SHARING THE FULLNESS OF LIFE

Health Policy of the Catholic Church in India

Commission for Healthcare
Catholic Bishops' Conference of India
2005

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"I have come that they may have
life and have it in fullness."

John 10: 10

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Foreword

Javier Cardinal Lozano Barragán
President, Pontifical Council for Health Pastoral Care
Vatican

When I think of the presence of the Church in healthcare in India, my heart is filled with sentiments of deep appreciation and gratitude. During my travels in India, I always made it a point to visit some of the health facilities of the Church. These visits have left in me a very good impression. I also recall the successful official international programme of the 10th World Day of the Sick, held from 9 to 11 February 2002 at the Shrine Basilica of Our Lady of Health, Vailankanni in Tamil Nadu. It was a unique gathering of so many of those working in the healthcare apostolate. It was a time of prayer, reflection and above all an occasion `to re-examine the role and task of the Church in the field of healthcare', as the theme had suggested. The golden jubilee celebrations of the Catholic Nurses Guild of India held in 2003 in Bangalore reminded me how much the Christian commitment to the sick and suffering can be witnessed by the Catholic nurses through their `humanizing care'. I am sure that this Health Policy of the Catholic Church in India, entitled "Sharing the Fullness of Life" will give still a greater impetus for the involvement of the Church in healthcare.

Reflecting on the Christian response to human suffering, the great Pope John Paul II, in his apostolic letter, "Salvifici Doloris", wrote, "Pain is a universal theme that accompanies man at every point on earth: in a certain sense it coexists with him in the world, and thus demands to be constantly reconsidered…Suffering remains a fundamental fact of human life".(1) When life is challenged by conditions of sickness and inexplicable pain, it is the constant and

intimate communion with the Absolute that springs forth in a person an incessant hope and serenity. The words of St. Paul to the Colossians give us a true testimony to this fact, as he wrote, "Now I rejoice in my sufferings for your sake. In my flesh I complete what is lacking in Christ's afflictions for the sake of his body, that is, the Church."(2) In the light of the affirmation of St. Paul, the only solution to the problem of pain and suffering in human life is the complete solidarity with Christ. The enigma of human suffering could find an answer only when we unite our sufferings with the suffering and death of Christ. And, our constant communion with Christ leads us to our solidarity with the sick and the suffering. It is precisely in this solidarity with the suffering we find a solution for the burning questions in human existence. This is the central point of the pastoral assistance in healthcare. Human life becomes a joyful experience and constant celebration when life itself becomes a `Sharing in the Fullness of Life'. Jesus clarified his mission in this world, as he said, "I have come that they may have life and have it in fullness." His mission was to make human life permeated with hope and fullness.

It is our solidarity with those who suffer and our sincere expressions of compassion, care and charity that bring to the sick a new sense of hope and serenity. Jesus in the parable of the Good Samaritan(3) summarises the Christian commitment in the world of suffering. The `stranger' lying wounded at the road-side, is seen as his `neighbour' and offers him compassionate attention and care. The mandate given by Jesus, "to go and heal", inspires us to take up the challenge and be a Good Samaritan today, to be sensitive to the pain and condition of the other, and thus do everything possible to bring relief to the sick and the suffering. `By doing so, you imitate the "Good Samaritan" and witness in practice to the missionary enthusiasm and evangelical love that must distinguish every authentic disciple of Christ.' In every apostolate, as St Paul says, "If I... have not love, I am nothing".(4) As Pope John Paul II wrote in the apostolic exhortation, Christifideles Laici, "In the loving and generous acceptance of every human life, particularly if weak or sick, the Church is today living the basic moment of her mission."(5)

In the message to the 11th World Day of the Sick, Pope John Paul II reminded us that, "Catholic hospitals should be centers of life and hope, where, together with the chaplaincies, ethical committees, the training of lay health care staff, the humanization of care and treatment of the sick, care for their families and a special sensitivity towards the poor and the marginalized should also grow. Their professional work should be expressed in a concrete way in an authentic witness of charity, bearing in mind that life is a gift of God, of which man is only the administrator and guarantor."

Today, there is a growing tendency which denies true commitment and solidarity for life and in many cases it takes the form of a veritable `culture of death'. In the encyclical letter, `Gospel of Life', Pope John Paul II said, "Today, the value of life is suffering from a kind of `eclipse'.(6) In fact, the world is not intended for death but for life, for the fullness of life. The Catholic Church has always been for life and has always defended life in all circumstances. If there is someone who is directly expected to bear this witness it is specifically the healthcare professional, because, in being a health care professional, one is a minister of life.

This year, on May 18th, addressing the 58th Assembly of World Health Organisation held in Geneva, I pointed out specially the deplorable spread of diseases, particularly infectious diseases, that are most virulent in the poorest countries which, precisely because of their poverty, have no resources with which to obtain the medicines that thanks to technological progress could easily provide a cure for some of them. I mentioned that, "as a matter of fact, infectious illnesses account for the death of 17 million people each year, 90 percent of whom live in developing countries. For example, 95 percent of those infected with AIDS have no money to pay for antiretrovirals. Today on the market of some of these countries it is impossible even to find the medicines necessary to treat the so-called "diseases of the poor", such as, for example, tuberculosis, malaria, smallpox, dengue haemorrhagic fever, leishmaniasis, certain forms of meningitis, sleeping sickness, etc."

The Church, following the footsteps of Jesus her Master, has a priority to commit herself especially for the sick who are poor and the less privileged. I am sure that the renewed emphasis of the Health Policy of the Catholic Church to concentrate more on the under-served areas, with greater attention to the "diseases of the poor", there will be a remarkable change in the health scenario of those areas where Church is strongly present. May God bless everyone to be his instruments of healing, by `Sharing the Fullness of Life'!

Introduction

Archbishop Bernard Moras
Archbishop of Bangalore and
Chairman, CBCI Commission for Healthcare

In India in the last fifty years there has been a remarkable increase in the number of dedicated healthcare personnel, hospitals, dispensaries and other health facilities. The general standard of health of the people has definitely improved. We see more and more people becoming steadily conscious about their health and well-being and their duty to prevent diseases and to be mindful of their rights and responsibilities.

But, even when the scientific and medical world has progressed so much and prevention strategies have considerably advanced, the presence of various diseases in our country in such a high proportion and covering such a large population, calls for a special attention and focus. India has more tuberculosis patients than any other country in the world. About 14 million people are estimated to be suffering from active TB of whom 3 to 5 million are highly infectious. India accounts for nearly one third of global TB burden. Every region in India is experiencing a snowballing increase in the transmission of HIV. It is said that if the rate of transmission is not reversed, India may become the `AIDS capital of the world' within a decade or so. It is reported that there are 2 to 2.5 million cancer patients at any given point of time with about 0.7 million new cases coming up every year. In spite of all efforts, Malaria deaths are still prevalent in our country. Kala-azar (visceral leishmaniasis – black fever) is one of the major problems in states like Bihar, Jharkhand, U.P. and West Bengal. Though so many new hospitals with most modern facilities are coming up in the major metros, the new market economy and the globalization have not helped the state of the poor, especially in attending to their healthcare

needs. By and large, healthcare has become the luxury of the rich, and the poor has generally been sidelined. This calls for an urgent need for a comprehensive planning, implementation of effective health and development programmes and accurate monitoring mechanisms. The public-private partnership has to be strengthened. Rather than just curative and rehabilitative approach, more and more promotive and preventive health strategy is to be adapted. Community health has to be given its due prominence. In this participatory strategy, the Church and other faith-based organizations can play a major role in bringing health to the people.

The Church's involvement in health and healing has its mandate from Jesus Christ. He healed the sick, consoled the afflicted and fed the hungry. He freed people from all that hindered their growth `into the fullness of life'. The Church, following the foot-steps of the Divine Healer, has been faithfully serving the poor and assisting the sick, as a part of her mission all over the globe. From the first century onwards the members of the Church had the unassuming privilege to serve their fellow citizens in this land. The contribution of the Church in the field of healthcare, besides other fields like education and social action, has been remarkable and praiseworthy. The Catholic Church remains as the single largest group, after the Government that has the highest presence in the field of health, when we consider the large number of personnel and healthcare facilities in our country. This revised Health Policy of the Catholic Church in India is a reminder to all its members to continue working with renewed zeal for `a healthy society where people, especially the poor and the marginalized, attain and maintain holistic well-being and live in harmony with the Creator, with oneself, with one another and with the environment'. We need to put together all our efforts to bring health to the people, especially to the poor and the marginalized. We need to intensify our collaboration with the Government, NGOs and others, basing on the just laws of our land and the teachings of the Magisterium, in `sharing the fullness of life'. This Health Policy offers valuable guidelines and effective strategies in view of a greater involvement in the healthcare field.

We are deeply indebted to all those who collaborated in the process of finalization of this revised Health Policy. It was on March 20, 2004 the Bishops of the CBCI Health Commission had come together at the CBCI Centre, New Delhi, and decided to revise the Health Policy of 1992.

The text of the Health Policy of 1992 was circulated to various experts requesting their comments on areas to be updated, new topics to be added and the revision process. Respecting their suggestions, at the end of the Workshops held at the CBCI Centre on June 19 and July 18, a Working Draft was prepared. On September 27-29, 2004, at a Consultation of all the 12 Bishops in-charge of health of the regional Bishop's Councils together with the representatives of major health and developmental organizations, the draft of the Health Policy was studied and revised.

During the period from November 2004 to January 2005 eleven regional consultations on the draft of the Health Policy were held. The participants were mostly representatives from the health and developmental sectors. From the reports of these regional meetings, certain region-specific issues were incorporated by the Drafting Committee when they came together on January 22 and 23 at the CBCI Centre. The Bishops of the Health Commission, together with Bishop Thomas Dabre, the Chairman of the Doctrinal Commission, finalized the revised draft during the meeting held on February 2, 2005 at St. John's. The CBCI Standing Committee during its 100th session held in Delhi on April 26-29, 2005 went through the draft of the Policy and gave its final approval.

Let me thank all those who collaborated in this extensive process of the formulation of the Health Policy of the Church and those who have rendered technical and financial assistance. This document is the fruit of collaboration, partnership and sincere sharing of views and concerns from many. In a way the participatory process of formulation itself was an expression of the commitment of all the members of the Church towards its implementation of these policies. Let us join hands in making health accessible to the people, especially the poor and marginalized. Following the footsteps of Jesus, the Master, let us strive to experience the fullness of life, and share it with everyone.

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Abbreviations

AAS	Acta Apostolicae Sedis
AIDS	Acquired Immuno Deficiency Syndrome
CBCI	Catholic Bishops' Conference of India
CHAI	Catholic Health Association of India
CNGI	Catholic Nurses Guild of India
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Scheme
IEC	Information, Education and Communication
ISM&H	Indian Systems of Medicine and Homeopathy
NGO	Non-governmental Organisations
SDFI	Sister-Doctor Forum of India
STI	Sexually Transmitted Illnesses
WHO	World Health Organization

Sharing the Fullness of Life

Health Policy of the Catholic Church in India

1. Health and Healing

The understanding of health is different for different people. Traditionally some people perceived health as 'absence of disease'. They viewed the human body as a machine, disease as a consequence of the breakdown of the machine, and the doctor's task to repair the machine. This model was found inadequate to solve some of the major health problems like malnutrition, chronic diseases, accidents, drug abuse and mental illness.

> Understanding of health varies with people. For some it is mere absence of disease; for others it is a dynamic equilibrium between the person and the environment.

Deficiencies in this model gave rise to the ecological concept that viewed health as a dynamic equilibrium between the person and the environment and, disease a maladjustment of the human organism to environment. Contemporary developments in social and behavioural sciences reveal that health is influenced by social, psychological, spiritual, cultural, economic and political factors, besides biological factors.

The holistic model is a synthesis of all the above concepts and recognises the influence of biomedical, social, spiritual, economic, political and environmental influences on health. It has been variously described as a unified or multidimensional process involving the well-being of the whole person in the context of her/his environment. This view

corresponds to the view held by ancients that health implies a sound mind, in a sound body, in a sound family, in sound environment. The holistic approach implies that all sectors of society have an effect on health, in particular, agriculture, animal husbandry, the food, industry, education, housing, public works and communication. The emphasis is on promotion and protection of health.

In recent years a new philosophy of health has evolved that considers health as a fundamental human right; as the essence of productive life and not the result of ever increasing expenditure on medical care; as intersectoral; as an integral part of development; as central to the concept of quality of life; health and its maintenance as a major social investment involving individuals, family, community, state and international responsibility and; health as a world-wide social goal

Health is a harmony of the physical, psychological, spiritual and social faculties of a person.

Health is multidimensional. The World Health Organization (WHO) definition envisages three specific dimensions – the physical, the mental and the social. As the knowledge base grew, the list expanded to add spiritual, emotional, vocational and political dimensions. Although these dimensions function and interact with one another, each has its own relevance.

As Christians concerned with holistic health, we draw on the understanding of health in the Bible and the *Magisterium* or official teachings of the Church. Pope John Paul II brought our understanding even deeper by explaining health as '…far from being identified with the mere absence of illness, [it] strives to achieve a fuller harmony and healthy balance on the physical, psychological, spiritual and social level. In this perspective, the person himself is called to mobilise all his available energies to fulfill his own vocation and for the good of others'.[1] In the age of super specialty

Health is the core of all human development. It implies harmony within oneself, with one another, with nature and with God.

the care of the whole person is often forgotten. Whereas in the true Christian understanding, a holistic approach is followed which includes both emotional and spiritual care.

Health is the core of all human development. It is to be understood in a broader sense to include all aspects of human life: physical, social, mental, and spiritual. Therefore, health would mean adequate food, housing, clean water, clean air, good social milieu, and good social and interpersonal relationships. In short, it means the satisfaction of ones basic needs: harmonious relationships with one another, nature and God. Together with the physical and psychological aspects, the spiritual and pastoral areas must also be properly tended to.

2. Health Scenario of India

In India, over the years, there has been an overall improvement in the health situation. The infant mortality rate (IMR) has declined significantly from 146 in 1951 to 70 in 2000; life expectancy at birth has increased from 36.7 in 1951 to 64.6 in 2000; and the crude death rate has declined from 25 per 1,000 population in 1951 to 8.7 in 2000. Infectious and parasitic diseases accounted for 34.6 per cent of the total 269 million DALY (disability-adjusted life-years) lost and one-third of the 9.3 million deaths in 1998.[2] The substantial improvement in key health indicators is the result of many factors including improved public health services, prevention and control of infectious diseases, access to modern medical practices in diagnosis and treatment as well as an overall improvement in socio-economic situation.

> India has achieved significant progress in health care in the last 50 years.

During the 1990s, mortality rates reached a plateau and the country entered an era of dual disease burden. Communicable diseases have become more difficult to combat because of the development of insecticide-resistant strains of vectors, antibiotic-resistant strains of bacteria, and the emergence of HIV infection. Poor drinking water and inadequate sanitation facilities also contribute to the spread

of communicable diseases. Longevity and changing life-styles have resulted in the increasing prevalence of non-communicable diseases. Under-nutrition, micro-nutrient deficiencies, and associated health problems coexist with obesity and chronic diseases such as cardiovascular ailments, cancer, cataract-induced blindness and diabetes.

Affordability, availability and sustainability: these are the three key factors in health care. Extensive inequality still persists in our country.

The National Health Policy (2002), National Population Policy (2000) and National HIV/AIDS Policy (2002) guide the actions of the public, private, voluntary sectors in the field of health and family welfare. The Health Policy provides the strategic framework for achieving an acceptable standard of good health amongst the general population of the country. The Population Policy enumerates certain socio-demographic goals to be achieved by 2010, which will lead to achieving population stabilisation by 2045. The Health Policy of the Catholic Church will be broadly guided by these policies in accordance with the values of the Gospel and ethical and moral teachings of the Church.

Despite decades of welfare-oriented development goals, inequities persist in the health system. The extent of access to and utilisation of health care services varies substantially among states, districts and different socio-economic sections of society. A study by the National Council for Applied Economic Research reveals that the richest 20 per cent enjoy three times the share of public subsidy for health compared with the poorest quintile. The poorest 20 per cent of the population has more than double the mortality rate, fertility rate and levels of under-nutrition compared with the richest 20 per cent. On average, the poor spend 12 per cent of their income on health care, as opposed to only 2 per cent spent by the rich.[3]

There is a substantial difference between states in health indices. There is a huge shortage in human resources in institutions, especially in the remote rural and tribal areas where health care needs are the greatest. Poor and undependable public sector services in rural areas and their consequent under-utilisation, and the cornering of secondary and tertiary care services in urban and metropolitan areas by the rich, leads to a skewed pattern in many states.

The last two decades have witnessed expansion in expensive health care-related technologies, broadening diagnostic and therapeutic avenues. Increasing awareness and rising expectations to access have widened the gap between what is possible and what is affordable. The bulk of the cost of treatment is seen to be met by out-of-pocket expenses, estimated at 84.6 per cent of the total health expenditure. [4] This has serious consequences for the poor.

Affordability, availability and sustainability- these are the three key factors in health care delivery system in any country. One of the recommendations of Bhore Committee Report (1946) was to ensure medical care for every individual including those who cannot pay for it. As early as 1946, our country had recognised health as a basic right of every citizen of India. Since then the government has made serious efforts to make health care available to the poor and the less privileged, sometimes free of cost. However, we have not succeeded in carrying out the recommendations of the Bhore Committee in its totality. Inefficiency of the system, improper planning, monitoring and evaluation, lack of true commitment among the implementers and above all, wide-spread corruption, led to the deplorable situation in which millions of the poor are deprived of basic health needs. The currently prevailing market economy has worsened the situation even further.

It is in this context that the health mission of the Catholic Church has to continue playing a vital role in promoting health of the people and alleviating the pain of the sick and suffering, especially of those who are poor and cannot afford adequate treatment.

3. Theological Foundation and Catholic Healthcare Apostolate

The deep interest which the Church has always demonstrated for the world of the sick and the suffering is well known. In this for that matter, she has done nothing more than follow the example of her Founder and Master. In his messianic activity Christ drew increasingly closer to the world of human suffering. 'He went about doing good' and his actions concerned primarily those suffering and seeking help. His mission was `to bring life, life in its fullness'.

3.1. Value of Human Life

From the moment of conception, the life of every human being is to be respected in an absolute way. God alone is the Lord of life from its beginning until its natural end.

Life and health are precious gifts entrusted to us by God. We must take reasonable care of them, taking into account the need of others and the common good. We are called to choose life rather than death. We are called to oppose the culture of death. God stands for life. Family is a sanctuary of life.

'From the moment of conception, the life of every human being is to be respected in an absolute way because the human being is the only creature on earth that God has wished for himself and the soul of each person is 'immediately created' by God; his whole being bears the image of the Creator. Human life is sacred because from its beginning it involves 'the creative action of God' and it remains forever in a special relationship with the Creator, who is its sole end. God alone is the Lord of life from its beginning until its end. No one can, in any circumstance, claim for himself the right directly to destroy an innocent human being'.(5)

"The Gospel of life … has a profound and persuasive echo in the heart of every person – believer and non-believer – because it marvelously fulfills all the heart's expectations while infinitely surpassing them. Even in the midst of difficulties and uncertainties, every person sincerely open to truth and goodness can, by the light of reason and

the hidden action of grace, come to recognize in the natural law written in the heart [6] the sacred value of human life from its very beginning until its end, and can affirm the right of every human being to have this primary good respected to the highest degree".[7] Therefore, respect for the sacredness of life marks an important element of a Catholic healthcare institution. Every medical procedure, care and treatment has to be oriented to the betterment of the quality of life of the patient.

3.2. Holistic View on the Human Person

In her approach to the sick, the Church is guided by a precise concept of the human person and of his or her destiny in God's plan. She holds that medicine and therapeutic cures be directed not only to the good and the health of the body, but to the person as a whole. The Church holds that illness and suffering are not experiences which concern only the person's physical substance, but the person in his/her entirety and in his somatic-spiritual unity. It is well-known that often the illness which is manifested in the body has its origins and its true cause in the recesses of the human psyche.[8] Healthcare must never lose sight of "the profound unity of the human being, in the obvious interaction of all his corporal functions, but also in the unity of his corporal, affective, intellectual and spiritual dimensions.[9]

> Jesus did not teach a cult of suffering. He healed the sick; consoled the afflicted; fed the hungry, freed people from deafness, blindness and leprosy. He called upon his disciples to follow after him in this healing mission.

3.3. Redemptive Meaning of Human Suffering

Jesus accomplished the salvation of the world through his suffering. "For God so loved the world that he gave his only Son, that whoever believes in him should not perish but have eternal life."[10] Jesus cured, remedied, relieved and removed suffering whenever possible. He intended to bring an offering of God's peace and happiness to

humankind. Therefore he healed the sick; consoled the afflicted; fed the hungry, freed people from deafness, blindness and leprosy. He called upon his disciples to follow after him in this healing mission.

"From a simply human point of view, pain and illness might appear as an absurd reality. However, when we allow ourselves to be enlightened by the light of the Gospel, we succeed in appreciating its profound salvific meaning."[11] The prayer of Jesus in the Garden of Gethsemane is a reminder for us about the reality of suffering in life that often cannot be avoided. Jesus prayed, "Father, if you are willing, remove this cup from me; yet, not my will, but yours be done".[12] That was Jesus' obedience and sacrifice. "The Son of Man must suffer many things and be rejected by the elders and the chief priests and the scribes, and be killed, and after three days will rise again."[13] That is how the divinely ordained suffering of Jesus became redemptive and salvific.

The life of suffering can be perceived as a liberating, redemptive and hope-inspiring experience by that person. "If you wish to be my disciple, take up your cross and follow me."[14] "Even though the victory over sin and death, achieved by Christ in His cross and resurrection does not abolish temporal suffering from human life, nor free from suffering the whole historical dimension of human existence, it nevertheless throws a new light upon the dimension and upon every suffering, the light of salvation".[15]

3.4. Solidarity with the Sick

There is an inescapable duty to make ourselves the neighbour of every one, who is in pain and distress, no matter who he or she is.[16] Whether one is old and abandoned by all; a stranger despised without reason, a suffering child or a patient with an incurable disease, each one awakens our conscience by calling to mind the words of Christ: "As you did it to one of the least of these my brethren, you did it to me".[17]

The Church is the Body of Christ. In the unity of the Body of Christ there is unconditional acceptance, love and care of all, with preferential attention to the suffering and the sick. "If one member suffers all suffer together, if one member is honoured, all rejoice together."[18] Rejection, stigmatisation, discrimination or neglect of a person who is sick, old or weak, is at variance with the nature of the Church as one integral, continuous and compassionate unity. A predominant characteristic of Jesus' preaching of the Kingdom of God and his ministry was his special love and concern for everyone, especially the sick, discriminated and stigmatised people.

Stigmatisation, discrimination or neglect of a person who is sick, old or weak, is at variance with the nature of the Church as one integral, continuous and compassionate unity.

3.5. Healthcare and the Ethical Teachings of the Church

The Second Vatican Council affirms that, "In forming their conscience the Christian faithful must give careful attention to the sacred teachings of the Church". For the Catholics, the Church is, by the Will of Christ, the teacher of truth. Her duty is to announce and teach authentically that the truth which is Christ, and at the same time with her authority to declare and confirm the principles of moral order which derive from human nature itself. It follows that the authority of the Church, when she pronounces on moral questions, in no way undermines the freedom of conscience of Christians. This is so not only because freedom of conscience is never freedom "from" the truth but always and only freedom "in" the truth, but also because the Magisterium does not bring to the Christian conscience truth which is extraneous to it, rather it brings to light the truths which it ought already to posses.[19]

4. Catholic Health Care Facilities

From the very beginning of the Church's presence in India, service to the sick was an integral part of her mission. With the arrival of the missionaries, the health care involvement gained a renewed vision and dynamism. Around 1513, the Portuguese missionaries

initiated the 'Santa Casa de Misericordia' in Cochin and Goa, which were probably the first steps towards institutional care of the sick by the Church in India.[20] In 1550, a Jesuit missionary, Fr. Henry Henriques, started a hospital in Punnaikayal, in Tirunelveli District of Tamil Nadu.[21] Since then, there has been a steady growth in the number of Catholic health care facilities, personnel and resources that is a result of self-sacrifice, exceptional dedication and above all heavenly providence. As per the Directory of Catholic Health Facilities in India (2003), the Church has 764 hospitals, 2,575 dispensaries and health centres, 70 rehabilitation centres, 107 mental health centres, 61 centres for alternative systems of care, 162 non-formal health initiatives, and 115 medical training centres that include six medical colleges.[22]

At present, 46 per cent of the health care institutions of the Church are in the four southern states of Kerala, Karnataka, Tamil Nadu and Andhra Pradesh. This strong presence of the Church in the health care field has had a positive impact on the health indicators of these states.

Christians are a tiny minority community in India, just about 2.3% of the total population. Yet, the contribution of this miniscule community in health care sector, besides the other fields like education, social action and so on, has been remarkable and effective.

In the field of medical education, the Church manages six medical colleges and many nursing and paramedical training institutions. Health service delivery is being provided through a network of primary, secondary and tertiary institutions that have a capacity up to 1,300 beds and non-formal facilities like mobile clinics. Health care needs of special groups are being taken care of through geriatric centres, hospices, homes for long term patients, palliative care centres, care homes for people living with human immunodeficiency syndrome/ acquired immuno deficiency syndrome (HIV/AIDS), centres for the disabled, rehabilitation centres for drug-alcohol

addicts, leprosarium, counselling centres and centres for mental health care.

> Christ always favoured the poor. In fact, `anawim Yahweh' (the poor of the Lord) is the most used phrase throughout the Bible for the people whom God especially favoured.

The Church has several health care facilities that offer alternative systems of medicine. However, alternative systems of medicine have not been given the attention that they deserve and they are not integrated into the dominant health care model for various reasons. Therefore, there is a need to collect complete, reliable and convincing data on the safety and the therapeutic efficacy of these systems.

A major area of intervention of the Church has been in the provision of curative care, though there is a gradual shift towards preventive and promotive strategies. There has been a shift from institutional to community-based care. The priority of the Church has been the poor and the less privileged. St. Benedict in Chapter 53 of his rule book wrote, 'the greatest care should be taken in receiving the poor, for, in them Christ is received more particularly than in the rich and powerful'. As a matter of fact, a large number of health care facilities of the Church are located in the inaccessible and underserved areas to serve the poor and marginalised people, and only a small per cent are located in urban areas. This reflects the real meaning of the Christian life and mission: to be at the service of the last, the least and the lost.

5. Vision

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 self, with one another and with the environment.

Having received the mandate from Jesus Christ, to ensure life in its fullness, and inspired by His compassionate love, the 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, the self, one another and the environment.

6. Mission

- To provide humanizing care considering the dignity of the person and the needs of society.
- To ensure promotive, preventive, curative and rehabilitative health care to all, particularly to the poor and the marginalised through their empowerment.
- To engage in social mobilisation of the community by creating awareness on rights, duties and responsibilities related to health issues.

7. Objectives

1. To make quality health services available, affordable and accessible to all, especially in the underserved areas.
2. To empower people to plan for their health and health care needs and access their health care rights.
3. To cooperate and collaborate with the government and other agencies to make health care accessible for all, in accordance with the teachings of the Church.
4. To observe all ethical norms according to the teachings of the Church, professional bodies and just laws of the country.
5. To show compassion for all, serve preferentially the poor, the vulnerable and the marginalised.
6. To practice and transmit the Christian vision of care, in a world of commercialised health care.
7. To facilitate spiritual assistance to everyone we serve, according to their faith, so that the experience of sickness and healing can be transformed into one of personal growth and development.
8. To promote health education, training and research

9. To encourage multi-dimensional programmes on promotion of health and prevention of diseases in communities.

8. Guiding Principles

The Health Policy of the Catholic Church in India is guided by the teachings of the Gospel, the *Magisterium* of the Church and the Charter for Healthcare Workers. The principles that guide the involvement of the Church in health and health care are as follows:

> Equal consideration for all.
> Special emphasis on the hitherto neglected.

1. Keeping in mind the wholistic development of the person, in the involvement of the Church in health and health care, the community health model will be given priority.
2. The interventions of the Church will be guided by Article 25 of the Universal Declaration of Human Rights, that says that all have the right to a standard of living adequate for the health and well-being of themselves and their families.
3. The Church will be committed in its actions to provide access to health and health care facilities and services in areas that lack adequate health care facilities.
4. There shall be no discrimination on the basis of age, sex, creed, class, caste, tribe, religion or other socio-economic, political and cultural realities in the delivery of services and facilities.
5. The policy is guided by the teachings of the Church to serve the poorest of the poor. Special emphasis will be given to disadvantaged groups like tribals, dalits, migrants, refugees and the differently-abled.
6. The decision-making in prevention, diagnosis, treatment and rehabilitation will be according to the teaching of the Church, ethically correct and will be based on complete and accurate technical information.
7. Evidence-based medicine will be practiced in health care including the use of rational therapeutics.

9. Human Resource Development

The Catholic Church in India, with its educational mission, is active in the field of human resource development for the health sector. Human resources in the field of health and health care comprise doctors, nurses, paramedical workers, support staff, administrators, social workers, chaplains and volunteers. In spite of the fact that the Church has a network of health care educational institutions, there is a shortage of dedicated health care providers to serve in the rural areas.

All who study in our institutions should be given an awareness of the total value of each human life, and the consequent need of each student to serve all with compassion.

Policy: The Church will maintain high standards in health care education by promoting multi-disciplinary approaches, by inculcating the values of care and compassion and implementing rigorous training schedules.

Strategies

- Catholic institutions that educate health care workers will endeavour to foster in their students the spirit of vocation to the healing ministry.
- The institutions will promote human and Christian values among their students and their staff.
- The students will be trained in holistic care of the patient. Approved text book in bioethics, the Health Policy and in other relevant policies of the Catholic Church will be included in the curriculum. They will be helped to develop an appreciation of alternative systems of medicine.
- Progress in medicine is continuous; hence, the institutions will conduct updates, change the curriculum as needed and conduct relevant research to help these institutions to be in the forefront of medical care.
- The institutions will encourage their staff and students to have a multidisciplinary approach to health care.

- The institutions will promote community oriented education so that the students are better equipped to serve the underserved areas and less privileged sections of the community.
- Encourage and enable people from poor socio-economic backgrounds to take up health care education.
- In order to increase the pool of priests and religious in health care, congregations are strongly encouraged to depute their members for professional health education.
- Admissions in Catholic health education institutions will be based on principles of fairness, merit and transparency.

10. Interventions

10.1. Communicable Diseases

> Prevention is always better, cheaper and less painful than any cure.

Communicable diseases constitute a major cause of premature death in India, killing over 2.5 million children under age five and an equal number of young adults annually. Since the global eradication of smallpox, 30 new pathogens have been identified, including HIV/AIDS, hepatitis C and E, and new strains of *vibrio cholerae*. The emergence of drug-resistant pathogens and insecticide-resistant vectors has made it difficult to control and treat some communicable diseases. Non-health determinants such as the environment, pollution, malnutrition, poverty, illiteracy and behavioural attitudes also contribute to the persistence of these diseases. Even though health is a subject addressed by state governments, different centrally sponsored schemes to prevent communicable diseases are in place. However, these sometimes fail to reach out to the needy areas.

Policy: The health care institutions will continue to give emphasis to the control and management of communicable diseases. Special attention will be given to non-health determinants and emphasis will be given to prevention programmes, such as immunisation.

Strategies

- Prevention programmes like immunisation, environmental sanitation, safe drinking water and health education will receive more emphasis than curative services.
- Communicable diseases will be tackled in accordance with, and in collaboration with, the national programmes.
- All health care institutions will contribute to the government's epidemiological information system by reporting the incidence of communicable diseases to the government.
- State and area-specific plans and strategies will be prepared depending upon the extent of communicable diseases and appropriate interventions will be identified, according to the feasibility of their implementation.
- The regional health commissions and diocesan health units will take active roles.

10.2. Non-communicable Diseases

Issues related to life styles that have a direct relationship to non-communicable diseases need to be addressed.

Demographic transition and life-style changes due to socio-economic development result in the increasing incidence of non-communicable diseases. In the 1990s, India accounted for 16 per cent of all deaths due to non-communicable diseases worldwide, with a higher incidence among middle-aged (35-69) people. Certain non-communicable diseases, such as goitre and blindness, have received adequate attention by government programmes, but other diseases-such as heart disease, cancer, diabetes, obesity, hypertension and occupation-related diseases, have not.

Policy: The Catholic health care institutions will raise awareness about non-communicable diseases among people so that they seek services for early diagnosis, treatment and care. Measures will be initiated to address the issues related to life-styles that have a direct relationship to non-communicable diseases. All Catholic health institutions

will collaborate with government programmes and involve local communities in programme implementation.

Strategies

- The areas of special concern will be identified and addressed by the health care institutions, depending upon the prevalence and incidence of diseases in their geographical areas.
- Efforts will be undertaken to prevent the spread of these diseases through counselling, behaviour change communication, changes in life-styles and community work.
- Health care institutions of the Church will cooperate, collaborate and participate in relevant government programmes dealing with non-communicable diseases and contribute significantly to the success of these programmes.
- Local communities will be involved in programme management and implementation in order to reduce the prevalence and incidence rates of non-communicable diseases, and to make the programmes sustainable.

10.3. Areas of Special Concern

Illnesses like tuberculosis, leprosy, malaria, kala-azar, filariasis, Japanese encephalitis, nutritional blindness and other deficiencies, HIV/AIDS, Sexually Transmitted Illness (STI), psychoactive substance abuse and other diseases are of special concern to the Church. The adverse effects of these illnesses are not limited to individuals. Families and communities as well face serious problems of economic deprivation, stigma and discrimination. Concerted efforts are required to reach out and provide services to millions of people suffering from these illnesses. There are also inter-state and intra-state variations in the incidence and prevalence of these diseases. The health and healing ministry of the Church, with its large network of institutions, has a major responsibility to deal with these issues.

Policy: The Church will continue to actively contribute to the prevention of illnesses and to the treatment, care and rehabilitation of

those infected and affected. All health care institutions will identify local needs, mobilise resources and work in collaboration with other partners to significantly reduce the prevalence and incidence rates of diseases. Special attention will be paid to the increasing occurance of alcohol and drug abuse that affects individuals and their families.

Strategies

- Effective collaboration with the government, national and international agencies for accessing vaccines and medicines and for participating in various disease control programmes, will be encouraged in accordance with the teachings of the Church.
- Adherence to accepted regimes of treatment would be ensured. Patients and families will be counselled and enabled to comply with treatment regimens and prevention methods to control the transmission of diseases. The use of prescription and addiction-producing drugs in medical care will be strictly monitored.
- Patients with HIV/AIDS, tuberculosis, leprosy and other debilitating diseases will be admitted and treated in the health care institutions with provision for treatment, including surgical requirements.
- Efforts will be made to remove stigma and discrimination against infected people and their human dignity and rights be protected.
- Tried and tested traditional systems of medicine in prevention, treatment and care will be promoted.
- Consumption of tobacco products, alcohol and psychoactive drugs will be prohibited in the health care setting. Promotional linkages with tobacco and alcohol manufacturers should be avoided.
- The health care institutions will conduct awareness programmes against smoking, alcohol use and drug abuse. Catholic health care institutions will initiate and become involved in de-addiction and detoxification centres and rehabilitation programmes depending upon their capacities.
- Since HIV/AIDS is a critical issue requiring urgent attention, a separate HIV/AIDS policy will be formulated.

10.4. Mental Health

> Mental health is essential to the total health of the person. It affects every part of the human being.

Mental health is the balanced development of an individual's personality and emotional attitudes that enable harmonious living within the family, the community and the society. Mental health and behaviour disorders need special attention because they lead to disability, and in some cases even death. The high prevalence of mental illness, limited number of beds and qualified psychiatrists in mental hospitals, inhumane treatment of mentally ill people, and the connection between physical and mental illness all call for the Church to extend its efforts and play an active role in this area.

Policy: The Catholic Health Policy recognises the importance of a comprehensive mental health approach to prevention, treatment and rehabilitation. Prime importance will be given to preventive and community mental health issues and services.

Strategies

- Primary preventive measures that consist of improving the social environment and promotion of social, emotional and physical well-being will be undertaken at the community level.
- Prevention programmes like school mental health activities, crisis intervention, stress management and family life enrichment will be initiated.
- Psycho-social support like counselling will be provided to individuals and families troubled with marital conflicts, domestic violence, child abuse, disturbed parent-child relationships and strained interpersonal relationships.
- Family members will be aided to cope with the problems of the mentally sick person and to create a conducive environment for treatment, support and rehabilitation, free from stigma and discrimination.
- Hospitals are encouraged to initiate Counselling Units with trained and experienced counsellors.

- Early diagnosis of mental illness and emotional disturbances through screening programmes in schools, universities, industry and other venues will be undertaken.
- Hospitals will be encouraged to have psychiatric departments and psychological services for specialised treatment.
- Training of mental health professionals will be promoted. Efforts will be made to create a cadre of community mental health professionals.

11. Special Groups

11.1. Children

Children are a priority group because they are the most vulnerable, and are our supreme assets and the future human resources of the country. Proper care with respect to the child's right to survival, protection and development will be ensured.

Children, who have neither a voice nor any political constituency, are a priority group for the Church because they are the most vulnerable, and are our supreme assets and the future human resources of the country. The constitution guarantees and protects the rights of the child, and the government has formed policies and programmes to ensure the fulfillment of a child's right to survival, protection and development. The National Policy and Charter for Children; National Policies on Health, Education and Child Labour; and legislation like the Juvenile Justice (Care and Protection) Act, 2001 and Child Labour Prohibition and Regulation Act, 2000 provide direction for the Catholic Health Policy.

India has a high infant mortality rate that varies widely between and within states and within socioeconomic groups. The infant and child mortality rate, an index of development, is a composite representing medical, social, economic and cultural factors. The medical causes for high infant and child mortality are the high proportion of low birth-weight children, lack of skilled attendance at delivery and inadequate newborn care, lack of timely and proper care of common

childhood illnesses, lack of complete and timely immunisation, and high levels of under-nutrition among children. The social factors that contribute to infant and child mortality include inadequate infant and young child feeding practices, lack of health-seeking behaviour in communities, poor reach of health care services to the disadvantaged and marginalised and gender discrimination.

Policy: The policy will endeavour to provide complete and proper care for children from conception that will ensure the child's right to survival, protection and development. The policy also reiterates our commitment towards the needs of children in difficult circumstances.

Strategies

- Newborn care will be provided in all heath institutions, especially for newborns with low birth weight.
- Facilities and services for proper care of common childhood illnesses will be strengthened in all health care centers. Catholic health care facilities shall be child-friendly.
- Growth monitoring of children will be actively promoted and those identified as malnourished will be followed up in the field and appropriate advice and counselling will be given to families. Care will be provided to severely under-nourished children.
- Early and exclusive breastfeeding for six months and timely complementary feeding will be promoted.
- Full immunisation of all children in the community will be ensured.
- Special initiatives will be launched to address the health needs of children in difficult circumstances including street and working children, child drug addicts, child sex workers, children in conflict with the law, children with disabilities, orphans and vulnerable children due to HIV/AIDS, and children affected by disasters and those in broken families.
- Issues of the girl child will be addressed as an integral component of all actions.

- Health facilities of the Church will develop effective linkages with government programmes like the Integrated Child Development Scheme (ICDS) and crèches.

11.2. Women

Preference for the male child in a male dominated society has led to a seriously low sex ratio in many communities. Health care providers will actively educate people about the ethical issues related to prenatal sex determination and abortion, and work actively for the empowerment of women.

The situation of women in India today directly reflects their status in society. This is seen in the unacceptably high maternal morbidity and mortality in the country and the high rate of domestic violence against women. Preference for a male child in a male-dominated society has led to the disturbing and increasing trend of female foeticide and infanticide, leading to a seriously low sex ratio in different communities. Preferential treatment of boys from infancy contributes to higher under-nutrition levels among girls. Hospital statistics across the country show more men and boys availing themselves of curative services than girls or women. Thus, girls and women are denied their right to life, survival, development and participation.

Policy: Recognising the challenges related to the right to life and the special needs of girls and women through all stages of their lives, health care providers will actively educate communities about the ethical, legal and other issues related to prenatal sex determination, foeticide and abortion. The Church will work actively with women's and men's groups and other fora for the empowerment of women.

Strategies

- Comprehensive prenatal, natal and postnatal health education and care will be provided in all health institutions. Facilities for safe delivery wherever possible will be ensured.

- Special attention will also be provided to the non-reproductive health needs of women like communicable diseases, anaemia, malnutrition and immunisation.
- Counselling services will be provided for men and women on responsible parenthood, including natural family planning.
- Community health and family life education will be imparted to men and women, so that they seek the necessary health services.
- In order to effectively address issues related to women's health and gender issues, the Church groups will actively work in collaboration with self-help groups and other community-based organisations.
- Every effort will be made to reinforce initiatives against prenatal sex selection, female foeticide and infanticide.
- Every effort will be made to provide adequate and compassionate care and support for unwed mothers and their children, thus promoting a pro-life culture.
- Traditional birth attendants will be trained so that they can help women in remote areas where health facilities are limited.

11.3. Adolescents

Adolescence, which is the transition phase from childhood to adulthood, is characterised by changes in physical, cognitive and emotional development and in social relationships. It is an important milestone in the life cycle of an individual and is a period of stress and strain. Adolescents face problems related to the changes occurring in their body, school/ learning, family relations, identity, abuse and depression. They also sometimes get involved in high risk behaviour and substance abuse. Statistics show an increasing incidence of teen deaths due to accidents, suicides, homicides and violence. In a country where early marriage still prevails, it is important to prepare adolescents for family life, child bearing and responsible parenthood.

> Recognising the importance of a healthy transition to adulthood, the Church will promote positive life skills necessary for healthy and responsible adulthood.

Policy: The Catholic Health Policy recognises the stress and strain that affects individuals in the transition from childhood to adulthood. Recognising the importance of a healthy transition to adulthood, the Church will promote positive life skills necessary for healthy and responsible adulthood.

Strategies

- Parents will be guided to understand and better support their children during adolescence.
- Parents, counsellors, teachers and health care workers will prepare adolescents to deal with physical, cognitive, emotional and social transitions.
- Efforts will be made to impart life-skills education including marriage, childbearing, and family life to in-school and out-of-school adolescents.
- Positive values will be inculcated among adolescents so that they engage in responsible relationships.
- Health issues will be an integral part of the marriage preparation courses.
- Peer group involvement and peer leadership will be effectively utilised.

11.4. Elderly

In a nurturing environment a feeling of well-being can over-ride physical discomforts in the elderly. Health care personnel will get involved in providing this within families and homes dedicated to this purpose.

One of the major features of the demographic transition in India has been the considerable increase in the number of elderly people, especially in rural areas. Ageing is associated with multiple illnesses and general disabilities. Along with the changes in biological composition, life-style factors also play an important role causing disorders and diseases. Old-age diseases are not always curable, causing a strain on the health infrastructure, physical as well as financial, at both the macro and micro

levels. However, a feeling of well-being can still override actual physical discomforts if the environment is nurturing. The National Policy on Older Persons was adopted in 1999, and the government has initiated programmes aimed at financial security, health care and nutrition, shelter, education, supplementation of care provided by the family, and protection of their life and property.

Policy: The policy recognises that the elderly have special needs that will be addressed at the individual, group, family and community levels. The Catholic health care facilities will increasingly get involved in the care of the elderly and also work towards creating an enabling environment for them within their own families.

Strategies

- Geriatric departments in the tertiary care system and geriatric services in other health institutions will be established, and the access to services by the elderly will be ensured. Services will be provided on a priority basis, like separate queues for older persons, in all health care facilities.
- The elderly will be treated with care and compassion and the health care staff will make efforts to explain medications to them.
- Counselling services and linkages with other institutions will be developed to deal with the psychological and social needs of the elderly.
- Priests, religious sisters and others working with families will ensure that the family environment will be conducive for the elderly.
- Efforts will be made to render palliative care in hospitals and care homes.
- Prepare the elderly for a graceful old age and the final moment of life, and protect the dignity of the dying person. The Church will prepare families and caregivers to understand and accept the needs of elderly and to support them with gratitude and respect.
- The Church will emphasise the responsibility of children to take care of their ageing as well as sick parents.
- The Church will provide training on geriatric and palliative care and counselling to health personnel.

Persons with disabilities are gifts of God. They have their abilities and needs. Following the example of Christ, we will offer them caring support and improved access to treatment, rehabilitation, welfare and development.

11.5. Persons with Disabilities

Persons with disabilities include those suffering from four types of disabilities: visual, locomotor, hearing, speech and mental disabilities. It is estimated that the country has 20.54 million disabled people, representing 2 per cent of the total population. The government has made a commitment towards persons with disabilities through enactment of the People with Disability Act, 1995, and has established the Rehabilitation Council of India and the National Handicapped Finance Development Corporation. In addition, several specialised institutions have been established through different programmes for treatment, rehabilitation, welfare and development. The Catholic Church has a large network of 188 medical facilities for the disabled, 70 rehabilitation centres and 107 centres for mental health care.

Policy: The Christian teachings urge us to consider persons with disabilities as 'differently abled' with special needs, problems and issues. Christ healed many disabled people—the lame, the deaf, the blind and the mentally affected - and we will follow His example through scientific means and improved access to services.

Strategies

- Measures will be implemented for the prevention of disabilities that include efforts directed towards elimination of the factors (disease, malnutrition, accidents, genetic factors, problems during childbirth, and such other factors) that cause disabilities.
- Church health institutions and other bodies will be encouraged to involve themselves directly or indirectly in the implementation of national programmes that deal with care and rehabilitation of the disabled.

- Early detection and correction of impairment that leads to disability will be a priority within health care institutions. Service providers will be reoriented and facilities will be strengthened. Medical rehabilitation will be provided through surgery and medicines; provision will be made for corrective appliances and aids; and training will be imparted to ensure correct use of the appliances and aids.
- Provision will be made to the extent possible for speech therapy, physiotherapy, developmental therapy, behavioural therapy and occupational therapy.
- Counselling services to the disabled to accept their disabilities and for social integration will be provided. They will also be involved in programmes to prevent stigma and discrimination, and efforts made to socially integrate them.
- More emphasis will be given to community-based rehabilitation rather than to institutional care to prevent segregation of the disabled from the community and to strengthen and facilitate the state of natural integration and improve the quality of life.

11.6. Terminally Ill

Persons in the dying stage have the same physical, emotional and spiritual needs as everyone else. In addition to the typical needs, persons who are dying are often concerned about being abandoned, losing control over their bodies and lives, and being in overpowering pain or distress. What they need most of all is to be especially cared for. Terminal care gives added quality to the remaining part of life, when medical treatment fails to arrest the progress of disease and death is imminent.

When medical treatment fails to arrest the progress of disease, and death is imminent, palliative care gives added quality to the remaining part of the lives of those who are terminally ill. Persons who are dying are often concerned about being abandoned, losing control over their bodies and lives, and being in overpowering pain or distress. What they need is to be especially cared for.

Policy: All terminally ill will be treated with respect, love and care and their families will be helped to strengthen their coping mechanisms. The Catholic Health Policy takes a positive attitude towards death, placing our trust in the Lord and helping patients and their families place their trust in the Lord.

Strategies

- All efforts will be made to make the patient as comfortable as possible until the moment of death. Refrain from methods which artificially delay death, without any real benefit to the patient which is contrary to the dignity of the dying person and to the moral obligation of accepting death.
- Efforts will be made to provide pastoral care in order to prepare the terminally ill to accept death and help them in preparing for it.
- Appropriate measures will be taken to relieve pain and other symptoms through palliative care.
- All facilities will be provided for meeting the spiritual needs for persons on the threshold of death.
- The presence of someone who can console will be ensured at the moment of death to help the bereaved. Necessary psycho-social counselling and linkages with services will be established.
- All help will be given for the preparation of the body, with respect and dignity.
- The terminally ill and their families will be encouraged to donate organs, if medically approved.

12. Behaviour Change Communication

The Catholic Church recognises the importance of behaviour change communication, which aims at inducing, reinforcing and sustaining changes in the life-styles that promote holistic health and encourage health care-seeking behaviour. Successful health programmes invariably have a strong communication component that helps to reduce the gap between awareness levels and desired practices.

The Church recognises and makes use of different means of behaviour change communication like counselling, interpersonal and group therapy and mass media. There are about 60 counselling centres; a few communication units are set up to produce, distribute and disseminate health and development related issues. In addition, there are about 307 publications by the Church in various languages. The Church acknowledges that the population is diverse in terms of literacy, culture and language/dialects and media reach is difficult. Appropriate behaviour change communication will be an integral part of all health programmes to achieve programme objectives on a sustainable basis.

> In many cases the attitude of people need to be changed. This process is achieved through `behaviour change communication'. This will be an integral part of all health programmes.

Policy: All health programmes will have an appropriate, effective and efficient behaviour change communication component using different media for sustainable positive behaviour change.

Strategies

- Health education will be an integral part of all interventions of the Church.
- Counselling, which is a confidential interaction through a professional relationship, will be provided only by trained counsellors to induce behaviour change.
- The Church will make efficient and effective use of traditional and folk media as well as print and electronic media in reaching out to the people to increase their awareness about health and bring about behaviour change.
- The media and communication units under the Church will produce films, videos and documentaries related to health, and try to create a niche in the mainstream media.
- The use of language will be appropriate and will be sensitive to gender, caste, tribe and language/dialect issues.

- The Healthcare Commission will work in collaboration with the Commission for Social Communication to mainstream health communication.
- Laity and the clergy will be encouraged to contribute to health-related communication messages and to publications by the Church.

13. Service Delivery Systems

13.1. Primary Health Care

Integrated promotive, preventive and curative services delivered through a network of PHCs form the referral points to secondary and tertiary centers and are the first level of contact between the individual and the health system.

This is the first level of contact between the individual and the health system, where a majority of prevailing health complaints and problems can be dealt with satisfactorily. The primary health care approach is based on principles of social equity, nationwide coverage, self-reliance, intersectoral coordination and people's involvement in planning and implementation of health programmes. Primary health care consists of seven essential services: education about prevailing health problems and methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care; prevention and control of endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs. The integrated promotive, preventive and curative services are delivered through a network of primary health centres and sub-centres across the nation.

The Church complements the government's efforts through its 2,587 dispensaries and health centres, mostly located in inaccessible areas, and takes care of the primary health needs of the most disadvantaged people.

Policy: Provision and accessibility of primary health care services will be made in rural and tribal areas and urban slums that lack access to public health services. The primary health care centres will function as referral points to secondary and tertiary care centres in the public and/or private sectors.

Strategies

- The role of health care facilities in providing primary health care will be reviewed, and the values of primary health care will be inculcated among all health staff.
- The Church health care facilities will actively participate in government primary health care initiatives in accordance to the teachings of the Church, and complement its efforts by filling in the gaps.
- Services that are both simple and effective with regard to cost, techniques and accessibility will be provided to all those who are in need.
- The Church will work towards making each person and family an agent for change, promoting health and nutrition.
- Primary heath care will be eco-friendly in nature.

13.2. Secondary and Tertiary Care

The secondary health care, which serves as the first referral level provides curative services through hospitals and the tertiary health care level offers super specialist care and teaching for specialised staff. The Church has six medical colleges and 764 hospitals that provide secondary and tertiary care.

Policy: In addition to providing specialised curative services by hospitals and medical colleges at affordable costs and without discrimination, the secondary and tertiary sector will provide supportive services to the primary health care centres.

Strategies

- Special provision for free/subsidised treatment of poor and needy patients in the secondary and tertiary care centres will be made.
- All efforts will be made to keep the cost of treatment at the minimum for people who can afford to pay.
- The health insurance schemes functioning in certain dioceses will be studied and efforts will be made to replicate them in parishes across the country. The Church will also make efficient use of health insurance schemes offered by government and other insurance companies.
- No discrimination shall be made on the quality of treatment and care provided based on economic or social grounds.
- Service linkages will be encouraged and developed with primary care centres, and provision will be made for treating patients needing specialised care.
- Villages near the secondary and tertiary care centres will be adopted to provide primary health services to the community and to develop referral linkages.

13.3. Emergency Services

Increasing mechanisation in agriculture and industry, induction of semi-skilled and unskilled workers in various operations, and the rapid increase in vehicular traffic have resulted in an increase in morbidity and disability. The road and rail traffic accidents, drowning, burns, poisoning, falls, injuries from sharp or pointed instruments, bites and other injuries from animals and industrial accidents account for significant proportion of deaths in India. Technological advances in the last two decades have made it possible to substantially reduce mortality, morbidity and disability due to accidents, trauma and poisoning.

Technological advances have made it possible substantially to reduce mortality and disability. Catholic health care institutions will welcome and cope with all emergencies.

Policy: Catholic health care institutions will receive, welcome and manage victims of all

emergencies understanding the emotional aspects and urgency of the situation, depending on the facilities available. The parable of the Good Samaritan will always guide us.

Strategies

- Church health care institutions will receive and manage victims of accidents with promptness, urgency, sympathy and understanding as per facilities available.
- The health care units will be equipped to manage emergencies to the extent possible under the constraints of resources.
- All records related to emergency cases will be scrupulously kept.
- If the patient requires further treatment, efforts will be made to transport the patient to the nearest specialty health care service centre, after giving first aid and other possible treatment.
- Each hospital will have its own policy for dealing with medico-legal cases, depending on the facilities available.

13.4. Disaster Relief and Rehabilitation

Disasters, whether natural or manmade, may happen at any point of time. In the recent times our nation has experienced various natural disasters like floods, droughts, earthquakes, and cyclones. Riots, industrial accidents, acts of terrorism, internal displacement and insurgency are forms of manmade disasters. Deaths, injuries, disability and other psycho-social consequences are involved during disasters, and some continue during the rehabilitation phase. The risk of outbreak of communicable diseases is greater due to lack of access to water, sanitation and health care. Recent research also has shown that people affected by disasters face psychological illness, during the post-disaster period.

> Disaster management consists of preparedness, response and mitigation, bringing relief to the infected and affected by providing medical supplies, counselling, trauma care and rehabilitation.

There are three fundamental aspects of disaster management: disaster

preparedness, disaster response, and disaster mitigation. Health care is an important component of disaster management. Caritas-India has been involved in disaster preparedness programmes in some disaster prone areas.

Policy: The health care institutions will respond to disasters by providing health and medical supplies, counselling, trauma care and human resources to those infected and affected.

Strategies

- A network of hospitals, health centres and other agencies will be established to provide immediate relief to a specific disaster-affected area.
- A pool of volunteers will be constituted and trained to form a multidisciplinary team to deal with issues related to disaster relief and rehabilitation.
- An emergency supply of essential medicines and surgical supplies will be provided to areas affected by disasters.
- The quality of services during a disaster will be in concurrence with the Humanitarian Charter and Minimum Standards in Disaster Response recommended by the Sphere Project.
- The geographical areas around the health care centres will be surveyed to identify potential for disasters, and disaster preparedness plans will be developed and implemented, when needed, with community involvement.
- The Church will cooperate and collaborate with the Indian Red Cross Society, non-governmental organisations (NGOs) and government agencies in all disaster management measures.

13.5. Alternative Systems of Medicine

Alternative systems of medicines such as ayurveda, homeopathy, siddha, unani and drugless therapies like yoga, naturopathy, acupuncture and accupressure are widely practised in India with effective cures and remedies for numerous conditions with minimal side effects. The National Policy on Indian Systems of Medicines

and Homeopathy (ISM&H) adopted by the government in 2002 aims to expand the outreach to ensure affordable ISM&H services to the people, and to integrate these services with the allopathic health care delivery system. Utilisation of alternative systems of medicines will expand the pool of effective health care providers, optimise utilisation of local remedies and cures, and promote low-cost health care.

Policy: The policy recognises the significant role of alternative systems of medicine and will optimally utilise the tried and tested concepts and practices of alternative systems of medicines.

Strategies

- Alternative systems of medicine will be mainstreamed and made an integral part of primary, secondary and tertiary care wherever feasible.
- Social workers, village health workers, volunteers and others will be trained on alternative systems of medicine to improve their awareness and skills in the provision of primary health care services.
- Awareness of the benefits of alternative systems of medicine will be improved through community-level meetings and interpersonal communication.
- The knowledge and skills of Indian Systems of Medicine and Homeopathy (ISMH) practitioners and traditional *vaidyas* will be enhanced to provide treatment based on tried and tested medication. Their services will be utilised in hospitals depending upon the situation.

13.6. Blood Safety and Rational Use of Blood and Blood Products

Blood transfusion services are considered as an integral part of the health care system. Development of a high-quality blood safety programme envisages universal provision of a safe, easily accessible, affordable and adequate supply of blood, blood components and blood products to the needy. Only licensed blood banks are permitted

Rational use of blood and blood products will be dealt with as per professional standards, promoting motivation, selection and retention of voluntary blood donors.

to operate in the country and voluntary blood donation is encouraged. Professional blood donation has been prohibited in the country since 1998.

Except for the large hospitals and medical colleges under the Church that have a blood bank facility, other health care units meet their requirements for blood from the district blood bank or other licensed blood banks. At present only few health centres have adequate means of storing blood received from blood banks. There is a shortage of blood collected through voluntary blood donation in the country. Despite information, education and communication (IEC) initiatives and the organisation of voluntary blood donation camps, recourse to replacement donations, although officially discouraged, is still a predominant practice.

Policy: The policy recognises blood as a life-saving mechanism. Rational use of blood and blood products will be met as per professional standards.

Strategies

- The critical set of strategies for ensuring a safe and adequate blood supply involves motivation, recruitment, selection and retention of voluntary non-remunerated blood donors. All these aspects will be rigorously pursued at all levels.
- All samples of blood collected will undergo the mandatory tests as recommended by the government.
- All relevant health staff will be trained in the clinical use of blood as per WHO guidelines.
- All blood requirements will be met through voluntary blood donations. Voluntary blood donation camps will be organised periodically in schools, colleges and other training institutions under the Church as well as in rural/urban communities.

- An effective IEC strategy will be developed and implemented that will promote voluntary blood donation.

13.7. Community Involvement and Participation

> Community involvement helps towards effectiveness and efficiency of programmes.

Involvement of the community in health care is very essential for optimum utilisation of health services. The different stages of community participation involve problem identification, decision-making, implementation, monitoring and evaluation and reaping the benefits of the health care programme. Involvement of the community leads to its empowerment. It is also important to make conscious attempts to involve Christian laity and non-Christians in programme implementation. This will help develop good relations with the community and make all actions more transparent.

Policy: All health care institutions will ensure the equitable participation of different sections of the community in the management and implementation of health care services at all levels.

Strategies

- Each health care institution will develop a structure that will aid community involvement and participation in the health care programme.
- Elected representatives at all levels will be invited, informed and involved in the health care programmes.
- The health care units will participate in the programmes organised by the government health system.
- Outreach programmes will be strengthened by using the services of *mahila mandals*, self help groups and other community-based organisations.

13.8. School Health Programme

School health programme gives impetus to responsible management of the health of the community by a dynamic, proactive process of interaction between the school children, parents, teachers, school management and community.

School is one of the most important and effective platforms to promote health among the future generation. School health education envisages an integrated, holistic and strategic educational, social and medical intervention in the school community for preventive and promotive health care. The implementation of school health education programmes is a means for interdependent, responsible management of the health of the community, by a dynamic, proactive process of interaction between the school children, parents, teachers, school management and community.

The focus of a child in school is the curriculum, which can touch the life of the student at all points and help in the evolution of a balanced personality, assisting her or him to develop intellectually, physically, mentally, emotionally, spiritually, morally and socially. In order to promote school health, the Health Commission of the Catholic Bishops' Conference of India (CBCI) had developed a school health programme curriculum in 1995, which has been adopted by many schools.

Policy: Integrate health education into the curriculum of all schools and invest in the health of the future generation.

Strategies:

- Awareness of the importance of school health will be generated among parents, children and their teachers within and outside the school environment.
- The school health programme curriculum developed by CBCI will be updated and adopted/adapted in all schools.

- Health issues with appropriate health messages will be integrated in the school curriculum without overloading the existing academic curriculum.
- All diocesan education coordinators and principals of schools will be oriented on school health education.
- Best practices in the field of school health insurance programme initiated by the Church will be documented and replicated in other parts of the country.

14. Systems Development

14.1. Management Practices

Management is a creative, innovative, systematic and dynamic force, which provides new ideas, vision to the work group and integrates its efforts to secure the maximum results out of limited resources. Management ensures the smooth flow of work in an organisation by strengthening problem-solving skills, overcoming difficulties and establishing team spirit among the personnel. New standards of governance are emerging. Citizens are demanding better performance in health care in all sectors and are increasingly aware of the cost of poor management and corruption.

With the increasing investment made by the Church in the health care sector, management practices need to be strengthened and updated. It must ensure that the guiding principles of compassion, love and justice are always followed.

Policy: Health care institutions, whether small or large, will follow effective and efficient management practices. Good governance practices, administration, accountability, honesty, transparency, and stakeholder participation will be the basis of management practices.

Strategies

- All health care institutions will have a governing body/ management committee with members representing the society/ congregation, and some from outside the institution. The members

from outside may be selected from amongst those who are involved in health care. As far as possible, gender representation should be made equal.

- With the accent on rights-based approaches, emphasis is increasingly on the participation of service users, not as 'beneficiaries' or 'consumers,' but as citizens who have the right to have a say in shaping of their health. Hence, stakeholder participation will be ensured in all health care institutions.
- Multidisciplinary advisory committees including members from government and non-government sectors will be constituted, to advise on the functioning of the institutions.
- User satisfaction is an indicator of good governance. A monitoring system to receive feedback from patients will be designed, which will help the institution to be patient-centered.
- All institutions are accountable to the patients, the donors, the society/congregation and the general public. Hence, utmost care has to be given to the utilisation of the resources, maintaining records and reporting. Administrative, financial and political accountability will be maintained. Horizontal, downward and upward accountability relationships will be strengthened within the organisations.
- Catholic health care institutions will continue to maintain transparency and fair management practices.

14.2. Human Resource Management

Large numbers of professionals and technical personnel, both religious and laity, are involved with the functioning of the health care institutions. Dedicated, qualified, competent, motivated and experienced personnel are essential to achieve the objectives set by this policy. Human resource policies determine the motivational levels and the sense of belonging. There is a shortage of qualified employees to work in institutions, especially in remote rural and tribal areas.

Policy: All health care institutions will develop their own human resource management system that will lay down clear policies with regard to manpower planning, recruitment, pay packages, recognition,

promotions and termination of employees. These policies will duly recognise the worth and dignity of individuals and will be marked by mutual respect and good interpersonal relationships.

Recognising the worth and dignity of dedicated, qualified and experienced personnel, health care institutions will lay down policies with regard to human resource planning, recruitment, pay packages, promotion and termination of employees.

Strategies

- Human resource planning will be done to estimate the current and future manpower requirements in each institution. To meet the demand of personnel in the health care institutions, efforts will be made to recruit motivated people through publicising the work of the Healthcare Commission and healing ministry. The medical educational institutions shall take an active role in this.
- Sufficient care to recruit and appoint personnel who have the requisite skills and knowledge, and who subscribe to and enhance the realisation of the objectives of the healing ministry, will be exercised.
- All appointments will be made formally with a letter of appointment stating the terms of appointment, duties, responsibilities, leave and termination rules as applicable to each position in a particular institution.
- The pay package for employees will be determined taking into consideration the qualification, skills, experience and the cost of living in a particular area, but not below the minimum wage determined by the government. Policies for providing increments, recognition, promotion and such matters will also be laid down clearly as will employee welfare schemes like retirement benefits.
- An open, flat channel of communication will be maintained within the organisation. Mechanisms for grievance redressal would be institutionalised. Rules and regulations will be applied with understanding, sympathy and fairness.

- The employees will be encouraged to participate in the decision-making of the organisation, and all efforts will be made to promote teamwork. Good performance will be recognised and rewarded, and corrective measures will be initiated against unsatisfactory performance.
- Every effort will be made to prevent sexual harassment of employees, patients and bystanders in the institutions and community. All institutions will develop guidelines for treating the victim and dealing with the perpetrator.

14.3. Training Systems

Training of employees is an integral part of human resource development of an organisation. It enables the employees to improve their aptitude, skills and knowledge that would be useful to provide quality care and treatment to the patients. Participation in training programmes will also increase the commitment and motivation levels to serve the organisation. There are many training courses, workshops, conferences, seminars and consultative meetings organised by other institutions/organisations that could also be useful for the employees.

Policy: Each health care institution should develop a training system to upgrade and enhance the knowledge, attitudes and skills of its personnel. While it is feasible for large institutions to organise in-house training systems, smaller organisations can either join the larger institutions or send their employees to programmes conducted by other organisations.

Strategies

- All health care facilities will have a policy to send their staff for appropriate training, including continuing medical education. A separate budget allocation for this will be created and maintained by those facilities which can afford to do so.
- Tertiary and secondary health care institutions are encouraged to take care of the training needs of the primary health care

institutions. They will develop a training calendar and share it with other institutions.

- Employees will also be encouraged to participate in short term and long term courses that are relevant to their job description and professional advancement.
- The institutions are encouraged to generate scholarships, endowments and fellowships for the training programmes.
- The Healthcare Commission and other national health and development agencies will organise programmes to train employees on management.

14.4. Financial Resources

Managing financial resources is another crucial aspect of organisational management. It involves the best use of available resources for optimum results. Many Catholic health care institutions do not have qualified finance personnel, resulting in mismanagement of resources. Financial accountability and transparency are vital in good governance.

Health care institutions will develop efficient financial management practices and be accountable for all resources spent.

Many of the Catholic health care institutions do not receive grants from the government and largely depend on user fees, donations, grants and loans from India and abroad.

Policy: Health care institutions will develop efficient financial management practices and be accountable for all resources spent. They shall explore, identify and seek resources from within India and outside, as well as from government and non-government sources.

Strategies

- The management of health care institutions will ensure that procedures and accounts of purchases, payments, receipts and so forth are maintained in a systematic, scientific manner. Internal

and external audits will be in place to prevent any malpractices or misuse of funds.

- Financial management should be effective so that the institution does not become dependent on outside resources, and becomes self-sustaining to a large extent.
- The Healthcare Commission and other national health and development agencies will mobilise, distribute and monitor use of financial resources for specific activities/programmes.

14.5. Rational Therapeutics

Rational use of drugs will be promoted also as a component of continuing medical education for medical and paramedical staff. Use of high quality drugs must be ensured.

Irrational drug use is widespread in many hospitals, health centres and dispensaries. Useless, hazardous and unnecessarily expensive drugs are often used. There are many reasons for this, some of which are lack of continuing medical education for medical and paramedical staff, high pressure promotion by drug companies—often using unethical methods—and absence of treatment recommendations and standard treatment guidelines to guide the medical and nursing staff involved in treatment.

Policy: All Catholic health institutions will follow the rational drug policy. The effective use of drugs of good quality will be promoted. The cost of drugs will be the deciding factor when quality is assured. Generic drugs will be used whenever possible.

Strategies

Drug Selection

- The selection of drugs will be based on the WHO Essential Drug List and the National Essential Drug List.
- A committee will be constituted in hospitals that will prepare the essential drug list. The list will be periodically reviewed.

- Drug promotion by drug companies through gifts and other incentives in Catholic health institutions will be discouraged.

Drug Use

- The available hospital formulary or the WHO Model Formulary will be used to ensure rational drug use.
- Standard treatment guidelines will be followed to treat common conditions, wherever applicable.
- Guidelines and treatment regimens for diseases under the national programmes (e.g., malaria, tuberculosis, and leprosy) will be followed.
- Polypharmacy (practice of prescribing too many medicines; unwanted duplication of drugs) will be strongly discouraged.
- Irrational, banned, useless and hazardous drugs will not be used.
- A monitoring and reporting system for adverse drug reactions will be set up in hospitals.
- Compliance will be ensured by appropriate patient education.

Drug Stocking and Storage

- All standard principles of materials management (e.g., inventory control, first-in-first-out, etc.) will be followed for drugs.

Others

- Non-drug therapies and simple home remedies will be promoted.
- Awareness of rational drug therapy will be created among all health personnel.

14.6. Management Information System

Catholic health care institutions are spread all over India, but there is no coordinated information sharing or networking among them. This leads to invisibility of the efforts made by the health and healing

All institutions will develop and utilise effective and efficient management information systems that will help networking, cooperation and collaboration.

ministry. To help remedy this situation, the Commission on Healthcare has compiled data from the health care institutions and published the Directory of Catholic Health Facilities in India in 2003. The Commission is also publishing a journal called *Health in Abundance*.

Policy: Collection, compilation and use of information for strategic planning, programme monitoring and evaluation are significant at the institutional and national levels. All institutions will develop and utilise effective and efficient management information systems that will help informed decision-making, cooperation and collaboration.

Strategies

- The Healthcare Commission and other national bodies will take the initiative to collect and compile data from, and disseminate information to, all health care facilitates at the national level.
- All health institutions will share regularly information about their activities and projects with the Healthcare Commission.
- The Healthcare Commission will make attempts to analyse, synthesise and disseminate this information. It will also use this data for public relations and advocacy activities.
- The Healthcare Commission will disseminate information about different policies, programmes, schemes, scholarships, fellowships and such matters through the media and other appropriate channels.
- All health care institutions and facilities will develop an efficient and effective management information system within the organisation.
- Medical and patient records will be maintained in accordance to the norms established by relevant bodies.

14.7. Research and Evaluation

Research will advance knowledge and humanity that can be put to use for productive purposes. While the health care units in the tertiary sector are encouraged to carry out research of a fundamental nature, others can undertake applied, action-oriented and participatory research. Everything that is scientifically and medically feasible need not be ethically correct.

Without excluding charity and the human approach, there should be a greater emphasis on professional services. Evaluation of the work will help to measure the achievements and to initiate corrective measures wherever required.

It is important to shift the approaches in all health care institutions from charity to professional services, where the inputs, processes, outputs and outcomes of interventions are measurable. Evaluation of the work will help to measure the achievements and to initiate corrective measures wherever required. Evaluations have already become an integral part of efficient programme management systems.

Policy: The policy encourages research that will contribute to knowledge development, especially for the advancement of humanity. Monitoring and evaluation will also become an integral part of any interventions.

Strategies

- Encouragement and support will be provided to staff to involve themselves in research that leads to the improvement of quality of life.
- Preference will be given to research based on local and national needs. Field-based, action-oriented and participatory research will also be encouraged.
- Periodic evaluations of the of health care service provided will be undertaken by such means as user satisfaction studies, in order to assess the quality of treatment and care.

- The results of research will be fully utilised to improve service delivery through corrective actions.
- All research that involves human subjects will comply with the teachings of the Church.
- An Ethics Committee will be established in all tertiary level institutions to deal with the ethical issues of research.

14.8. Standards of Treatment and Care

Standards of diagnosis, treatment and care will be set at each stage. It provides a framework for the expectations of the patient, family and caregivers, in a patient-centered approach to health care.

Policy: The health care institutions will evolve and maintain quality of treatment and care that will meet high standards.

Strategies

- Efforts will be made to establish medical audit committees at the tertiary care centres to develop maintain and monitor standards in diagnosis, treatment and care.
- All health care facilities will develop and establish an effective and sustainable system of standards for service delivery.
- The health care institutions will ensure accepted standards of treatment and care for their patients.
- A charter of rights of clients/patients from the client's perspective will be prepared. This will include the right to information, access to services, choices, safety, privacy and confidentiality, dignity and comfort.
- All health care facilities will aspire to improve their standards and get accreditation from relevant bodies.

The institutions will strive to achieve high standards of diagnosis, treatment and care, attempting to get accreditation from relevant bodies.

14.9. Quality Assurance Systems

Assessment of quality of health care is often thought to be a value judgment, but there are determinants and ingredients of quality that can be measured, such as infrastructure and manpower, processes such as diagnosis and treatment or outcomes such as case fatality, disability and patient satisfaction. Health care quality evaluation also includes safety, effectiveness and timeliness of intervention.

> Regular assessment of quality of patient care and diagnostic services will be given priority.

The quality of services and facilities offered by Catholic health facilities varies widely. Quality consciousness among medical and paramedical staff is generally low and, in fact, is not considered by some as an essential element of Health care services.

Policy: Catholic health facilities will offer health care of the highest quality appropriate to the level of the institution.

Strategies:

- Prevent overuse, abuse and misuse of facilities.
- Minimise barriers to appropriate diagnosis, treatment and care at different levels by matching the level of facility to the level of need.
- Quality control of laboratory and other diagnostic services will be carried out.
- Accreditation of all diagnostic services will be done with appropriate bodies.
- Appropriate continuing education will be given to medical, nursing and paramedical personnel.
- Use of patient management protocols will be promoted to improve management of complex problems.
- Regular assessments of the quality of patient care by prescription and medical record audits will be done wherever possible.

14.10. Standard Precautions and Health Care Waste Management

To prevent transmitting of infections between patients and health care providers rules set up for waste management will be followed.

In the health care setting, the risk of transmitting infection between patients and health care providers is fairly high. Standard precautions are designated to reduce the risk of transmission of microorganisms in health care settings.[23]

Policy: All health care institutions will follow the standard precautions and will follow rules set for hospital waste management.

Strategies

- Depending upon the nature of interventions, every institution would have a well-written, readily available and updated list of standard precautions.
- Apply standard precautions to all patients, regardless of their diagnosis.
- As a part of in-house training, all health care workers will be trained in occupational risks and application of standard precautions.
- Health care waste management will follow the rules set up by relevant bodies in respective places.

15. Environment and Health

The key to an individual's health lies largely in the environment—physical, biological and social. In fact, much of an individual's ill-health can be traced to adverse environmental factors such as water, soil and air pollution, poor housing conditions, presence of animal and insect vectors of disease. Industrial growth leads to environmental pollution from industrial wastes. Advances in nuclear technology have led to the problems of radioactive pollution. Often people are responsible for polluting the environment through urbanisation, industrialisation and other activities.

WHO has defined environmental sanitation as the control of all those factors in the physical environment that exercise or may exercise a deleterious effect on the physical development, health and survival of the population.[24] The objective of environmental health is to create and maintain ecological conditions that will promote health and prevent disease.

A healthy environment will be promoted by creating awareness among the people to control factors that have the deleterious effect on their health, survival and development.

Policy: The Policy will promote awareness among the people and decision-makers on the adverse effect of an unsatisfactory environment on health and take measures to prevent, mitigate and reduce its impact.

Strategies

- Awareness programmes will be conducted for health care staff and the general population on the environment and its effect on health.
- Church agencies will initiate, involve and participate in social movements for a better environment.
- Health and environment will be an integral component in all development programmes.
- The health care institutions will assess the condition of environmental sanitation in the area adjoining the institution and initiate corrective measures.

16. Ethical and Legal Issues

Health care institutions and their personnel are constantly faced with the necessity of deciding how best to promote the total good of the patients. In general, decision-making involves both technical judgments and judgments of ethical values, legal rights, duties and responsibilities. These judgments of what is right or wrong are ethical or moral decisions. When legal rights, duties or values appear to be in conflict, ethical reflection based on established principles and

To maintain the highest quality of care and treatment, the Church institutions will observe the highest ethical standards based on the teachings of the Church, just laws, and professional norms and standards. The decisions should be based on an understanding of human life perceived by human reason and in conformity with the best medical information available.

appropriate decision-making processes can assist patients and care- givers to arrive at sound decisions.

Policy: In order to maintain the highest quality of care and treatment, the Church institutions will observe the highest ethical standards based on the teachings of the Church, just laws, and professional norms and standards. The decisions should be based on an understanding of human life perceived by human reason and in conformity with the best medical information available, enlightened by what is revealed in the life, death and resurrection of Jesus Christ.

Strategies

- Healthcare institutions will follow the teachings of the Church with regard to the ethical issues related to patient care, research and academic activities.
- All the employees working in the institutions will follow the ethical standards of the institution irrespective of their personal beliefs. This clause will be a part of their condition of employment.
- Church institutions will adhere to the just laws of the country in regard to healthcare.
- The institutions will provide a mechanism for the employees to know about the ethical code of the institutions.
- All institutions will have a forum to address the ethical conflicts that their employees experience in relation to patient care and management.
- The institutions will make available a copy of patient records to the patient on request.
- The institution will provide protection to its employees against

compensation claims by providing group insurance against medical negligence.

- In case of medical negligence has occurred in the process of giving care, just compensation will be provided.
- If an institution does not have a research ethics board, the institution should refer medical research or clinical trial studies to the ethics board of another Catholic institution.
- If there is a national and state law that is in violation of Catholic teaching and tradition, the institutions will cooperate with each other and will seek legal remedies as a united body.

17. Dignity and Inviolability of Human Life

17.1. Human Right to Life

Human life must be respected and protected absolutely from the moment of conception. From the first moment of its existence, a human being must be recognised as having the rights of a person—among which is the inviolable right of every innocent being to life.[25] 'Before I formed you in the womb I knew you, and before you were born I consecrated you'.[26] 'My frame was not hidden from you, when I was being made in secret, intricately wrought in the depths of the earth'. [27]

From the first moment of its existence a human being must be recognised as having the right to life.

The Church knows that this Gospel of life, which she has received from her Lord, has a profound and persuasive echo in the heart of every person—believer and non-believer alike. 'Even in the midst of difficulties and uncertainties, every person sincerely open to truth and goodness can, by the light of reason and the hidden action of grace, come to recognise in the natural law written in the heart' [28] the sacred value of human life from its very beginning until its end, and can affirm the right of every human being to have this primary good respected to the highest degree. 'Upon the recognition of this right, every human community and the political community itself are founded'. [29]

In a special way, believers in Christ must defend and promote this right, aware as they are of the wonderful truth recalled by the Second Vatican Council: 'By his incarnation the Son of God has united himself in some fashion with every human being'. This saving event reveals to humanity not only the boundless love of God who 'so loved the world that he gave his only Son' (30), but also the incomparable value of every human person.(31)

The Church firmly believes that human life, even if weak and suffering is always a splendid gift of God's goodness. Against the pessimism and selfishness that cast a shadow over the world, the Church stands for life.(32)

17.2. Threats and Attacks against Human Life

17.2.1. Abortion

The inviolability of the human person from conception prohibits abortion as the suppression of prenatal life. This is a direct violation of the fundamental right to life of the human being and is an abominable crime. There is need to make explicit reference to suppression of life by abortion and its moral gravity because of the ease of recourse to this homicidal practice today and the ethical indifference towards it induced by a hedonistic and utilitarian culture which has spawned a truly abortionist mentality.(33)

The Church has affirmed the moral evil of every procured abortion. This teaching has not changed and remains unchangeable.

The Church, like every person who holds life dear, cannot become accustomed to this mentality, and she raises her voice in defense of life, especially that of the defenseless and unborn, which is what embryonic and fetal life is. She calls health care workers to professional loyalty, which does not tolerate any action that suppresses life, despite the risk of incomprehension, misunderstanding, and serious discrimination which this consistency might cause.(34)

Since the first century, the Church has affirmed the moral evil of every procured abortion. This teaching has not changed and remains unchangeable. Direct abortion, that is to say, abortion willed either as an end or a means, is gravely contrary to the moral law.(35)

17.2.2. Euthanasia

"Euthanasia is one of those tragedies caused by an ethic that claims to dictate who should live and who should die. Even if it is motivated by sentiments of a misconstrued conpassion or of a misunderstood preservation of dignity, euthanasia actually eliminates the person instead of relieving the individual of suffering."(36)

> Euthanasia is killing. A health care provider cannot cooperate in any euthanastic practice even at the request of the one concerned, and much less at the request of the relatives.

Euthanasia is a homicidal act, which no end can justify. Medical and paramedical personnel – faithful to the task of always being at the service of life and assisting it to the end – cannot cooperate in any euthanstic practice even at the request of the one concerned, and much less at the request of the relatives. In fact, the individual does not have the right to euthansia, because he does not have a right to dispose arbitrarily of his own life. For medical science it marks a backward step of surrender, as well as an insult to the personal dignity of the own who is dying. Its being depicted as a "further harbor of death after abortion" should be understood as a "dramatic appeal" for effective, unreserved fidelity to life.(37)

Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of "over-zealous" treatment. Here one does not will to cause death; one's inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or; if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always, be respected.(38)

Particularly in the stages of illnes when proportionate and effective treatment is no longer possible, while it is necessary to avoid every kind of persistent or aggresive treatment, methods of "palliative care" are required. In fact, palliative care aims, especially in the case of patients with terminal diseases, at alleviative a vast gamut of symptoms of physical, psychological and mental suffering; hence, it requires the intervention of a team of specialists with medical, psychological and religious qualification, who will work together to support the patient in critical stages.[39]

17.2.3. Prenatal Diagnosis

Prenatal diagnosis makes it possible to know the condition of the embryo and of the fetus while still in the mother's womb. It permits, or makes it possible, to anticipate earlier and more effectively, certain therapeutic, medical or surgical procedures. Prenatal diagnosis is permissible, with the consent of the parents after they have been adequately informed of the methods employed, if the methods safeguard the life and integrity of the embryo and the mother without subjecting them to disproportionate risks.

Prenatal diagnosis is permissible, with the consent of the parents after they have been adequately informed of the methods employed, if the methods safeguard the life and integrity of the embryo and the mother. But this diagnosis is gravely opposed to the moral law when it is done with the thought of possibly inducing an abortion.

But this diagnosis is gravely opposed to the moral law when it is done with the thought of possibly inducing an abortion, depending upon the results: a diagnosis that shows the existence of a malformation or a hereditary illness must not be the equivalent of a death-sentence.[40]

Besides, any directive or programme of the civil and health authorities or of scientific organisations which in any way were to favour a link between

prenatal diagnosis and abortion, or which were to go as far as to directly induce expectant mothers to submit to prenatal diagnosis, planned for the purpose of eliminating foetuses that are affected by malformations or that are carriers of hereditary illness, is to be condemned as a violation of the unborn child's right to life and as an abuse of the prior rights and duties of the spouses.(41)

17.2.4. The Demographic Question

Another present-day phenomenon, frequently used to justify threats and attacks against life, is the demographic question. This question arises in different ways in different parts of the world. In the rich and developed countries, there is a disturbing decline or collapse of the birthrate. The poorer countries, on the other hand, generally have a high rate of population growth, difficult to sustain in the context of low economic and social development, and especially where there is extreme underdevelopment. In the face of overpopulation in the poorer countries, instead of forms of global intervention at the international level—serious family and social policies, programmes of cultural development and of fair production and distribution of resources—anti-birth policies continue to be enacted.(42)

Contraception, sterilisation and abortion are certainly part of the reason why in some cases there is a sharp decline in the birth rate. It is not difficult to be tempted to use the same methods and attacks against life where there is also a situation of 'demographic explosion'.(43)

The state has a responsibility for its citizens' well-being. In this capacity, it is legitimate for it to intervene to orient the demography of the population. This can be done by means of objective and respectful information, but certainly not by authoritarian, coercive measures. The state may not legitimately usurp the initiative of spouses, who have the primary

The state has a right to intervene to orient the demography of the population by means of objective and respectful information, but certainly not by authoritarian and coercive means.

responsibility for the procreation and education of their children.(44) In this area, the state is not authorised to employ means contrary to the moral law.(45)

17.2.5. The Contraceptive Mentality and Abortion

The close connection that exists in mentality between the practice of contraception and abortion is becoming increasingly obvious. It is being demonstrated in an alarming way by the development of chemical products, intrauterine devices and vaccines which, distributed with the same ease as contraceptives, really act as abortifacients in the very early stages of the development of the life of the new human being.(46)

17. 3. Responsible Parenthood

Called to give life, spouses share in the creative power and fatherhood of God. Married couples should regard it as their proper mission to transmit human life and to educate their children; they should realise that they are thereby cooperating with the love of God the Creator and are, in a certain sense, its interpreters. They will fulfil this duty with a sense of human and Christian responsibility.(47)

A particular aspect of this responsibility concerns the regulation of procreation. For just reasons, spouses may wish to space the births of their children. It is their duty to make certain that their desire is not motivated by selfishness but is in conformity with the generosity appropriate to responsible parenthood. Moreover, their behaviour should conform to the objective criteria of morality.(48)

> The responsible exercise of parenthood implies that husband and wife recognise fully their own duties towards God, themselves, the family and society, in a correct hierarchy of values.

In relation to physical, economic, psychological and social conditions, responsible parenthood is exercised either by the deliberate and generous decision to raise a numerous family, or by the

decision, made for grave motives and with due respect for the moral law, to avoid for the time being, or even for an indeterminate period, a new birth.

Responsible parenthood also and above all implies a more profound relationship to the objective moral order established by God, of which a right conscience is the faithful interpreter. The responsible exercise of parenthood implies, therefore, that husband and wife recognise fully their own duties towards God, towards themselves, towards the family and towards society, in a correct hierarchy of values.(49)

The work of educating in the service of life involves the training of married couples in responsible parenthood. In its true meaning, responsible procreation requires couples to be obedient to the Lord's call and to act as faithful interpreters of his plan. This happens when the family is generously open to new lives, and when couples maintain an attitude of openness and service to life, even if, for serious reasons and in respect for the moral law, they choose to avoid a new birth for the time being or indefinitely. The moral law obliges them in every case to control the impulse of instinct and passion, and to respect the biological laws inscribed in their person. It is precisely this respect that makes legitimate, at the service of responsible procreation, the use of natural methods of regulating fertility.(50)

18. Implementation Mechanisms

The CBCI Commission for Healthcare will partner with associations of health care providers such as the Catholic Health Association of India, Catholic Nurses Guild of India, and Sister Doctors Forum of India and others, to disseminate and implement the health policy.

Linkages between medical institutions like St. John's National Academy of Health Sciences, other Catholic medical colleges, health care institutions and other relevant institutions will be strengthened and promoted to develop them into model institutions.

Measures will be taken to develop model health care institutions covering primary, secondary and tertiary levels.

All hospital chaplains will be oriented in all the aspects of the health policy and pastoral care will be strengthened.

Inter-sectoral collaboration between different Commissions of the CBCI such as health, education, youth, and social communication will be ensured to implement this policy.

As per the directives of the CBCI, all dioceses shall establish a Health Commission. Regional Bishop Conferences will take a lead role in dissemination and implementation of health policy with the help of Regional and Diocesan Health Commissions, Diocesan Social Service Societies, pastors in the parishes and religious congregations.

Ecumenical networking with other Christian denominations and people of other faith-based organisations will be initiated and strengthened.

The Healthcare Commission during its meetings will review the implementation process and effectiveness periodically. If necessary, a committee will be formed that would visit regions to review policy implementation.

Documents that should be kept in all hospitals and made accessible to its staff:

- Pontifical Council for Pastoral Assistance to Health Care Workers, Charter for Health Care Workers, St. Paul's publications, 1995.
- Drugs and Cosmetics Act 1940 with amendments.
- Guidelines on Biomedical Research 2000, Indian Council of Medical Research, New Delhi.

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23. Cf. W.H.O., Safe Management of Waste from Healthcare Activities, Geneva, 1999.
24. Cf.http://www.who.int/water_sanitation_health/Environment_sanite/envintex.htm
25. *Donum Vitae*, n. 5
26. Jer 1:5; Cf. Job 10:8-12; Ps. 22:10-11
27. Ps. 139:15; CCC, 2270
28. Cf. Rom 2:14-15
29. *Evangelium Vitae*, n. 2 b
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31. *Evangelium Vitae*, 2 c
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Appendix

Process of the Revision of the Health Policy

Phase I	
March 20, 2004	The CBCI Health Commission discusses with the Futures Group regarding the technical assistance in the revision of the policy.
April, 2004	Health Commission approves the proposal from Futures Group on the process to be followed in revising the Health Policy.
May 04, 2004	Health Policy of 1992 sent to experts requesting comments on areas to be updated, new areas to be added and the revision process.
May-June, 2004	Written response received from experts; comments studied and compiled.
June 19, 2004	Workshop on the outline for Revised Health Policy attended by 10 participants. Two outlines for revision proposed. The workshop approved of one outline. Sections chosen by experts to draft the policy.
June-July, 2004	The sections written by different experts were compiled, additional points were incorporated, text formatted and draft prepared.
July 18, 2004	Presentation of the draft Health Policy in a workshop participated by 19 members. The text was studied in groups and presentations of comments and suggestions made. Sequencing of topics was done. A committee was formed to further study the document and finalise the draft.
July-August, 2004	The draft was also circulated online among experts, discussed in groups. Inputs from these discussions and comments were incorporated. Content editing was done.

September 27-29, 2004	National Level Consultation attended by 13 bishops of the Health Commission, representatives of CHAI, SDFI, Nurses Guild, Caritas-India, CRI, CRS and subject experts read the policy, discussed and amendments were made.
Phase II	
October 2004-November 2004	The suggestions were incorporated into the health policy. Copies of the draft Health Policy were printed and online presentations on CD were prepared.
October 13-14, 2004	Training of Nodal Trainers for Regional Consultative Meeting on the Policy.
November 2004-January 2005	11 Regional consultations on the draft Health Policy was coordinated by CHAI and organised by Regional Units of CHAI. The regional consultations were attended by Bishops in the region, representatives from CHAI, Regional Forum, DSSS, Medical Colleges, Nursing Schools and Colleges, SDFI and others. The document was studied in the regional consultations and comments and suggestions compiled. About 350 people participated in these consultations
January, 2005	Comments and suggestions from the 11 regional consultations were compiled
January 22-23, 2005	Drafting Committee Meeting attended by 25 participants: Discussed the comments and suggestions from the regional consultations and also revisited the document. Relevant points were incorporated into the draft policy
February 2, 2005	The Executive Committee of the Health Commission along with the Chairman of the Doctrinal Commission, CHAI, CMMB and Futures Group revisited the revised draft policy and finalised the document.
February 20, 2005	Copy of the Health Policy circulated among Bishops of the regional Health Commission for comments, before submitting to the Standing Committee of CBCI.
April 28, 2005	Approval of the Policy by the CBCI Standing Committee

The Church's involvement in health and healing has its mandate from Jesus. He healed the sick, consoled the afflicted and fed the hungry. He freed people from all that hindered their growth. 'Sharing and Fullness of Life', the Health Policy of the Catholic Church in India is a reminder to all its members in joining hands to work for 'a healthy society where people, especially the poor and the marginalized, attain and maintain holistic well-being and live in harmony with the Creator, the self, one another and the environment'. This document calls to intensify Church's collaboration with the Government, NGOs and others, basing on the just laws of this country and the teachings of the Magisterium, in bringing to the people 'the fullness of life'. The Policy offers valuable guidelines and strategies in view of a greater effective involvement in the healthcare in India.