we are told by the Gospel according to Matthew, Jesus pointed out to them, on the one hand, that this mission also implied engaging in activity such as healing the sick, raising people from the dead, the purification of lepers, and casting out devils (Mt 10:7-8). On the other hand, he did not conceal that he was sending them out into a world that was hostile in which they would have to be 'wary as serpents and innocent as doves'

* This text was read on 23 November 2011 on the occasion of the meeting of bishops in charge of pastoral care in health organised in the Vatican City by the Pontifical Council for Health Care Workers.

for their mission to be successful (Mt 10:16).

Ever since its establishment in Burundi, the Church has wanted to obey this mandate of the Lord. In proclaiming the Good News, the Church has not failed to illustrate the nearness of the Kingdom of God, trying, amongst other things, to meet as much as possible the needs of populations in the field of health. Today, as was the case yesterday, the pastoral care of the Church in this field is based upon a concern to be conformed to the will of the Lord, and it is engaged in paying attention to the needs of reality. Thus my paper will begin with a rapid look at the socio-administrative context in which this form of pastoral care is organised and implemented. I will then try to outline the current profile of this pastoral care and highlight the most important challenges that the Church has to address and what we intend to do to meet them.

The Socio-Administrative Context of the Church's Pastoral Care in Health in Burundi

The Church in Burundi is called to perform its pastoral role in the field of health in a context that is characterised in particular by a significant level of morbility and mortality linked to transmissible diseases, in particular HIV/AIDS and malaria; the under-development of the country and the extreme poverty of the population, the blame for the principal cause of which is simply given to the galloping birth rate; the medicalisation of the demographic problem and the non-declared imposition of contraception under the totalitarian impetus of donors who adhere to the ant-birth ideology of new world ethics; and a reform of the public health-care system to achieve greater access of the population to medical care, the efficiency of services, and the participation of the communities who are their targets.

In addition, one should observe that in March 2009 the Bishops' Commission for Economic and Social Affairs signed with the Ministry for Public Health and the Fight against AIDS a cooperation agreement called 'The Specific Cooperation Agreement in the Field of Health' which, theoretically, governs the relations of cooperation between the State and the Church in the field of health.[1] Unfortunately, this agreement has suffered many violations that are difficult to counter because the permanent mixed committee envisaged by this agreement has never come into existence.

These are the principal elements of the context in which the pastoral care in health of the Church in Burundi is provided and from which the challenges that have to be addressed themselves come.

Pastoral Care in Health in Burundi Today

The activity of the Church in the field of health in Burundi has two dimensions and takes place at two different levels. It is first of all spiritual and religious in character, as is appropriate given the mission of the Church. As such it is rightly expressed in taking care in a religious and spiritual sense of patients in their homes or in hospitals. But it also has a technical and professional dimension because it involves the creation and management of health-care institutions. For that matter, it takes place first of all at the level of each diocese as a local Church, and then at the level of the Bishops' Conference of Burundi in order to support and coordinate the activities that are engaged in at the level of the dioceses.

The religious and spiritual accompanying of patients, as well as their treatment, takes place at the level of each diocese. It is here that the chaplaincy services of health care and the role of parishes and the basic Church communities of this apostolate are organised. But it also here that the professional services of the health-care institutions that belong to dioceses themselves, or are owned by Institutes of Consecrated Life, are engaged in. It is therefore the task of each diocese to provide the necessary ministry of supervision and pastoral accompanying of the work of these institutions.

Wanting to help each other in performing their duty of pastoral vigilance in the field of health and health care, the bishops created at the level of their conference a service for the promotion of health. This service, which is under the supervision of the Bishops' Commission for Economic and Social Affairs, is included in the services of the executive secretariat of the national Caritas. Its task is to follow from near to hand the developments underway in the health-care situation of the country and to study the questions and issues that it involves so as to inform the Bishops' Conference of Burundi about the various questions that are at stake, thereby helping it to undertake those pastoral measures that are needed. Unfortunately, it has not yet been equipped with a sufficiently competent personnel that would enable it to perform this task adequately.

Hitherto, this service has been limited to offering the various health-care institutions of the Church the technical and logistical support that is often need in Bujumbura, the capital of the country. On the other hand, in particular it coordinates their activities which must be accounted for to the Ministry of Public Health or which require the Ministry to be consulted. It thus acts as a channel to maintain the relationship with the state both as regards the institutions and the diocesan services for the promotion of health which coordinate them, and the Bishops' Conference, with respect to the activities of the Church in the field of health.

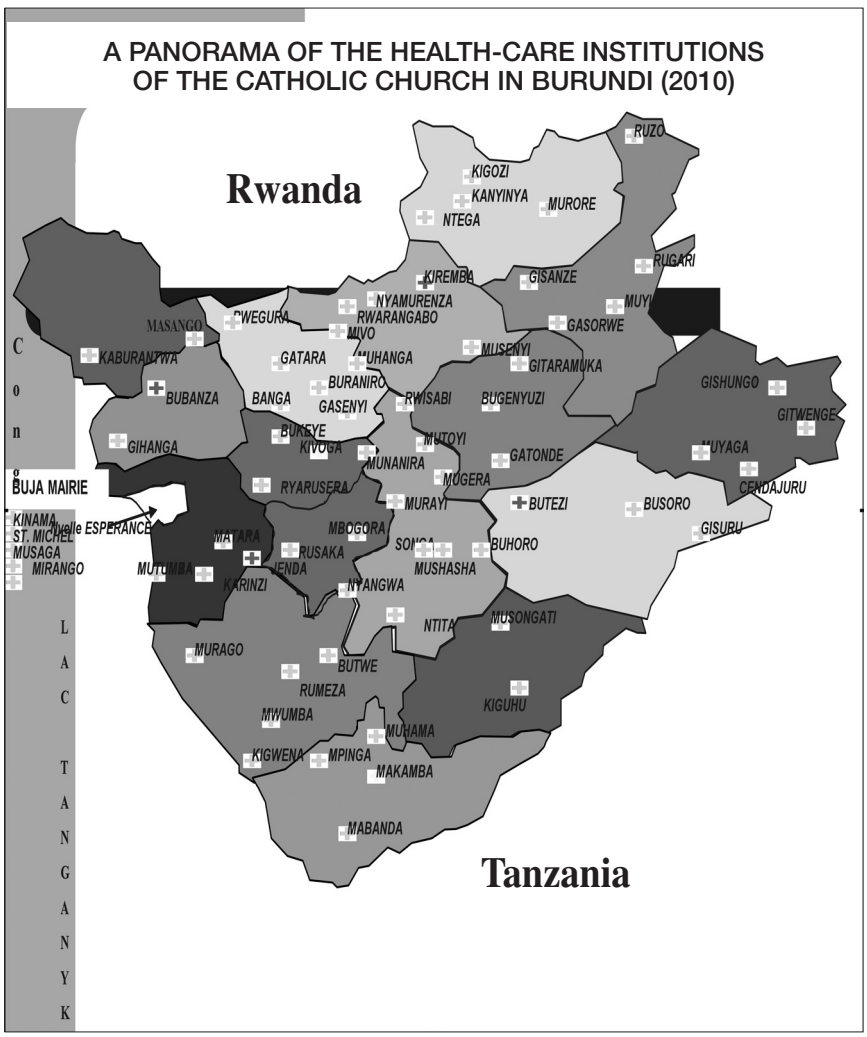
But it has to be recognised that the support of this service for health-care institutions displays a shortcoming which should be countered as soon as possible, that is to say a lack of a pastoral, spiritual and moral accompanying of the professionals who work in these institutions. This will obviously require a reorganisation of this service in order to enrich it with people who are able to contribute to the performance of this task which, indeed, is so important nowadays.

For the moment, the following is the organisational structure by which the Church in Burundi engages in pastoral care in health.

At a central level it has the *Service for the Promotion of Health* which is directed and supervised by *CED-CARITAS BURUNDI*, a permanent delegate of the Bishops' Commission for Economic and Social Affairs. *At an intermediate level*, it is based upon a similar service that is directed and supervised from within by each of the eight diocesan organisations for development (*Organisations Diocésaines pour le Développement* – ODD). *At a grassroots operational level*, it has eleven hospitals, seventy health-care centres, seventy-two voluntary centres for the monitoring of HIV/AIDS, and seventy-one places for the prevention of the transmission of HIV from mother to child.

In the illustrative map that follows, we find marked the health-care centres and hospitals. Unfortunately, there are only four of these last, when in reality they are eleven of them. The other seven are, respectively, in Songa, Ntita and Mutoyi in the archdiocese of Gitega, in Gihanga in the diocese of Bubanza, in Jenda in the archdiocese of Bujumbura, in Mivo in the diocese of Ngozi, and in Musongati in the diocese of Rutana.

Even though at the present time the governments of the local communities are creating a large number of health-care institutions, their number is still insufficient if one takes into account the density of the population and its needs in the health-care field. In addition, the contrast in the quality of services that is to be seen when the health-care institutions of the Church are compared with those of the state is enough to enable us to understand that the Church would increase their number she it had the means to do so. But before thinking of creating new infrastructures to increase the number of health-care structures, there are many other difficulties that have to be overcome.



The Challenges that have to be Met

The first challenge is to find the means that are necessary to make the health-care institutions that already exist function as they should. And this has to be done at a time when the external aid on which one could count in the past is diminishing every year while the generation of internal resources is obstructed not only by the economic difficulties of our members but also by the mentality of waiting for things which they inherited from the paternalism of our first evangelisers.

In addition, the Church must meet the challenge of the increasingly pressing need to conform the way in which these institutions work to the structural and managerial norms that have been developed elsewhere in line with criteria that do not take into account our socio-cultural realities and even less of the spiritual, religious and moral needs of our Christian faith. Produced by the financial blackmail inherent in the system of the remuneration of services on the basis of performance, these norms make problematic not only working with the state, which imposes them, but also with some of our health-care institutions which seek to cover expenses to the detriment of moral consistency.

Then there is the challenge linked to the medicalisation[2] of the demographic problem, as a result of which the question of family planning is approached from the point of view of 'reproductive health and rights'.[3] The Ministry of Public Health and the Fight against HIV/AIDS has also created within it a new body called 'The Department of the Health of Reproduction' which is entrusted with promoting programmes of contraception under the guidance of the United Nations Fund for Population Activities (UNFPA).

The challenge that has be met

lies in the fact that this department seek to make these programmes respected by all the health-care institutions, both those that are public and those that are private and authorised, such as ours are. The implementation strategy here is the incorporation of an attractive offer of funding based upon services and the refunding of expenditure on obligatory free treatment prescribed by the state for expectant women and children under the age of five. These costs are not refunded directly according to the medical activity that is engaged in but as compensation on the basis of the indicators for measuring performance that are utilised by the Ministry. However, these do not include the service of medical products and laboratory tests which make up the bulk of the activities engaged in by our health-care institutions.

In addition, because of family planning, the system of funding that is currently in force only remunerates indicators of performance that relate to *artificial* contraception. Our health-care institutions are indirectly discriminated against because natural methods, which can make their contribution to this area, are indirectly censured under the pressure of blackmail both at a psycho-social and a financial level in order to involve them in all the costs for the promotion of the use of artificial contraceptive methods. The specific agreement of cooperation signed with the Bishops' Conference for Economic and Social Affairs has thus endured an only slightly veiled violation. What, therefore, should we do to help our health-care institutions to meet this and other challenges? This is exactly the question to which our pastoral care in health should respond.

What Conclusions for Tomorrow's Pastoral Care in Health?

In the context of the reform of the health-care system that is currently underway in Burundi, there is an urgent need to reorganise the structure and the forms of the way in which the service for the promotion of health created by the Bishops' Conference of Burundi functions. This service should be able to coordinate and support in a better way not only technically and professionally but also, and above all, from a spiritual and moral point of view, the similar services of our dioceses and health-care institutions in their respective jurisdictions. We have to create a supportive and active Catholic network in order to address – with a single voice – the needs for ongoing dialogue with the Ministry for Public Health and the Fight against HIV/AIDS in order to promote cooperation that respects our moral convictions.

But to achieve this end it is not sufficient to update the organisational structure of the service or diversify and strengthen the competences of the personnel. We will need, in addition, to assure them that they will encounter the right approach to health-care problems and instil in them the spirit that is needed so that this structure can really match its vocation as an instrument of pastoral care of our Church. In communion with the universal Church, we should manage to impress on this structure an integral approach that takes account of the fact that 'illness afflicts the whole of a person and not just a part of his body'.[4] It is this that will nurture in this structure a concern to create a service that 'embraces all the dimensions of the human person'.[5] As regards the spirituality that should be cultivated, the Service for the Promotion of Health should arm itself with a living and deep sense of being called to the service of life and it should be prepared to promote the meaning of this service in every health-care worker.[6]

This service, lastly, should pay especial attention to the 'medicalisation of the demographic problem' and its gravity in our country. That is to say with the intention, in the health-care institutions it is responsible for and in relation to their personnel, of making the teaching of the Church on responsible procreation and the demographic question respected. In this way, it must in particular hold dear the recommendation of 'instilling conviction and offering practical help to those who wish to live out their parenthood in a truly responsible way'.[7] In other words, this Service is called upon to promote, on the one hand, a serene approach to the question of the galloping increase in population of our country in order to liberate people's minds from the panic that afflicts them today and the manipulation that follows from this. On the other hand, it has the responsibility of promoting, at the level of national coordination and the various dioceses, pastoral care for the family that integrates accompanying couples and an effective use of natural methods for the regulation of births. It will also be necessary to engage in a work of advocacy with the decision-making organs of the Ministry for Public Health and the Fight against HIV/IDS so that these methods are recognised not only as valid but also as the only ones that are appropriate to the dignity of the human person.

Notes

[1] In line with this agreement 'the Ministry is committed to respecting the mission and the doctrine of the Church as well as its administrative and financial organisation', attending at the same time 'to the quality of the treatment that is provided in all the health-care institutions of the Church in line with national health-care policy'. 'The Commission is committed to working in way that respects the laws and the regulations in force in the field of health, to basing itself on the orientations of national health-care policy, to carrying out the programmes of the state in the field of preventive, curative and promotional health, and to working with state programmes in conformity with its mission as determined by Doctrine and the Code of Canon Law'.

[2] This concept is borrowed from M. Schooyans, *La dérive totalitaire du libéralisme* (Mame, Paris, 1995), p. 159

[3] Press release on the occasion of the International Conference of Cairo on Population and Development.

[4] H. E. Msgr. Z. Zimowski, allocution at the opening of the seminar on 'The Ethics of the Spirituality of Health. Traditional and Complementary Medicines. Research and New Direction', Rome, 20 October 2009..

[5] *Ibidem*.

[6] Cf. *Charter for Health Care Workers*, 'Introduction'.

[7] *Familiaris Consortio*, n. 35.

6. The Organisation of Pastoral Care in Health in the Indian Church. The Contribution of Bishops in Charge of Pastoral Care in Health*

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Introduction

After the government network, the Catholic health network is the largest health-care network in India, with a presence all over the country. Through her health-care network, the Catholic Church is involved in all the three levels of health care, i.e., Primary Health Care/Community Health, Secondary Health Care, and Tertiary Health Care. Of the 5,524 Catholic health-care facilities in India, only 788 are hospitals. The rest are dispensaries, health centres, rehabilitation centres, non-formal health initiatives and so on.[1] In other words, only about 14% of Catholic health-care facilities are involved in secondary and tertiary care, whereas about 86% are involved in primary health care, community health, and rehabilitation services. This is significant in the Indian context where the vast majority of the population do not have access to essential health care due to the problem of affordability. Thus the Catholic Church through her vast health-care network, especially through primary health care and community health, reaches the unreached and continues the healing mission of Jesus Christ, especially among the poor and marginalised.

The Catholic Bishops' Conference of India (CBCI)[2]

The CBCI, the permanent association of the Catholic Hierarchy of India, was constituted at the Metropolitans' Conference held in Madras in September 1944. The CBCI is at the service of 164 dioceses, of which 28 are Syro-Malabar dioceses, 8 are Syro-Malankara dioceses, and 128 are Latin dioceses. The Catholic Church in India is divided into thirteen regions which function through the Regional Bishops' Councils, with a Bishop-Chairman, a Bishop-Secretary, and a Priest-Secretary.

In the wake of the Letter of Pope John Paul II (1987) to all the Bishops of India, the CBCI is the face of the Catholic Church in India and deals with 'questions of common concern and of national and supra-ritual character' (Letter of Pope John Paul II). Besides other roles or functions, the CBCI Secretariat strengthens and fosters the relations among the three *sui juris* Churches as communion; promotes advocacy on national issues; makes representations to the government, liaising with the central government and Ministries/Departments of the centre; influences government policies for nation building and the development of peoples; and networks with other Christian Churches (associated with the NCCI and the EFI through the NUCF), associations of civil society, and people of other religions and all people of good will to work for peace and harmony, for probity in public life, and for the promotion of human rights and Gospel values.

The CBCI functions through its five National Centres/Institutes and thirteen Offices which include the Office for Health Care. Each Office has one Bishop-in-Charge, two Bishop Members and one Secretary.

The CBCI Office for Health Care[3]

This office was established in 1989 to function as the coordinating body for all the health-related organisations of the Church in India. This Office is the forum for discussing various vital issues of national importance relating to health and for planning common action. The office is to inspire and guide all the health-related organisations according to the spirit of Catholic teaching, practice and tradition (Report of the CBCI General Body Meeting, Pune, 1992). The official website of the CBCI Office for Health Care is *cbcihealth.org*

Vision of the CBCI Office for Health Care. Having received the mandate from Jesus Christ, the Divine Healer, to ensure life in its fullness, and inspired by his compassionate love, the Catholic Church in India envisages a healthy society where people, especially the poor and marginalised, attain and maintain holistic well-being and live in harmony with the Creator, with themselves, with one another and with the environment.

The Mission of the CBCI Office for Health Care. To provide humanising care, considering the dignity of the person and the needs

* This text was read on 23 November 2011 on the occasion of the meeting of bishops in charge of pastoral care in health organised in the Vatican City by the Pontifical Council for Health Care Workers.

of society; to ensure promotional, preventive, curative and rehabilitative health care for all, particularly to the poor and the marginalised through their empowerment; to engage in the social mobilisation of the community by creating awareness about rights, duties and responsibilities relating to health issues.

The Catholic Health Organisations of India Officially Recognised by the CBCI

The Catholic Health Association of India (CHAI) was founded on 29 July 1943 by Sr. Dr. Mary Glowrey JMJ, in association with sixteen religious sisters. It was founded with the motto of improvement in standards of health education and the promotion of Catholic values and the option for the poor.

The Vision of CHAI.[4] The CHAI upholds its commitment to bringing 'health for all'. It views health as a state of complete physical, mental, social and spiritual well-being, and not merely the absence of sickness. Accordingly, the CHAI envisions an India in which people are assured clean air and water and a clean environment; do not suffer from any preventable disease; are able to manage their health needs; are able to control the forces which cause ill health; enjoy dignity and equality and are partners in decisions that affect them, irrespective of caste, creed, religion or economic status; and respect human life and hold and nurture it to grow into its fullness.

The mission of the CHAI. To promote Community Health understood as a process of enabling people, especially the poor and the marginalised, to be collectively responsible in attaining and maintaining their health and demanding health as a right, and ensuring the availability of health care of reasonable quality at reasonable cost.

The Catholic Nurses Guild of India (CNGI). The CNGI was formed in 1957. Its main objectives are 'to improve and elevate the nursing profession in its religious, apostolic, ethical, social, cultural, economic and technical aspects; and to provide an agency through which Catholic nurses will be able to speak and act corporately in matters of common interest to their profession'. There are about 40,000 members of the organisation. The headquarters is in Mumbai.

The Sister Doctors Forum of India (SDFI). The inspiration to organise a forum of Sister-Doctors originated in the Golden Jubilee evaluation of the CHAI. Finally, the Sister Doctors' Forum of India (SDFI) was formed in 1993 during the national convention of the CHAI at Kaloor, Ernakulam. As of now, the forum has more than 600 registered members who are working for the rural and urban poor as sister-doctors. The SDFI was formally registered as a separate legal entity in the year 2009.

The CBCI-Coalition for AIDS and Related Diseases (CBCI-CARD). Considering the need for more collaboration between the health and development sectors of the Catholic network in India, and to facilitate collaboration with the state (the Government of India), the CBCI-CARD was registered as a separate society under the auspices of the CBCI on 10 July 2009 with the Registrar of Societies, New Delhi.

The following members* with an institutional role constitute the Governing Board of the CBCI-CARD. **President*: the Chairman of the CBCI Office for Health Care; *Vice-President*: the Secretary General of the CBCI; *Secretary*: the Secretary of the CBCI Office for Health Care; *Treasurer*: the Executive Director of Caritas India; *other members*: the Deputy Secretary General of the CBCI; the *Chairman of Caritas India;* the Chairman of St. John's Medical College and Hospital; *Director of St. John's Medical College and Hospital*; the President/Representative of the Catholic Health Association of India (CHAI); the President/Representative of the Sister Doctors Forum of India (SDFI); and the President/Representative of the Catholic Nurses Guild of India (CNGI).

Membership of CHAI at a Glance on 3 March 2011[5]

S No.	CATEGORY	LIFE	ANNUAL	TOTAL	%
1	Leprosy Care Centres	52	5	57	1.7
2	Health Centres-1 [Nil Beds]	1,196	177	1,373	41.4
3	Health Centres-2 [01-06 Beds]	572	73	645	19.4
4	Health Centres-3 [07-10 Beds]	150	20	170	5.1
5	Hospitals [11-25 Beds]	215	19	234	7
6	Hospitals [26-50 Beds]	154	17	171	5.1
7	Hospitals [51-75 Beds]	29	6	35	1
8	Hospitals [76-100 Beds]	28	6	34	1
9	Hospitals [101 Beds & Above]	54	12	66	1.9
10	Schools of Nursing	26	0	26	0.7
11	Diocesan Social Service Societies	118	14	132	3.9
12	Non-Diocesan Social Service Societies	40	16	56	1.6
13	Associate Members	260	3	263	7.9
14	Individual Members	40	12	52	1.7
	TOTAL	2,934	380	3,314	

The Organisation of Pastoral Care in Health in the Church in India

Due to a scarcity of trained full-time chaplains in most of the hospitals of India, a large part of pastoral care in India is not carried out by chaplains but by nursing staff and volunteers, by sitting alongside someone when they are anxious or distressed and simply listening to them with a non-judgmental attitude. Most of the time it seems that the main weight of pastoral care rests with the person nearest to the situation who has

sufficient time to listen and some kind of authority to effect some change.

Wherever there is the availability of a chaplain, direct pastoral care to patients is provided, especially when a patient is not connecting with the nursing team and the volunteers. As representatives of God, they offer to the sick and suffering, hope, freedom from guilt and fear, acceptance of sickness and suffering, reconciliation, and peace. However, in most situations much more than direct pastoral care for patients: a key role of the chaplains is to support and empower the nurses, other staff and volunteers who perform the primary role of providing pastoral care, as people working in a challenging environment.

In addition to the health-care ministry, the health-care personnel of the Catholic network in India are also directly or indirectly involved in pastoral care for the sick and suffering. They do this through informal prayer, informal counselling and the 'ministry of presence'. In hospitals where secondary and tertiary care is given, pastoral care is more organised. Some of the large hospitals/medical colleges have a chaplaincy department where full-time chaplains provide the above-mentioned services in an organised way. In addition to this, they also organise seminars, recollections and retreats mostly for health-care providers, students and so forth. They also minister the sacraments of healing, i.e. the Eucharist, the sacrament of the sick and reconciliation, which are available to patients, their loved ones and health-care providers.

When it comes to small health facilities like dispensaries, especially in the remote areas of the country, usually a convent is also associated with the parish. In many of these places, the nuns and the priest work together managing a school, the dispensary and the pastoral and socio-economic needs of the parish community. In addition to the services provided through the above-mentioned institutions, they also visit people in their homes. Through these activities they provide pastoral care at the level of the community. In many cases, the priest supports the nuns as chaplains by providing them with pastoral care.

The Role of the Bishops in Charge of Pastoral Care in Health

Most of the dioceses have a health commission with a priest or a nun appointed to coordinate the pastoral care of the health-care activities of the diocese under the guidance of the bishop. Every Regional Bishops' Council has a health commission with a bishop in charge. In many cases there is a priest or nun to assist the bishop in charge.

At the CBCI level, there is a team of three bishops (Archbishop Vincent M Concessao, Delhi; Bishop Jacob Manathodath, Palghat; and Archbishop William D'Souza, Patna) with Archbishop Vincent M Concessao as the bishop in charge of the office. The bishop in charge of the CBCI office for health care is also the president of the CBCI-CARD, the ecclesiastical advisor to the CHAI, the SDFI and the CNGI. The bishop in charge is invited to the board meetings and general assembly meetings of these organisations and accompanies them giving them pastoral guidance. It is mainly at these meetings and the Eucharistic celebrations that take place during such occasions that he exercises his pastoral ministry among them.

CBCI Policies and the Health-care Ministry

The CBCI has four policies: the Health Policy of the Catholic Church in India – Sharing the Fullness of Life; the HIV / AIDS Policy of the Catholic Church in India – Commitment to Compassion and Care; the Gender Policy of the Catholic Church of India – Empowerment of Women in the Church and Society; and education policy. Of these four policies, two directly deal with the health-care ministry and the other two mention the role of women and the education ministry in promoting the healing mission of the Church.

Cooperation between the Church and the State in the Field of Health Care in India

The Catholic Church in India is implementing countless projects across the country through its various dioceses, religious Congregations and institutions. At a national level, the CBCI collaborates with the government of India in the field of HIV, TB and malaria through its 'Global Fund' projects. However, there are multiple other projects being run all across the country by various Catholic institutions. These projects are not implemented directly by the CBCI and are funded from various sources. These projects cover all areas including health care, education, women, community development, self-help groups, etc. Other than the Global Fund, for the multiple projects being implemented across the country there are various donors – local, national and international e.g. the government of India, the CRS, Misereor, Missio, various UN Organisations, Caritas Internationalis, etc.

The National AIDS Control Programme (NACP III). As part of the efforts to halt and reverse the HIV / AIDS epidemic in India, the government is implementing NACP-III, which includes components relating to prevention, the provision of care and treatment facilities and strengthening infrastructure for surveillance and health management information systems. The 'Promoting Access to Care and Treatment' (PACT) project is implemented within the NACP III component, which aims to increase the availability of antiretroviral therapy (ART) by scaling up the number of ART centres and improving access to care and support by setting up Community Care Centres (CCCs) and district level networks of People Living with HIV (PLHIV).

The major services related to the Community Care Centres aim at enhancing drug adherence to ART and include the following: the provision of minor opportunistic infections (OI) treatment; the provision of five day in-patient care; counselling on drug adherence, nutrition, and preventive behaviour after the initial diagnosis;

the verification of the patient's address and follow up for adherence through house visits; and outreach activity which also ensures advocacy for early testing and counselling at the ICTCs.

The CBCI PACT project has successfully achieved the following targets:[6] 52 CCCs established in the 6 highly vulnerable states of Bihar, Chattisgarh, Gujarat, Jharkhand, Orissa, and West Bengal; 72 new and 69 turnover staff (a total of 141 CCC staff) have been trained with 30% additional turnover staff accommodated in the induction training sessions; 16,873 PLHAs received the CCC services in RCC year 1 against a target of 10,082; ARTC-CCC coordination meetings are arranged regularly in all the districts in which CCCs have been established; and all CCCs submit monthly and quarterly reports regularly by utilising the CMIS system developed by PFI.

The Revised National TB Control Programme (RNTCP). The CBCI RNTCP Project[7] began in 2008 under the aegis of the Global Fund to fight AIDS, TB and Malaria, Round 4 component. In January 2010, the Rolling Continuation Channel (RCC) of the Global Fund Project came into existence with the signing of the MoU between the CBCI CARD and the Central TB Division, Ministry of Health and Family Welfare, Government of India. Through this project, RNTCP services are provided in Catholic Health Facilities (CHFs) along with the government in nineteen States. Some of the achievements of this project are: number of patients referred – 50,600; number of Catholic health facilities (CHFs) involved – 143; number of schemes signed with the government – 192.

Conclusion

In the field of health care, the Church in India has contributed for more than its small numbers, particularly in the rural areas and among the poor. For millions in India, our health-care personnel, especially our religious sisters, are the face of the Church. However, there is plenty of scope for being better equipped for more effective and witnessing service. The Church in India is moving in this direction even as it networks with other health agencies both to mobilise resources and reach out to more people with the healing ministry of Jesus, the divine healer. ■

Notes

[1] Directory of the Catholic Health Facilities in India, CBCI Commission for Health Care, 2008, p 7.
[2] http://www.cbci.in/About-CBCI.aspx
[3] http://www.cbci.in/all-Commissions/health-care.aspx
[4] http://www.chai-india.org/vision-mission.htm
[5] http://www.chai-india.org/membership.htm
[6] Annual Report, RCC Yr. 1, CBCI PACT Project, p. 7.
[7] Annual report, CBCI-CARD, 2010-11, p. 2.

7. The Organisation of Pastoral Care in Health in Indonesia*

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Introduction

In this brief paper I would like to highlight some information on pastoral care in health in the Church supported and encouraged by the Bishops' Conference of Indonesia (BCI). Pastoral care in health is usually provided by religious sisters of Congregations in collaboration with lay people, in particular with Catholic doctors and other people involved in hospitals and medical treatment. Bishops in their dioceses support and encourage this pastoral work and the Indonesian Bishops' Conference at its annual meeting through the Delegate hears reports on these activities.[1]

At the level of general information, Indonesia has around 17,000 islands and 3,000 of these are inhabited, with around 235 million people. There are six official religions: Islam (majority, around 70%), Protestantism, Catholicism, Hinduism, Buddhism and Confucianism. There are around eight million Catholics (3% of the population), and thirty-seven dioceses. We have an annual meeting that lasts ten days at the beginning of November and this takes place in Jakarta, the capital of Indonesia.[2]

This sharing of information and problems about pastoral care in health can be a small contribution to enriching the universal Church in helping the poor, especially those who need particular attention in order to live in a good condition of heath in accordance with

* This text was read on 23 November 2011 on the occasion of the meeting of bishops in charge of pastoral care in health organised in the Vatican City by the Pontifical Council for Health Care Workers.

human dignity. I follow the outline as presented at this meeting.

1. The Ideology of Gender and Reproductive Health: Doctrine, Legislation and Pastoral Care

The ideology of gender and reproductive health[3] in Indonesia has its focus on the programme of family planning. It is not easy to describe the whole background and the consequences of doctrine, legislation and pastoral care in relation to this. At a doctrinal level, the Church at its starting point addresses the traditions, customs and cultural background of the people. The government concentrates on demography, on birth control, and has its own approaches and systems. Therefore, the government does not pay attention to religious teaching but concentrates on the results of family planning or on a reduction of the population and achieving zero growth.

The efforts to cope with reproductive health affect, and link up with, some problems connected with personnel, methods and devices. In addition to this, the government and the Church encounter the problem of abortion, HIV / AIDS, and the misuse of devices for family planning among young people. The Church sometimes, in certain cases, can work together with the government. But in some cases the government follows its own policy and target, so that women become the objects and victims of this target. The project of the government as regards family planning also creates disagreement with the Church's teaching and doctrine, especially with respect to natural birth control. The government allows and pays for all kinds of methods of family planning.

The ideology of gender and reproductive health according to the Catholic Church developed in an atmosphere of faith, in accordance with the Word of God taken from Holy Scripture. 'So God created humans to be like himself; he made men and women' (Gen 1:27). The Church in Indonesia faced a crucial problem because the people were made up of so many tribes, with a great variety of cultures, languages, philosophical views of life, and religious beliefs. It is not easy to generalise and to simplify these individual backgrounds. Some preliminary observations can explain that the Church's doctrinal teaching has influenced society and has been easily accepted as common ground for a way of life and standard of living. Even the majority of Muslims have no problems with the Church's doctrinal teaching on gender and reproductive health.

Another serious problem is abortion as a consequence of free sex and the misuse of family planning devices. This is a serious phenomenon because there are around two million abortions every year.[4] Unfortunately, very many cases are performed in poor and unsafe conditions. Although abortion is strictly prohibited, the number of abortions has been growing. Another serious effect of free sex and the misuse of devices is the increase in HIV / AIDS. In some cities and regions, HIV / AIDS has been increasing significantly. Again, women and children become the victims and they suffer from it more than men.

As regards legislation, the government and the Church have the same concerns and views so that from a legislative point of view there are no serious problems. But, in fact, at a practical level, men have a certain privilege in society. In the cultural lives of several tribes, especially those with patriarchal systems, women have fewer rights and men are dominant in all public questions. This situation involves a crucial problem regarding the equality of men's and women's rights. The privileges of men sometimes mean the oppression for women. Therefore, the doctrinal and legislative level does not match daily practical implementation.

The Church through pastoral work is trying to provide a proper service, especially in the field of reproductive health. Based on God's will as expressed in Holy Scripture, the Church engages in some efforts and pays especial attention to the dignity of women being equal to the dignity of men. Health care as articulated in reproductive health should be allocated to the respective genders in a way that maintains justice for both genders.

2. Cooperation between the Church and the State in the Field of Heath Care

Since the beginning of missionary work in Indonesia, health care has been one of the principal focuses of the Church. The missionaries faced the actual situation at that time (the beginning of the nineteenth century) and engaged in a strategic approach to bringing the Good News. Pastoral care in health became a means of promoting the Gospel as the actualisation of the Kingdom of God. At that time the State was very weak and had no suitable instruments or power to perform its duty in the field of health. Religious missionaries and some sisters of religious Congregations took part in pastoral care in health by opening hospitals and health centres and by visiting villages. Religious sisters met the people, brought medicines and engaged in pastoral care in health. Through this work in the field of health, the Church was able to penetrate the villages and brought people to salvation.

Catholic health work is carried out for all people and for the whole of society in Indonesia. Therefore, the health work of the Church, on the one hand, inevitably, has to obey the laws of the Indonesian government regarding health. But, on the other hand, the government has to respect and to accept the special characteristics of Catholic health work which is based on the Catholic faith, which in turn is based on Holy Scripture, Tradition, Canon Law, and all the formal teachings of the Catholic Church. In this context, and from this point of view, there are many problems and tensions because the laws and regulations made by the government are not always in line with the teachings, moral views and faith of the Catholic Church.

In facing a situation that damages Catholic teaching and faith, the Catholic Church in Indonesia does not keep silent. The Church in Indonesia takes the following steps:

Step 1

The Church strives to take part actively in preparing and arranging regulations together with the government. When the government plans to make a new law or regulation, the Church, through the Bishops' Conference of Indonesia, takes the initiative of cooperating with Catholics who have a leading role in Parliament (the DPR or the MPR), of arranging a team made up of experts familiar with the law or regulation that will be ratified. This team is given the task and authority to take part in controlling, when this is possible, and shaping, the regulation to prevent the prospective law from contradicting Catholic teachings. These efforts are sometimes successful; sometimes they are not.

Step 2

An effort is made to impede the ratification of the regulation if it contradicts Catholic teaching. When the first step is not successful, then the second one has to be taken, if this is possible: putting scientific writings in newspapers and bulletins in order to point out its weaknesses and its failings and negative consequences if certain points are not corrected before it is ratified. In this case, hopefully, the intellectuals who read these scientific writings, no matter what their religion or political groups may be, can understand the weaknesses and failings of the prospective laws and take part in impeding the ratification of problematic regulations.

Step 3

Using forms of protest that are allowed by the law. When the second step is not successful, sometimes we use the allowed ways such as going into the streets and demonstrating for rejection and engaging in efforts to prevent the approval of the problematic law. This path was taken to secure the rejection of the ratification of the national Education Law. These demonstrations took place together with other religions and groups who were aware that the regulation was harmful for their works. The demonstrations took place on the same day and in several cities simultaneously.

Step 4

When the third way is not successful and the government still declares that the law will be ratified, then the last step is taken. The Catholic Church has to be courageous, on its own or together with other religions and groups, and ask for a judicial review, that is to say writing a letter of complaint to the Supreme Court, asking for a review and modification of the problematic parts and their replacement by ones that have been already prepared. In some cases, this strategy has been successful.

3. The Organisation of Pastoral Care in Health in the Indonesian Church

Before the Bishops' Conference of Indonesia was founded in 1961, pastoral care in health was the work of sisters of religious Congregations in several parts of Indonesia. In some big islands such as Java, Sumatra, Kalimantan and Sulawesi, and in some places where Catholics were numerous, such as the Island of Flores, the organisation of pastoral care in health was thus established. Step by step, its organisation grew wider and wider and then reached a national level.

a. The PERDHAKI and the organisation of medical staff in Indonesia

PERDHAKI, ('*Persatuan Karya Dharma Kesehatan Indonesia'*; 'The Association of the Work of the Health Service of Indonesia') was founded on 22 July 1972. 28 dioceses are members of PERDHAKI, as well as 79 Catholic hospitals and health-care centres.[5] The Bishops' Conference of Indonesia assigns a bishop as a delegate for health work in order to connect the Bishops' Conference of Indonesia with Catholic hospitals. The annual meeting of PERDHAKI endorses the betterment of relations between the Bishops' Conference and all hierarchical levels (this includes parish priests) with the personnel of PERDHAKI.[6]

The service of Catholic health work in Indonesia is not directly coordinated by the Bishops' Conference of Indonesia. Each unit of the Catholic health service (hospitals) that are owned by religious sisters and the diocese are independent. PERDHAKI has its representative in dioceses, which are responsible for pastoral care in health in their parishes. The annual meeting of PERDHAKI is intended to share information about the development of medical issues and the progress of their plans and programme. In addition, some members of PERDHAKI visit Catholic hospitals, clinics and health centres, which are spread out over many dioceses. Through these activities they can help each other and thus the service of Catholic health care in Indonesia is very highly appreciated by the people and the government. In some dioceses Catholic health centres are favoured because of their excellent service.

b. The organisation of Catholic medical personnel in Indonesia

The organisation of Catholic medical personnel is called the KMKI ('*Komunitas Medik Katolik Indones*ia', 'The Catholic Doctors, Dentists and Medical Personnel of Indonesia). This organisation was founded on 11 February 2001 with the goal of communicating with each other and sharing information, in particular deepening the Catholic spirituality of workers and personnel in the pastoral care in health. Though regular meetings they intend to develop and improve the professionalism and capacities of their service in health care.[7] Its activities can be divided into three kinds: 1. spiritual activities: monthly Eucharistic celebrations, recollection, retreats, deepening ethical and moral analysis, pilgrimages, etc.; 2. professional and technical meetings: seminars on ethics and medical knowledge and information, international congresses, etc.; and 3. social activities: helping the victims of the earthquake in Yogyakarta (2006), Padang, and other social and charitable activities.

The KMKI has its representatives in several dioceses: Jakarta,

Semarang, Denpasar, Manado, and Pontianak. In Asia, KMKI is also the member of the AFCMA (the 'Asian Federation of Catholic Medical Associations'). Therefore, KMKI takes part in activities of the AFCMA. At an international level, the KMKI is also member of the FIAMC ('*Fédération Internationale des Association Médicales Catholiques*'). The KMKI took part in the international congresses of the FIAMC in Barcelona (2006) and in Lourdes (2010).

At the meeting of the AFCMA XIV in Hong Kong in 2008, the KMKI was elected to be the host of the AFCMA XVI and the AFCMA will hold its fifteenth congress in Bali on 18-21 October 2012. The theme will be: 'Challenges of Catholic Doctors in the Changing World'. The sub-themes will be: 'Challenges of Catholic Doctors: a. in upholding Biomedical Ethics; b. at the beginning of Human Life; c. at the end of Human Life; d. in Promoting Natural Fertility Awareness; e. in the Controversy of the Use of Condom in HIV Prevention'

Through this organisation, pastoral care in health in the Indonesian Church has two links: *first*, in an internal direction: the Bishops' Conference facilitates, and is connected with, all the units of pastoral care in health all over Indonesia.[8] This internal direction is done by PERDHAKI. *Second*, in an external direction, to the AFCMA and the FIAMC which connects the Indonesian Association of Pastoral Care in Health to the Asian and the international association.

Conclusion

This brief paper is very limited and incomplete. However, I hope that it still can enrich and give some new information to those who are not so familiar with the Church in Indonesia. Pastoral care in health, ever since the beginning of evangelisation in Indonesia, has played a great role, and therefore the Bishops' Conference pays special attention to supporting this field of pastoral care. This humanitarian work becomes a strategic way of evangelising that is based on Jesus' work for the sick. The Bishops' Conference of Indonesia continues this work to proclaim the Good News to all people in Indonesia. ■

Notes

[1] The last pastoral letter of the BCI was written in November 2009 and was entitled: 'The Work of Evangelization of the Catholic Church in Indonesia in Pastoral Care in Health'. This letter was released after three days' study and reflection on pastoral health on 2-4 November 2009. In this letter, the bishops stressed again the relevance and the importance of pastoral care in health for the poor and those in need of medical health, as expressed in *Dolentium Hominum* art. 2 and *Gaudium et Spes* art. 10.

[2] This data was based on statistics of 2010, and the '*Petunjuk Gereja*' (The Indonesia Church Directory), issued by Department of Documentary and Public Relation, *Konferensi Waligereja*, Indonesia (BCI), Jakarta 2009.

[3] The definition of 'reproductive health' was published by the International Conference on Population and Development (ICPD), Cairo 5-13 September 1994. It was adopted by the World Health Assembly in May 2004.

[4] See BKKBN, KB, *Program National (National Family Planning)*, Jakarta, 2007, p. 61.

[5] See Direktori Rumah Sakit & BP/RB Unit Anggota Perdhaki 2007.

[6] The Conclusion and Result of the Annual Meeting 2010, Jakarta 23-25 July 2010, point 3.

[7] Letter from the Chairman of KMKI (Dr. Ignatius Harjadi Wijaja) to the Bishops' Conference of Indonesia, 8 November 2011.

[8] Since its foundation of PERDHAKI, the BCI has written some messages and pastoral letters, among which: 'Messages of the BCI to Pastoral Care in Health', 2 Feb. 1978; 'An Ethical and Pastoral Directory for Catholic Hospitals', 1 Dec. 1987; 'The Work of Evangelisation of the Catholic Church in Indonesia in Pastoral Care in Health', 2-4 November 2009.

8. Pastoral Care in Health in Spain *

H.E MSGR. RAFAEL PALMERO RAMOS
Bishop of Orihuela-Alicante, Head of Pastoral Care in Health in Spain

1. What is Pastoral Care in Health for us?

Pastoral care in health is the activity that all Christians, in local and parish communities, as members of a diocese and of the universal Church, devote to every human being – whether healthy or infirm – in order to offer him or her:

- The *meaning* that the Christian message gives to the great human realities of life: health, sickness, treatment, suffering, death, and the care that is offered to sick people.
- Presence at the side of patients, their family relatives and those who take care of them in order to communicate, with words, deeds and concrete facts, that the Gospel of the Love of God, manifested in Christ, is implemented here and now through the Eucharist and the sacraments of the sick.
- The exercise of Christian fraternity which takes concrete form in *humanised and humanising care* and in help in illuminating

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the ethical problems present today in the world of health and health care.

Pastoral care in health is, in definitive terms, *the appropriate presence of the Church in the world of health and health care*, pastoral care that offers evangelical answers to the questions of today's man. Over time there has been a change in what is offered: *pastoral care for the sick, pastoral care in health care, and then pastoral care in health*.

2. This change has not only been a matter of an appellation – it also refers to the direction taken and new contents.

- The intention is to go beyond a model of pastoral care of an exclusively sacramental kind, or involving a charitable/care service and help in 'dying well', in order to provide it with contents that are more evangelising. The aim of this pastoral care is to make present in the world of the sick and the complex problems that accompany it the humanising and healing force offered by Jesus Christ, our Saviour.

- The field of action of pastoral care has been expanded: defending health and fighting against illness, its causes and consequences; cooperating to assure that health-care institutions and hospital technology are at the service of health and not profit or other interests; the increasing humanisation of the process of care and treatment; cooperating in everything that can foster the health of today's man: donating blood and organs, the prevention of drug-addiction, the fight against alcoholism, initiatives to defeat loneliness and lack of communication, the promotion of health with the elderly…

- A more positive approach has been acquired because on its horizon there is not only illness – there is also health which is understood in a complete way and open to salvation. Health is no longer seen as the absence of illness, yet at the same time an attempt is made to go beyond the definition of health offered by the World Health Organisation: 'health is a state of complete mental, physical and social wellbeing of man dynamically integrated into his natural and social environment and not only the absence of illness', in order to live it as the realisation of the truth of a person's life. In definitive terms, one can say that the purpose of pastoral care in health is 'to proclaim and render visible salvation in its totality', revealing the healing force of Jesus Christ in the world of the sick, in our world, whose society is ardently looking for health and feels that it is in need of salvation.

With this kind of definition of pastoral care in health – as the activity of Christians in their local communities, as the commitment and work of the diocesan Churches, and as the work of each member of our parish and hospital communities, one can well understand the slogan of a few years ago: 'in pastoral care in health we are all responsible'.

2. In Spain, our department for *pastoral care in health* forms a part of the Bishops' Commission for Pastoral Care and works with increasingly definite objectives and concrete activities that are shared in large measure by all of the dioceses of Spain. This has been the case for more than twenty-five years.

The pilgrim Church of Spain, following the example of her Founder and Teacher, has always understood that the duty to serve the sick and suffering is an integral part of her mission.[1] As pastors of the Church we bishops are aware that 'The Church today lives a fundamental aspect of her mission in lovingly and generously accepting every human being, especially those who are weak and sick'.[2] This activity of the Church includes proclaiming, celebrating and engagement.

This approach leads us to believe that evangelising activity must be promoted, encouraged and coordinated. For this reason (given that our world always depends on organisation charts), we conceived of *diocesan delegations* which would implement this presence of the Church in response to a commission of the bishop and on his behalf. Every year we engage in three days of sharing ideas and experiences, ongoing formation, and planning. These involve the diocesan delegates, the bishop who is in charge of pastoral care in health, and the director of the department.

Our work of pastoral care takes place and is implemented in three actions, on three fronts, or through three channels: the evangelisation of pastoral care in relation to the Word of God; the sacraments and the celebration of the Eucharist; and Christian commitment which seeks to translate at specific moments what the Word of God proclaims and what the sacraments achieve symbolically.

4. Formation, activities and results are organised into five fields in our national department. These are as follows: 1. religious services in hospital centres; 2. pastoral care in health in parishes; 3. men and women religious who are health-care workers; 4. Christian health-care professionals (PROSAC); and 5. specialist movements.

Our chaplaincies are present in hospitals in line with specific agreements that were established in the seventeen Spanish autonomous communities. The teams are made up of priests, deacons and lay people, whom we define as 'suitable people'.

In order to prepare these services for continuing their work in the near future as well, we have held fifteen summer courses on pastoral care in health for seminarians from various dioceses in Spain.

From 11 February of every year, the liturgical memorial of Our Lady of Lourdes, until the sixth Sunday of Easter, in every diocese, in the best way possible, we engage in what we have called the Campaign for the Sick. This culminates in the celebration of the Easter of the Sick in parishes and health-care centres, and a Holy Mass which every year is celebrated in a different place and is usually presided over by the bishop in charge of pastoral care in health at a national level and broadcast by Spanish television. A report on the centre that refers to this campaign is published before these celebrations.

4. The literature that we use is broad, abundant and rich (books,

dossiers and articles), with *basic documents that direct us*, and our intention is provide an adequate and timely pastoral response – this means it being suitable at every moment. In particular, we emphasise the following: I. the apostolic letter *Savifici Doloris* of John Paul II, 1984; II. the proceedings of the National Congress on '*Iglesia y Salud' ('Church and Health')*, held in Madrid in September 1994; III. the document *Iglesia y Salud* (*'Church and Health'*) which was approved at the sixty-fourth plenary assembly of the Bishops' Conference of Spain of 22 November 1995; IV. *Religious Assistance in Hospitals. Pastoral Guidelines*; V. the annual messages of the Holy Father for the World Day of the Sick; VI. the annual messages of our commission for pastoral care in health; and VI. a collection of essays for formation in pastoral care in health (ten titles).

In this way we enter the dynamic of the personal dedication of Christ the physician and teacher, seeking to take part, together, and each time to a greater extent and in a better way, in the life of God,[3] with everyone being responsible for pastoral care in health.

Notes

[1] *Dolentium hominum*, n. 1.
[2] *Christifideles laici*, n. 38.
[3] Cf. *Deus caritas est*, n. 13.

9. The Contribution of Bishops in Charge of Pastoral Care in Health from an Australian Perspective*

H.E. MSGR. PATRICK POWER
Auxiliary Bishop of Canberra and Goulburn, Chairman of the Australian Catholic Bishops' Commission for Health and Community Services, Australia

"A Samaritan came near the man who had been mugged, and when he saw him, he was moved with pity. As ministries of the Catholic Church spread across Australia, our work is inspired by the God who in Jesus went out to strangers to heal and to make our world just. Like the Good Samaritan, we in Catholic health and aged care in Australia are committed to walk with those in need, regardless of their beliefs, rich and poor alike. In this way, we remain true to the call of the Gospel."

I am very humbled to have received this invitation to be with you during this conference, and I express my thanks to the President and the members of the Pontifical Council for being able to share these few days with you.

The words I opened with, that reflect on the Samaritan and the importance of the parable to the Church's health ministry, are not my words. They are instead the words of the shared purpose statement under development by the hospitals, medical research centres, aged care homes, and home visiting services that are operated by our wonderful Catholic lay people and religious in Australia.

It is really on behalf of these talented lay people and religious that I am here today. We are blessed that Catholic hospitals and aged care services in Australia are strong. There are 75 hospitals, and 550 aged care services. The Church operates 10% of the nation's hospitals and aged care services. These services are growing. A decade ago there were 55 hospitals. 2,000 extra aged care beds have been added to Catholic services in the last three years. 40,000 staff work in these services, almost all of them lay people.

Our hospitals and aged care services in Australia are organised by nature of their history. Nearly all services were started by religious congregations over past decades in response to community need. As the numbers of religious started to decline, a number of partnerships were formed between different religious congregations to ensure ministries were able to continue. In more recent times, lay people have started exercising managerial and governance roles once performed by religious. In all, there are 76 different canonical bodies that today oversee health and aged care services. Very few of these are Bishops. In fact, there is only one Bishop in Australia, the Bishop of Lismore, who has responsibility for a Catholic hospital. Unlike the case of Catholic schools, most Bishops in Australia readily acknowledge that it is the religious and lay peo-

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ple who have given the gift of Catholic healthcare to the Church in Australia, and that it is these religious and lay people who deserve the support to carry these ministries through into the future.

We the Bishops of Australia have three separate means of relating to these wonderful Catholic ministries in health care.

The first is through the Australian Catholic Bishops' Conference. I chair the Bishops Commission for Health and Community Services, and we meet with the leaders of health and community services as needed. The relationship this Commission has with Catholic hospitals and aged care services is very good, and we are grateful that whereas the hospitals and aged care services are mostly canonically independent of the Bishops' Conference, we nonetheless have a sound working relationship built on the principles of mutual respect.

The second is through Catholic Health Australia, the association of Catholic hospitals and aged care services. The association is very strong, reflecting the collegiately with which the different hospitals and aged care services work together in fulfilling the health ministry of Jesus. Catholic Health Australia is a key advisor to the Bishops on health policy. Catholic Health Australia is a strong voice for Catholic teaching in the political and media landscape of Australia, and not only focuses on health and aged care policy but is also a champion of the social determinants of health. It is the social determinants, known as early childhood experiences, schooling, access to food and housing, and employment security, that the World Health Organisation says determine how long a person will live and how healthy they will be. Catholic Health Australia is driving governments to focus on the social determinants of health, and the Church through its social services and schools is well qualified to be making this case on behalf of the poorest and neediest within the Australian community.

The third is through our diocesan connections. Each of the hospitals and aged care services within a Bishop's diocese is constantly seeking Bishops' involvement in the health ministry of the Church. We Bishops are blessed to have excellent working relationships with those who exercise the mission of the Church in health care in Australia.

Through these three channels of engagement between Bishops, hospitals, and aged care services, we have put in place several formal mechanisms.

The first is the *Code of Ethical Standards of Catholic health and aged care*. I have several copies with me for anyone who might be interested. It is a practical guide for staff in Catholic hospitals and aged care services on how to live the mission of Christ through informed understanding of Church teaching of health ethics. It was authored by both the Bishops and Catholic Health Australia, and is used even beyond the walls of Catholic hospitals. It is a document that draws from the teachings of this Pontifical Council's *Charter for Health Care Workers*.

The second mechanism is near to completion. The Bishops and Catholic Health Australia have authored the *Guide for understanding the governance of Catholic health and aged care services.* It came about in recognition of the reality that lay people are today exercising the governance responsibilities once carried out by religious, and that Bishops themselves have very rarely, if ever, exercised such responsibility. The *Guide* expresses agreement of Catholic Health Australia and the Bishops on how Catholic governance can best be practised in recognition of civil law, canon law, and theological requirements. The *Guide* also describes certain requirements of Catholic formation, and the need for this formation to be ongoing and more engaging over the course of a person's maturity in faith. It is my hope that back in Australia where the Bishops are this week meeting as a Conference that they will ratify the final draft of this *Guide* which is the product of 18 months of work by Bishops and Catholic health administrators.

We Bishops are very proud of our Catholic hospitals. They are some of the best and most trusted hospitals in Australia. At a time when many Australians are suspicious or cynical about organised religion, they trust the place of Catholic hospitals within the community. The face of Jesus is presented with compassion and expertise to the Australian community through our excellent Catholic hospitals.

Governments across Australia have a high regard for Catholic hospitals and aged care services. Unlike the situation in some other countries, our State governments actively fund 21 Catholic public hospitals to provide services to any person in need. Our 550 Catholic aged care services all receive some type of Federal government funding. Government health funding is in fact very good in Australia, as universal access to health care is provided through a tax payer funded system called *Medicare*. *Medicare* enables any Australian to see a doctor, be treated in hospital, or receive pharmaceutical treatment for free if they are not themselves able to afford the cost of their healthcare.

That does not mean that Governments always take the same view as the Church when it comes to certain ethical positions. Abortion is legally accessible in Australia. Euthanasia is not legal, but there are many in the community including some parliamentarians who are campaigning to have it legalised. The Bishops and Catholic Health Australia are working to ensure that the movement in favour of euthanasia does not see it legalised in the years ahead. This will continue to be a very difficult task.

Governments do, however, respect the ability of Catholic hospitals to operate in accordance with Catholic ethical teaching. No Catholic hospital does or is required to provide abortion services, or to provide contraceptive advice or assisted fertility services. Governments respect Catholic ethical teaching within Catholic hospitals and aged care services, allowing them to operate in compliance with the *Code of Ethical Standards of Catholic health and aged care.*

Catholic hospitals in Australia face many of the same problems

as the wider Church in western nations. Church attendance is declining in Australia, as is the number of practising Catholics. The number of people willing to take on a life-long commitment in the priesthood or religious life is similarly falling. This is placing pressure on Catholic hospitals and aged care services as to how they are able to administer the sacraments to hospital patients or aged care home residents. Lay people are undertaking bachelor degree qualifications in theology to serve as mission leaders and pastoral care givers. Committed Catholics are working in large lay pastoral care teams to tend to the spiritual needs of the sick. Clergy continue to have a presence, but this presence is declining. As well, some of our brother priests find the pace of modern day hospitals a very real challenge. Just as many Australian parishes do not have priests, some hospitals and aged care services have difficulty in having clergy available on all occasions when they are needed. In some circumstances, particularly in country areas where clergy are most stretched, access to the sacraments is sometimes limited. There are no easy solutions to this problem under current circumstances where committed Catholic lay people are available but not empowered to celebrate those sacraments reserved to the ordained clergy.

Whilst our Catholic health services in Australia are vibrant today, the challenge for us Bishops is to keep pace with the changes which are continually occurring. We need, in partnership with all involved in Catholic health care, to "read the signs of the times". Technology is moving fast, new ethical challenges arise with almost every new treatment, and with declining numbers of Catholics in the Australian community there are less Catholic lay staff, religious, and priests available to work in Catholic organisations. We must support those willing to work in the service of the Church, and find pathways to sound ethical decisions. The future for the Church in healthcare is strong, if we put faith in our lay leaders and continue to assist them in their formation and understanding of Catholic identity and support them in their work for God and his people.

Those of us involved in Catholic Health Care in Australia take heart from Pope Benedict's words to this Council last November (2010). "To bend down like the Good Samaritan to the wounded man, abandoned by the side of the road, is to perform that 'greater justice' that Jesus asked of his disciples and actuated in his life." We in Australia commit ourselves whole-heartedly to continuing our ministry in that spirit.

Speeches of the Pontifical Council for Health Care Workers

65th Session of the WHO Regional Committee for Africa

Symposium on 'Supportive Health Care: Public and Private Health Care that Respects the Person'

65TH SESSION OF THE WHO REGIONAL COMMITTEE FOR AFRICA
N'Djamena, Chad
31 August – 4 September 2015

Statement by Msgr. Mupendawatu

MSGR. JEAN-MARIE MUPENDAWATU
Secretary of the Pontifical Council for Health Care Workers, the Holy See

Madame President, the WHO Regional Director for Africa, Dr. Matshidiso Rebecca Moeti, Honorable Ministers, distinguished delegates, I have the honor and pleasure to participate in this 65th session of the WHO Regional Committee for Africa. I wish to thank the Regional Director, Dr. Matshidiso, for the invitation extended to me to participate as an observer at this august assembly. I bring to you warm greetings from the Holy See and particularly from the Pontifical Council for Health Care Workers, where I am honored to serve as the Secretary. I had received invitations from your predecessor Dr. Sambo to participate in previous sessions, however I was unable to come. Thank God, it has materialized this time. I thank you for your commitment to the promotion of public health in Africa, particularly your leadership in helping countries raise capacities and address public health emergencies like the recent Ebola outbreak in some west-African countries.

The Catholic Church has always been committed to the promotion of human life and health, making care for the sick and needy an integral part of her mission. By so doing, it follows the eloquent example of her Founder and Master, who in his messianic activity on earth, went about doing good, especially to the sick and suffering (Acts. 10: 38). Indeed, in many parts of sub-Saharan Africa, the Church is proud to be one of the main partners of the State in providing health services, through its many health facilities, oftentimes located in the hard to reach rural areas. To date, the Catholic Church has over 110,000 social and health care institutions around the world, of which 5,034 are hospitals and 16,627 are dispensaries. In Africa alone, she runs 1,167 hospitals and 5,252 dispensaries (*Statistical Yearbook of the Church* 2013). This underscores the deep interest of the Church for the world of human suffering and health.

The Church is also pleased to contribute to the training of health personnel, through its nursing schools in most countries and through its medical faculties in some countries. In many African countries, in collaboration with the State and with the help of Church-based international organizations, it contributes to the rolling out of effective response to epidemics and strengthening of health facilities.

Madame President, this being my first meeting with you, allow me to share with you briefly the mission and work of the Pontifical Council for Health Care Workers. Exactly 30 years ago, on 11 February, 1985, Saint John Paul II established the Pontifical Council for Health Care Workers, entrusting it with the mission to show the solicitude of the Church for the sick by helping those who serve the sick and suffering, so that the apostolate of mercy may ever more effectively respond to people's needs (*Pastor Bonus*, 152). This mission is promoted through the accomplishment of various tasks namely:

i) To spread the Church's teaching on the spiritual and moral aspects of illness as well as the meaning of human suffering (cf. John Paul II, Apostolic Letter, on the Christian Meaning of Human Suffering, *Salvifici Doloris*, 11 February 1984).

ii) It lends assistance to particular Churches to ensure that health care workers receive the spiritual help they need in carrying out their work according to Christian teaching.

iii) To foster studies and actions which international Catholic organizations or other institutions undertake.

iv) To follow with keen interest the new developments in science and health care regulations so that they may be duly taken into account in the pastoral work of the Church.

All this Madame President translates into a multitude of activities aimed at promoting the mission and accomplishing the tasks assigned to the Council. To this end, I wish to mention but a few:

1. Organization of an annual international conference on a topical health issue. Over 700 participants from 50 to 70 countries

normally attend the Conference. In recent years, we have had Conferences on HIV / AIDS; care for the sick and elderly people with neurodegenerative pathologies; people with autism spectrum disorders; equitable and human health care; the child as a person and patient: therapeutic approaches compared.

2. Raising awareness through the publication of messages on the various health days: World Leprosy Day; World Day Against AIDS; World Autism Awareness Day; International Day of Older Persons; World Diabetes Day; World Day of the Disabled; and World Day for the Collection of Medicine.

3. Promotion of the Celebration of the World Day of the Sick (February 11) and the dissemination of the Message of the Holy Father for the day.

4. Publication of the Review *Dolentium Hominum* in 4 languages and other documents like the *Charter for Health Care Workers, Drug Addiction,*

5. Support to and collaboration with international Catholic Health Care Associations: the International Federation of Catholic Medical Associations (FIAMC); the Catholic International Committee of Nurses and Medico-Social Assistants (CICIAMS); the International Federation of Catholic Pharmacists (FIPC) and the International Committee of Health-Care Institutions of the Church (CIISAC).

6. Through the Good Samaritan Foundation instituted by Saint John Paul II, the Council offers economic support to sick people most in need, especially those affected by HIV / AIDS. The Foundation also organizes international study meetings on health issues, it promotes the donation of medical products to health centers in low-income communities, provides food and education for children and offers scholarships to medical students. In the recent years, it has embarked on the building of a network between Catholic medical faculties in Africa, in order to promote collaboration and sharing of expertise, in their endeavor to form medical professionals. So far, seven faculties have joined the network.

7. Madame President, another important activity of the Council that I would like to bring to the attention of this august assembly is the collaboration with International and regional organization involved with the world of health and health care. On behalf of the Holy See, the Pontifical Council carefully follows the work and the initiatives of the World Health Organization in relation to health-care policies. To this end, the Dicastery takes part every year in the Executive Committee meeting of WHO and the World Health Assembly in Geneva as an observer, and makes a statement on the general subject.

The Pontifical Council also works with various institutions of the United Nations Organization, involved in the struggle against drug addiction and related criminality: the United Nations Office on Drugs and Crime (UNODC); the International Narcotics Control Board (INCB) and the Commission on Narcotic Drugs (CND). The purpose is to be close to these agencies in order to promote dialogue and cooperate for life and the dignity of the person.

Madame President, it is in the same spirit that I wish to envision my presence at this session of the WHO Regional Committee for Africa. My sincere hope is that this will mark the beginning of a fruitful collaboration in the interest of public health in our African nations. May it help to enhance the existing collaboration and mutual recognition between the Church and State, in the common effort to guarantee access to quality health care services for all our citizens, in respect of their rights and dignity! It is true sub-Saharan Africa still has many health challenges and restraints; nevertheless, with the combined effort of all who are committed to the cause of human health, we can pave the way forward towards a healthier environment for our citizens.

Thank you all! ■

SYMPOSIUM ON 'SUPPORTIVE HEALTH CARE: PUBLIC AND PRIVATE HEALTH CARE THAT RESPECTS THE PERSON' Pordenone, 28 October 2015

Speech of Greetings by Msgr. Mupendawatu

MSGR. JEAN-MARIE MUPENDAWATU
Secretary of the Pontifical Council for Health Care Workers, the Holy See

Dear friends, I am particularly happy to be able to be present here at this symposium and I bring, in addition to my own personal greetings, also those of the Pontifical Council for Health Care Workers.

The event that sees you gathered here together constitutes a valuable opportunity to reflect and to engage in dialogue within a scenario of particular intensity and involvement for pastoral care in health. I am taking part with pleasure in your deliberations, certain to be able to draw from them, but also with the hope that I will be able to provide illuminations and observations that are useful in being able to carry out as far as is possible our pastoral mission of service, above all else to the sick Person and all of his or her surrounding context.

In this sense, this initiative, which I applaud, is a propitious one to express certain observations.

What, today, is a Catholic hospital? We could answer this question according to a subjective criterion, meeting the question according to the outlook of those who draw near to such a hospital or use it or work in it, or according to an objective criterion, meeting the question of how a hospital which has the attribute or definition of being Catholic must present itself to society and to patients in particular. This is not a marginal distinction given that whereas the subjective meaning can give rise to personal and debatable assessments, the objective meaning underlies centuries, or to put it better millennia, of the history of pastoral care in health, which is the salient expression of evangelisation.

I want, however, to make clear that a hospital as a Catholic hospital does not have the duty to be different from other hospitals or similar health-care institutions: it is simply called to be, or to strive to be, better than others because to serve Christ in providing assistance to those who suffer is to place at the service of the sick the utmost of one's professionalism with generous dedication, well aware, however, that, as St. John Paul II wrote, 'no institution on its own can replace the human heart, human compassion, human love, human initiative, when it is a matter of responding to the suffering of others'.

And I would like to dwell upon some assumptions about a Catholic hospital that 'cannot be abandoned' which I would define as 'ideals' because they are paradigmatic as regards the foundation of a real and exemplary Catholic hospital. Amongst very many, I would like to focus on three, dedicating to each one of them an analysis that is short, indeed very short.

1. Seeing a Hospital as a Privileged Place for Evangelisation that is Open to Different Cultures and Situations

As regards the institutions of the Catholic Church, hospitals are those institutions that are most widespread in all those parts of the world where the Church is present. The first census of Catholic health-care institutions carried out after the institution of the Pontifical Commission – and then Pontifical Council – for Health Care Workers, caused surprise because of the unexpected, massive and direct presence of the Church in the field of health and health care at a global level. For a Catholic hospital to be a privileged place of evangelisation, however, it should know how to belong to the cultural structure and situations of its location. The basic reason why, ever since the institution of this Pontifical Council which I represent, an attempt has been made to ensure that every Bishops' Conference has a bishop entrusted with responsibility for pastoral care in health, is specifically this! The directives of the Magisterium of the Church have to be implemented by being inserted in a suitable way into specific cultural, social, political, economic and religious realities, that is to say within the framework of the leading ideas of the culture of the individual continents of the world.

The Church in Africa, for example, is seen as the 'Family of God': it should not amaze us, therefore, that specifically in Africa, where Catholics make up 14% of the population, Catholic health-care institutions make up 17% of all such institutions in that continent. This can be connected to the need of African populations to find, especially in settings of care, a family climate. Catholic hospitals in Africa, therefore, must have the Christian face of a Family.

In the Americas, and principally in Latin America, a Church near

to the weak, to the poor, and to the weak and sick poor, has been shown to be the most credible one, despite the condition of oppression that was experienced with colonisation by the populations themselves.

Obviously enough, the situation in Europe and in countries with an ancient and solid Christian tradition, where any function of support by the Church in the field of health and health care has ceased, is different. It is specifically in the so-called Catholic countries of these countries that a 'complete Church community' must be achieved in the clearest and most direct way.

In this field, pastoral care in health is the most convincing synonym of evangelisation specifically because nearness to those who suffer is what inspired the teaching of Jesus. European Catholics, at all levels, however, do not appreciate adequately the unifying factor of the role of the Church in the health-care field in all countries.

Starting from this one can prepare the way for the hoped-for unity of Europe which can really only be such if there is unity in service to man and his dignity: this is to say, that an evangelisation centred around the problems – and their solution – of health care and health should encounter the complete concept of civilisation and the globalisation of love and service.

Medicine perhaps more than other branch of science is emblematic of the very close relationship between progress and civilisation given that one cannot have an improvement in quality of life without the safeguarding, the promotion and the recovery of health. And even when medicine is powerless in the face of the gravity of an illness it is able to lighten its burden! It is sufficient, however, to look at the world and the civilisation in which we live to realise that, despite being a child of civilisation, scientific and technological progress runs the risk every day, and in an increasingly threatening way, to go against civilisation.

Medicine itself, which has attained very high goals with organ transplants, genetic engineering and pharmacology, is today increasingly often and in a threatening way transformed into arbitrary control over the lives of other people, introducing techniques and concepts of selectivity that are the masked face of a new racism. And this happens specifically in countries with an ancient and consolidated Christian tradition where the number of Catholic hospitals is greatest. It is precisely here that they must constitute the advance guard, the advanced frontier of evangelisation!

2. The Need for Health-Care Personnel to Stand out for their Solid Moral Formation

Amongst the emerging aspects of our time, there is the increasing gap between the technical-scientific training of our health-care workers and their moral training or formation.

In the medical field, indeed, civilisation is called service to life: this service, every day, calls on the moral conscience because nothing connected with life and its sacredness and inviolability escapes the domain of the conscience and the moral law.

In the Hippocratic Oath itself one encounters a moral vision of human life: a vision of service to it and its sacredness and inviolability. It is, indeed, a moral approach that we are called to adopt as regards the defence of unborn life and against abortion; as regards responsible motherhood and fatherhood against a selfish population control; as regards a genetic biology that threatens, at the roots, the personality of the person; as regards the safeguarding of the right to die in peace against euthanasia; as regards the humanisation of medicine against every form of bureaucracy and depersonalisation; and as regards the right of everyone to health, without any form of discrimination!

What is the moral formation that underlies these tasks – which cannot be abandoned – not only of medical doctors but all health-care workers who, according to St. John Paul II, are also pharmacists, nurses, chaplains, men and women religious, administrators and volunteers?

Here I will quote with pleasure the *Charter for Health Care Workers*, a document that is able to offer 'an organic and exhaustive synthesis of the Church's position on all that pertains to the affirmation, in the field of health care, of the primary and absolute value of life: of all life and the life of every human being' (p. 5, preface to the first edition 1994).

Although there is a distinction between health care and pastoral care in health, a rigorous interdependence exists between them: just as medical doctors or nurses cannot ignore the moral consequences of the decisions that they are called to make in relation to a patient, so an agent of pastoral care in health must have a knowledge not of an approximate character of questions that are strictly medical in character. A priest or an agent of pastoral care in health does not take the place of a health-care worker but, rather, he or she is called to work at his or her side, albeit with great delicacy and discretion.

The lack of an incumbent awareness of the integration of tasks is at the origin of the difficulties of the action of a health-care worker who is wrongly seen as he or she who has the task of recognising the failure of medicine when even scientists who are not believers recognise the therapeutic value of prayer.

The moral formation of a Catholic health-care worker cannot be delegated because it is an integral part of his or her professional formation. This is why it is of fundamental importance for Catholic health-care institutions, individually but above all together, to be endowed with suitable instruments for the moral formation of the personnel that work in them.

An ongoing ethical and up-to-date formation is required as regards the complexity of the problems that follow one another in the contemporary health-care world, a formation that is able to make a Catholic health-care worker a stranger to forms of exploitation and forms of careerism that damage the rights of the patient.

3. The Duty to Work to Ensure that the Human and Spiritual Budget of the Management of a Catholic Hospital Takes Priority over the Economic and Administrative Budget

It is not unusual, on the part of the Catholic heads – and even those who belong to religious Institutes –

of a hospital to hear it said that everything is going well because, during a difficult and complex time, which is the time we are living through, the accounts are healthy. Where society is advanced and organised in its multiple expressions, a hospital and a place of care is certainly also a company that must be administered with honesty, transparency, and correctness as regards the laws, but also with a necessary administrative ability. It is not always easy to act within legislation that is often chaotic and also exposes the administration of a hospital to economic risks.

This being said, however, it must be clear that a Catholic health-care institution is behaving completely and truly well only if its spiritual budget is in the black. This is a spiritual budget that relates to care for the sick, the involvement of the families of patients, and the professionalism of health-care workers in being authentic Good Samaritans in relation to physical infirmities that must be treated but also spiritual needs that have to be cultivated.

Recent experiences, as well, demonstrate that approaches to health care that act from premisses taken from anthropological visions that are different from the Christian vision, or from needs of an economic, organisational and managerial kind, to facilitate the encounter with contemporary man, in the end turn out to be inadequate. Above all else today there is a need to rediscover how healthy it is for the economy and for social and health-care organisational models to be based upon the solidarity that Jesus taught us in the parable of the Good Samaritan (cf. *Salvifici Doloris*, n. 29). The centrality of the sick person has a value that is also social and economic and it requires the investment of resources to pursue the values expressed in the commandment to love one's neighbour.

As the parable of the sower teaches us (cf. Mk 4:3), if good intentions are not well rooted in the gospel, almost always they are suffocated by hegemonic cultural demands or by interests and compromises that have nothing to do with the requirements of the kingdom of God on earth.

A Catholic hospital must be involved, and distinguish itself, in scientific research, in the improvement of therapeutic and care techniques, but it cannot, and it must not, neglect sick elderly people, the chronically sick, the terminally ill, and those who need a spiritual therapy that teaches them to value the condition of pain.

A Catholic hospital must become a centre for the spiritual reconstruction of man: the spiritual action that must characterise a Catholic hospital is the humanisation of care. Perhaps because we live in a time that repudiates it, the humanisation of medicine and care is spoken about a great deal. And yet it is precisely humanisation which prepares the terrain for spiritual and pastoral action because Christian values that are not implemented are above all else human values that are not implemented!

The humanity to which the Church provides service above all in places of admission and care is humanity as a whole: the Church community itself, which has always been present in Catholic hospitals, expresses itself in communion with man as a whole. Not communion between Christians alone, not even communion that privileges Christians alone, because a man, specifically because he is Christian, is able to accept the values that are common to everyone, independently of their faith, their race, their culture and their social background, and their social classification according to a census. As Christians, therefore, we are called to defend and champion all the supreme values of the human condition.

Unfortunately, the conditioning effects of an inescapable mentality of our time weighs upon the complex organisation of hospitals: that of working according to sectors, thereby exasperating the sub-division of tasks; today, more than ever before, people ignore what others are doing and the pretext of a necessary professionalism accentuates incommunicability.

The image of the Good Samaritan (Lk 10:31ss), which is commonly associated with the medical profession and the health-care professions in general, remains today a rather extrinsic and completely personal reference point, with all the implications of a spiritual and moral character that are involved.

Proof of this is the fact that in the face of increasing ethical responsibilities, the medical culture of our times, the child of an idea of science and progress that is always good and positive and which upholds absolute freedom (cf. *Spe Salvi,* nn. 16-18), tends to transform a medical doctor increasingly into a technician who offers solutions outside any possible horizon involving the meaning of man and a vision of man. But spiritual action within a Catholic hospital involves a communion that is much more than a simple coordination, a communion that must be understood as the sharing and participation of everyone.

It follows from this that humanising a hospital involves a readiness to help and participation and thus no preclusion in the face of any value; readiness to help as a capacity to cooperate, to understand, to enter into communion, and, therefore, to share and to participate in order to affirm in the real health-care world the values of Christian culture which is always a culture that is profoundly human.

It is towards this human and spiritual, scientific and supernatural reality that we have to move so that this pathway will lead on to an increasing faithfulness to the will of God and is translated into a commitment to treat everyone with that respect, that welcome and that delicacy that is required by their dignity as human persons created in the image and likeness of God, and is also the practical achievement of that fraternity that must characterise the community of the disciples of Jesus, in their efforts to live the Gospel every day.

Despite the cultural and social problems, a fixed point of the Christian community in the health-care field is a form of thought which sees man in his totality.

Nothing can turn out to be so disastrous for faith and for health-care and medical culture as losing sight of the totality of the person!

With these simple observations that I have wanted to share with all of you, and hoping that this is a symposium that will be rich in illuminations at the service of Life, I express to all of you, in a heartfelt way, my best wishes for fruitful work!