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The Changing Landscape of Catholic Bioethics and Its Implications for the Zambian Healthcare

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ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
AMECEA	Association of Member Episcopal Conferences of Eastern Africa
BCE	Before the Common Era
CCC	Catechism of the Catholic Church
CCD	Catholic Commission for Development
CCJP	Catholic Commission for Justice and Peace
CCZ	Christian Council of Zambia
CDF	Congregation for the Doctrine of the Faith
CHA	Community Health Assistants
CHAZ	Churches Health Association of Zambia
CHI	Church Health Institutions
CHW	Community Health Worker
CoP	Conference of Parties
CRS	Catholic Relief Services
CST	Catholic Social Teaching
CT-Scan	Computed Tomography Scan
DDF	Dicastery for the Doctrine of Faith
DEP	Development Educational Programme
DNR	Do Not Resuscitate
ECM	Episcopal Conference of Malawi
EFZ	Evangelical Fellowship of Zambia
EHT	Environmental Health Technologist
EJA	Economic Justice for All
ERDs	Ethical and Religious Directives
ESCRs	Economic, Social, and Cultural Rights
GDP	Gross Domestic Product
GIFT	Gamete Intra-fallopian Transfer
GRZ	Government of the Republic of Zambia

HAZ	Hindu Association of Zambia
HIV	Human Immuno Virus
ICOZ	Independent Churches of Zambia
ICSI	Intra-cytoplasmic sperm injection
IMF	International Monetary Fund
ISCZ	Islamic Supreme Council of Zambia
IVF	In Vitro Fertilization
JCTR	Jesuit Centre for Theological Reflection
MRI	Magnetic Resonance Imaging
NAC	National AIDS Council
NCCB	National Conference of Catholic Bishops
NDP	National Development Plan
NHIMA	National Health Insurance Management Authority
NSAB	National Spiritual Assembly of the Baha'i
OPD	Outpatient Department
SAP	Structural Adjustment Programme
TB	Tuberculosis
UN	United Nations
USA	United States of America
USCCB	United States Conference of Catholic Bishops
VAT	Value Added Tax
WHO	World Health Organisation
WTO	World Trade Organisation
ZCCB	Zambia Conference of Catholic Bishops
ZEC	Zambia Episcopal Conference
ZINGO	Zambia Interfaith Network Group

GENERAL INTRODUCTION

This study begins with a foundational question: Is healthcare a fundamental human right? The answer, from the perspective of Catholic social teaching, is unequivocally affirmative. The Catholic Church has consistently upheld the right to healthcare as intrinsic to the dignity of the human person and essential to the promotion of the common good.[1] Despite this moral clarity, many nations, including Zambia, have yet to realize universal healthcare coverage that effectively guarantees this right for all citizens. This study is anchored on the principle that all moral issues are linked and that Catholic social teaching can be integrated in every aspect of Catholic teaching such as bioethics.

The integration of Catholic Social Teaching (CST) and bioethics within the framework of universal healthcare represents a profound and sustained commitment to human dignity, justice, and the common good. Grounded in the Gospel and shaped by centuries of theological reflection, CST upholds the intrinsic worth of every human being, advocates the preferential option for the poor, and affirms the moral obligation to promote social equity. These foundational principles align closely with the normative aims of bioethics, which seek to guide medical practice and health policy in a manner that respects human life, fosters compassionate care, and preserves the moral integrity of healthcare systems.

In the context of universal healthcare, the convergence of CST and bioethics provides a compelling moral vision for the development of healthcare systems that are accessible, equitable, and of high quality—especially for those who are most marginalised. This integrated perspective calls for policies and practices that harmonise clinical effectiveness with ethical discernment, ensuring that health systems are not only technically efficient but also grounded in justice, solidarity, and the sanctity of human life.

Moreover, the evolving dialogue between CST and bioethics reflects an ongoing trajectory of ethical and theological engagement with contemporary healthcare challenges. This dynamic interaction must be understood within both immediate and long-term policy frameworks. Accordingly, this study is guided by a central research question: To what extent has the development of Catholic moral theology beyond the manualist tradition reshaped bioethics into a framework that, informed by Catholic Social Teaching, can ground and guide the pursuit of universal healthcare under conditions of economic and structural constraint, as in the case of Zambia? An important follow-up question is: which resources within Catholic social teaching can be leveraged to help Zambia achieve universal

[1] John XXIII, *Pacem in Terris* (April 11, 1963), no. 11.

healthcare? In addressing this question, the study adopts a theological-analytical methodology, drawing from key contributions in CST and bioethics across six chapters, with the aim of constructing a morally coherent and contextually relevant approach to universal healthcare.

Chapter One seeks to establish the foundational framework of this study within the Catholic bioethical tradition by addressing the guiding question: "Why Catholic Bioethics?" This chapter positions Catholic bioethics as a distinct yet integrative discipline that responds to the complex ethical challenges posed by contemporary developments in medical science and technology. Grounded in the broader Catholic moral tradition, Catholic bioethics draws on Scripture, natural law, magisterial teaching, and theological reflection to offer a coherent and principled approach to moral reasoning in healthcare. Central to this tradition is a Christian anthropology that affirms the inherent, inviolable dignity of the human person as created in the image of God. This anthropological vision serves as the cornerstone for ethical deliberation, shaping the Church's commitment to the sanctity of life, and the moral integrity of clinical practices. By situating bioethics within this rich theological and philosophical context, Chapter One lays the groundwork for a sustained inquiry into how Catholic ethical principles can inform and transform healthcare systems in pursuit of justice, equity, and human flourishing.

Chapter Two explores the development of medical ethics within the manualist tradition, a formative period in Catholic moral theology that spanned approximately four centuries. This era is distinguished by its systematic and codified approach to ethical inquiry, exemplified through the widespread use of moral manuals—comprehensive texts intended to guide confessors, theologians, and the faithful in resolving complex moral dilemmas, including those emerging from the practice of medicine. Within this framework, medical ethics was articulated through a structured methodology that sought clarity, consistency, and practical applicability. Manualist theologians categorized moral questions according to established principles and normative rules, thereby enabling the faithful and practitioners to navigate morally ambiguous situations with confidence and fidelity to Church teaching.[2] Key ethical concepts emerging from this tradition include the principle of respect for patient autonomy, the sanctity of life, the principle of totality, the principle of double effect, and early moral analyses of reproductive technologies. These foundational principles not only shaped Catholic responses to medical issues during the manualist period but also continue to influence contemporary bioethical discourse. Through this historical lens, the chapter critically assesses the legacy and limitations of manualist moral theology in shaping modern Catholic approaches to healthcare ethics.

[2] Charles J. McFadden, *Medical Ethics* (London: Burns & Oates, 1961), 16.

Chapter Three examines the evolving integration of Catholic Social Teaching (CST) and bioethics, highlighting a growing interdisciplinary dialogue that expands the ethical conversation from clinical settings to broader social contexts. This development marks a significant shift in contemporary bioethical discourse, moving beyond individual patient care to engage systemic issues of justice, equity, and access. Prominent and frequently cited contributions to this dialogue include *Theological Bioethics: Participation, Justice, and Change* by Lisa Sowle Cahill and *Catholic Bioethics and Social Justice*, edited by Therese Lysaught and Michael McCarthy. These works illustrate a concerted effort to ground bioethical reflection in the principles of CST—particularly the preferential option for the poor, the common good, and human dignity. Cahill advances a conceptual framework of participatory bioethics, situating ethical deliberation within the public sphere, which she defines as an inclusive and open forum for diverse contributions to policy and moral reasoning. Her emphasis on justice and participatory dialogue reflects a move toward socially engaged bioethics. Lysaught and McCarthy, meanwhile, underscore the structural and systemic dimensions of healthcare, emphasizing how cultural, organizational, and policy-level factors significantly influence access to care. They highlight how organizational ethics and policy advocacy, often marginalized in traditional bioethical discourse, are crucial to realizing universal healthcare.[3] These scholarly texts are not only widely cited but are also valued for their clarity and accessibility, making them essential references for understanding the interface between Catholic social ethics and contemporary bioethical challenges.

Chapter Four examines the contributions of the Catholic bishops in Zambia to the field of bioethics, with particular attention to their engagement with healthcare-related issues. The Zambia Conference of Catholic Bishops (ZCCB) has played an active role in shaping the moral discourse on bioethical concerns through the issuance of pastoral letters and public statements. Among the most notable is the *Declaration on Abortion* (1972), which represents an early and explicit articulation of Catholic moral teaching on the sanctity of life. Beyond this, the ZCCB has consistently engaged in advocacy aimed at improving access to healthcare, particularly for impoverished and underserved rural populations. These efforts often intersect with broader appeals for poverty alleviation and social justice, in line with the Church's preferential option for the poor. This chapter critically investigates the extent to which the Zambian Catholic bishops have incorporated the broader vision of Catholic Social Teaching (CST) into their healthcare interventions. It evaluates their contributions not only in terms of

[3] Therese M. Lysaught, and Michael McCarthy, eds. *Catholic Bioethics and Social Justice: The Praxis of US Health Care in a Globalized World* (Collegeville, Minnesota: Liturgical Press Academic, 2018), 23.

doctrinal fidelity but also in relation to their responsiveness to structural injustices within the Zambian healthcare system.

The penultimate chapter examines the efforts undertaken by various sectors and regions of the Catholic Church to integrate Catholic Social Teaching (CST) with bioethics. A compelling example of such integration is found in the work of the United States Conference of Catholic Bishops (USCCB), whose contributions illustrate a broadened ethical framework that extends beyond clinical concerns to encompass social determinants of health. In their document *Ethical Challenges in Global Public Health*, the USCCB underscores the importance of moving beyond a narrowly clinical focus in bioethics toward a more holistic approach that addresses structural and systemic factors influencing health outcomes. This shift reflects a deep alignment with CST's emphasis on justice, human dignity, and the preferential option for the poor. Moreover, the U.S. bishops have been at the forefront of advocacy for healthcare reform, consistently affirming that access to healthcare is not a privilege but a fundamental human right. Their interventions highlight the moral obligation of political systems to promote equitable access to quality healthcare, particularly for the most vulnerable.

The final chapter seeks to apply the principles of Catholic Social Teaching (CST) to the Zambian context, specifically regarding healthcare provision. Zambia faces significant socio-economic challenges, with approximately 60% of the population living in extreme poverty. These conditions are compounded by underdeveloped infrastructure, limited access to healthcare services, high unemployment rates, and restricted financial opportunities. Grounded in CST, the Church has a moral obligation to advocate for universal healthcare as a fundamental, non-negotiable, and pragmatically essential requirement for social justice. The principles of human dignity, the common good, and the preferential option for the poor compel the Church to insist that healthcare be accessible, available, and affordable for all. Therefore, policies and practices in the healthcare sector must consistently align with these ethical imperatives.

This study contends that universal healthcare is not merely an ideal, but a moral necessity for any nation committed to justice and equity. Such a commitment inevitably raises complex questions surrounding healthcare financing. Future research should explore models from countries that have successfully implemented universal health coverage, analysing their approaches to taxation, public investment, and resource allocation. In Zambia, moving toward this goal will require a collaborative effort. The Zambian Catholic bishops, in partnership with theologians, economists, healthcare professionals, political leaders, and policymakers, must engage in sustained dialogue to discern viable

fiscal strategies, such as equitable taxation or alternative financing mechanisms, that can support universal healthcare while respecting the broader principles of CST.

CHAPTER ONE

THE NATURE AND RELEVANCE OF CATHOLIC BIOETHICS

1.0 Introduction

Catholic bioethics is a branch of moral theology that focuses on moral questions regarding medical practices, healthcare, and biotechnology. Its main thrust is safeguarding the dignity of the human person from conception to natural death. Every bioethical activity considers the good of the human person as the core value that should be respected in medical practice, healthcare and reproductive technology. From millennia of practice in healthcare, the Catholic church has developed principles and identified values that still protect and promote the sacredness of human life and the dignity of the human person. This is theologically important for two reasons: respecting the image of God in every human person and sharing in God's mandate for humanity to "be fruitful, multiply and fill the earth" (Genesis 1:26-28). This implies that at creation, God gave humanity certain mandates for the sustenance of human species. These values are interpreted and shared with other traditions for universal considerations and application in different cultural traditions.

This chapter, *The Nature and Relevance of Catholic Bioethics*, situates Catholic bioethics within its historical development from the manualist tradition to more contextually engaged approaches. It critically examines whether this transformation provides a sufficiently robust framework to support the pursuit of universal healthcare under conditions of economic and structural limitation, as exemplified by Zambia. It argues that the principles and values rooted in Catholic bioethical tradition continue to hold enduring significance in promoting and safeguarding the dignity, sanctity, and respect for human life across all aspects of healthcare practice. Given the complex ethical terrain shaped by rapid technological advances and widening social disparities, it is imperative to examine the foundational principles of Catholic bioethics and their relevance to contemporary healthcare contexts. Such an exposition is particularly critical considering the evolving understanding of health as shaped not only by clinical interventions but also by social determinants such as poverty, access, and systemic inequality. In this regard, universal healthcare, a central concern of this study, emerges as both a bioethical imperative and a matter of social justice. This chapter will therefore engage with the question: *What is the nature and relevance of Catholic bioethics in shaping universal healthcare practices?* In addressing this, it will demonstrate how Catholic bioethics provides a coherent moral

framework capable of guiding equitable and compassionate healthcare systems responsive to both technological developments and human needs.

1.1 Medical Ethics as the Foundation of Bioethics

Bioethics was born out of medical ethics. For a very long time, the science of medical practice and healthcare was referred to as medical ethics. To comprehend the subject of bioethics requires an exploration of the foundation and nature of medical ethics. Medical ethics emerged "when the shaman, or religious leader, became distinguished from the doctor or expert in physical healing."[1] Initially, the powers to heal physically and spiritually were believed to reside in the shaman. Conceptually, "A *shaman* is a tribal healer who can act as a medium between the visible world and the spirit world. Shamans are kind of a mix between priests and doctors. Like a priest, a shaman is a holy man who represents a religion — in this case, *shamanism*. Like a doctor, a shaman heals people — or at least claims to do so."[2] Following the split of duties, doctors assumed more responsibility to deal with physical healing while performing their duties without evoking spiritual powers or claiming to possess mysterious powers to do their job.

By the 5th century BCE Greek physician Hippocrates was instrumental in bringing about the concept of ethics in the realm of physical healing associated with medicine.[3] Known as the father of medicine he formulated the famous Hippocratic oath, a principle that has remained relevant to modern day physicians in their practice of medicine. For that reason, Hippocratic ethic/tradition and medical ethics began to be used interchangeably. By definition, medical ethics is "concerned with the application of general principles to the moral problems of the medical profession."[4] This means that by nature, "The Hippocratic tradition [medical ethics] is a virtue-based ethic that emphasises personal competence and probity, as well as a personal relationship with the patient characterised by beneficence, non-maleficence, and confidentiality."[5] Where virtue is evoked, integrity becomes a paramount value for guiding decision, behaviour, and action by those concerned. The deeper meaning of virtue ethic is that one acts rightly and correctly out of the watch of anyone or a compelling law. Medical ethics had placed a major responsibility on the physicians to determine what was best for the

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[1] Patrick Guinan, "Medical Ethics versus Bioethics." *The National Catholic Bioethics Quarterly* 6, no. 4 (Winter 2006), 653. DOI: 10.5840/ncbq200644.

[2] *Vocabulary.com Dictionary*, s.v. "shaman," accessed November 06, 2024, https://www.vocabulary.com/dictionary/shaman.

[3] Saurabh Gupta, "Hippocrates and the Hippocratic Oath." *Journal of the Practice of Cardiovascular Sciences* 1, no. 1 (January – April 2015), 82. DOI: 10.4103/2395-5414.157583.

[4] Charles F. McFadden, *Medical Ethics* (London: Burns & Oates, 1962), 3.

[5] Guinan, "Medical Ethics versus Bioethics," 652.

patients, believing they will always act with integrity for the best interest of the patient. The given responsibility was the basis for "a covenant between a competent physician and a sick patient, the purpose of which is to effect healing."[6] Although unwritten, the contract between a medical practitioner and the patient remains a solemn one considering that it deals with matters of life and death. The underlining principle of the relationship between the physician or any other healthcare worker and the patient is TRUST. This is because the patient is often vulnerable and helpless in front of medical experts when in need of help and support.

The operation of medical ethics was paternalistic in nature since the doctor was deemed to know best what the patient needed. Upon examinations, physicians could proceed with any treatment and medical procedure with little patient participation in the decision making regarding proposed interventions trusting their faithful adherence to beneficence and non-maleficence. Principles of the Hippocratic tradition, especially beneficence and non-maleficence, guided medical care ethics for more than two and half millennia. That is not to say that physicians operated without infringements or violation of the oath. Occasionally, self-regulation failed. History is replete with examples of some abuses in research involving human subjects which may not have raised much alarm. For instance, there is a reported experiment involving Captain Lancaster in the scurvy control research.[7] In that report, there is no indication that the involved sailors had signed any consent to participate in the scurvy research, nor is there record that they had the choice to opt out. Nonetheless, many sailors who were deliberately deprived of vitamin C died of scurvy. The final results of the experiment contributed greatly to the progress in healthcare and nutrition supplements for long-distance sailors, but the research has remained tainted with the unethical approach.

Many more violations were committed by some physicians over centuries, but it took the two major accidents of the 20th century to draw the world's attention to these challenges and the need for a proper code of conduct in medical practice and research. The first accident involved the Nuremberg trial following the Jewish Chronic Diseases Hospital cancer cell experiments. Guinan reports that the most blatant disregard of medical ethics was the Nazi's medical atrocities in the Nuremberg case of

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[6] Guinan, "Medical Ethics versus Bioethics," 651.

[7] In the early days of long sea voyages, scurvy killed more sailors than did warfare, accidents, and other causes. For instance, of Vasco da Gama's crew of 160 men who sailed with him around the Cape of Good Hope in 1497, 100 died of scurvy. In 1601, an English sea captain, James Lancaster, conducted an experiment to evaluate the effectiveness of lemon juice in preventing scurvy. Captain Lancaster commanded four ships that sailed from England on a voyage to India. He served three teaspoonfuls of lemon juice every day to the sailors in one of his four ships. These men stayed healthy. The other three ships constituted Lancaster's "control group," as their sailors were not given any lemon juice. On the other three ships, by the halfway point in the journey, 110 out of 278 sailors had died from scurvy. So many of these sailors got scurvy that Lancaster had to transfer men from his "treatment" ship in order to staff the three other ships for the remainder of the voyage.

1948 which led to the Helsinki Declaration.[8] The second accident concerned the Tuskegee syphilis experiments. The U.S. Public Health Service (USPHS) Untreated Syphilis Study at Tuskegee was a study conducted between 1932 and 1972. The study was supposed to observe the natural history of untreated syphilis.[9] As part of the study, researchers did not collect informed consent from participants. Sadly, all the recruited participants of the Tuskegee experiment were African American men. The scandal culminated into the "The Belmont Principles." Both the Nuremberg atrocities and the Tuskegee abuses revealed the deficiencies of the then existing medical ethics and revealed that physicians were not blameless and did not always adhere to the expected self-regulation code of conduct. The shocking part of the two medical progress experiments was that racial discrimination was evidently applied in selecting the targets for the experiments. The victims were Jews and Blacks in the Nuremberg trials and Tuskegee experiments respectively.[10] Apart from racial discrimination involved, the experiments tolerated harm to the patients who had their human dignity violated and their human rights grossly abused.

Following these atrocities and abuses, putting in place more restraining measures became inevitable to prevent future abuses on human subjects in any research. The Helsinki Declaration stressed that future experiments should not be conducted without respect for the individual, autonomy of the participant, and informed consent (with permission for consent by proxy).[11] The Belmont report identified and recommended additional principles to govern biomedical research namely beneficence, respect for persons, and justice.[12] Although, the formulations of principles greatly reduced the risk of abuses concerning human subjects in research, transgressions have not ended. As McWhirter observed, "the continuing of ethical scandals is an indication that effective means of self-regulations has not yet

[8] Guinan, "Medical Ethics versus Bioethics," 654.

[9] Centres for Disease Control and Prevention, https://www.cdc.gov/tuskegee/about/index.html#:~:text=Background,collect%20informed%20consent%20from%20participants.

[10] Rebekah E. McWhirter, "The History of Bioethics: Implications for Current Debates in Health Research." *Perspectives in Biology and Medicine* 55, no. 3 (Summer 2012), 331-332. DOI: https://doi.org/10.1353/pbm.2012.0025.

[11] McWhirter, "The History of Bioethics," 331.

[12] Guinan, "Medical Ethics versus Bioethics," 655. Note: The Declaration of Helsinki, first adopted in June 1964, outlines ethical principles for medical research involving human subjects. It was developed by the World Medical Association (WMA) and serves as a cornerstone document for research ethics, emphasizing the protection of human subjects. The declaration stresses the importance of obtaining informed consent from research participants, ensuring they understand the nature of the research, potential risks, and benefits before agreeing to participate (https://www.wma.net/what-we-do/medical-ethics/declaration-of-helsinki/doh-jun1964/).

been attained."[13] At the same time other concerns emerged regarding "provision of healthcare to the elderly and the impoverished sick."[14] Such issues and many more emerging issues revealed that medical science needed a broader framework than simply physician-patient relationship.

Several other traditions have held special place for the care of the sick and the dying. The Catholic Church is among the notable religious traditions that have developed such medical ethics over the millennia. It is part of the Catholic Church's mission of evangelisation to care for the sick (Luke 9:2). Catholic medical ethics is "based on the Catholic moral tradition and its understanding of the nature and source of human dignity."[15] Therefore, medical ethics deal with what is approved and what is not permitted when dealing with human life, health, and healthcare. According to John Paul II, medical science is "a service to human fragility aimed at the cure of diseases, the relief of suffering, and the equitable extension of necessary care to all people."[16] From the very start the Church wanted equality in the practice of medicine. As such, values such as compassion, justice, and respect for life have always been guiding principles for Catholic care of the sick even before any principles for medical ethics were formulated and codified. The fundamental value of medical ethics is the service to human life and health.

1.2 Foundations and Development of Catholic Medical Ethics

Catholic medical ethics is a branch of moral theology, a discipline that deals with responsible human behaviour formulated within the context of Christian religious belief and its theological foundation. To understand how human beings should act, William May explains, "the systematic effort to discover who we are and what we are to do if we are to be fully the beings, we are meant to be is carried out exclusively using human intelligence, the domain of moral philosophy or ethics. When this effort is systematically undertaken by those whose human intelligence is informed by Christian faith, it is the work of moral theology."[17] Moral acts are integral and concrete expressions of the human person. Traditionally, for an act to be good, all conditions namely the object, the intention, and the circumstances must be good. The implication here is that humans must become fully aware of their

[13] McWhirter, "The History of Bioethics," 334. Note: The Belmont principles guide researchers and Institutional Review Boards (IRBs) in ensuring ethical conduct in research. The three core ethical principles for research involving human subjects according to the Belmont report are Respect for Persons, Beneficence, and Justice. The report was published in 1978, the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research (https://irb.wisc.edu/regulatory-information/belmont-report/).

[14] Guinan, "Medical Ethics versus Bioethics," 654.

[15] Irish Catholic Bishops' Conference, *Code of Ethical Standards for Healthcare* (Dublin: Veritas Publications, 2018), 19.

[16] John Paul II, *Evangelium Vitae* (March 25, 1995), no. 89.

[17] William E. May, *An Introduction to Moral Theology* (Huntington: Our Sunday Visitor, Inc., 2003), 24.

actions on the understanding that through the actions they freely choose to do they reveal their character. In other words, moral theology is the "reflection on the moral principles and narratives as found in the Scriptures and Church tradition from the perspective of faith."[18] Tradition here means millennia of lived experience and practices.

The distinctive nature of moral theology lies in the fact that it has two constitutive elements, namely morals and ethics. Morals are interested in the fundamental Christian beliefs, the character of the moral agent, norms, and situational analysis.[19] On the practical level, "morality concerns the principles and teachings about right and wrong that organise a group of people."[20] Morality is also the basis for rewards and punishments within a given society which presupposes knowledge of values. On the other hand, "Ethics is a term that usually refers to the academic study of morals and moral systems."[21] Ethics "involves a level of thinking prior to making a decision and taking action."[22] The process of reflection presupposes: (i) knowledge of the good as the end (goal) of moral life and the basic reason for being moral, (ii) the conception of the human person as a moral agent, and (iii) knowledge of the points of reference that act as the standard for moral judgement.[23] In other words, ethics is concerned with the nature of the good, the nature of the human person, and the criteria for judgment. Medical ethics falls under the category of the broader area of ethics.

The writings on Catholic medical ethics date as far back as the nineteenth century, but the field evolved to become an organised subject of teaching and instructions in the 1940s with the emergence of teaching manuals for Catholic medical institutions. The initial works ran with almost an identical title that highlighted the need for professional ethics in the practice of medicine. David Kelly has outlined the writings in a more or less chronological order. Among the notable manuals indicated by David Kelly includes *The Catholic Doctor*, by Alphonsus Bonnar, which appeared first in 1937 and remained a significant manual of medical ethics way into the fifties. In style and content Bonnar's work was a compendium for Catholic Doctors on matters regarding the teaching of the Church on medico-moral questions of practical importance.[24]

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[18] Craig A. Boyd and Don Thorsen, *Christian Ethics and Moral Philosophy*: *An Introduction to Issues and Approaches* (Grand Rapids, MI: Baker Academic, 2018), 4.

[19] Richard M. Gula, *Reason Informed by Faith*: *Foundations of Catholic Morality* (New York: Paulist Press, 1989), 9 – 11.

[20] Boyd and Thorsen, *Christian Ethics and Moral Philosophy*, 2.

[21] Boyd and Thorsen, *Christian Ethics and Moral Philosophy*, 1.

[22] Gula, *Reason Informed by Faith*, 9.

[23] Gula, *Reason Informed by Faith*, 11.

[24] David Kelly, *The Emergence of Roman Catholic Medical Ethics in North America* (New York and Toronto: The Edwin Mellen Press, 1979), 150.

Stanislas La Rochelle and Charles Fink worked together on a manual entitled *Handbook of Medical Ethics for Nurses, Physicians*, *and Priests*. The original publications first appeared in French, in 1940. The first edition was bound into pocketbook format to allow for quick perusal by the nurses, physicians, and priests when dealing with practical questions. According to David Kelly two other French-Canadian works appeared around the same time namely, *Éléments de morale médicale* - Elements of Medical Morality (1940) and *Application de l'éthique professionelle* – Application of Professional Ethics (1943) by Armand Perrier and Josephat-Zéphirin Dufort respectively. These two works, like the earlier ones, were intended to equip the health personnel in their day-to-day duties when dealing with challenging issues in the practice of medicine. In their work, Perrier and Dufort endeavoured to define medical ethics to be "the science which treats of the obligations of the nurse [and doctors]."[25] Further, the authors added that "Medical ethics is thus a division of professional ethics. It has as its subject matter the particular rights and obligations of doctors and of their assistants in the exercise of their profession."[26] Credit must be accorded to this generation of authors for their great effort in grounding medical ethics as an appropriate tool in the practice of medicine and their contributions to the emergence of medical ethics in general. One notable limitation of the manuals at this stage is that they were all focused on the nurses and doctors with little reference to the patients.

Some of these manuals also introduced a range of additional emphases and themes, several of which conveyed deeply negative and damaging perceptions of women and their bodies. Within early Christian thought, women were frequently interpreted through the figure of Eve—particularly her transgressive act, which was understood to have led Adam, and by extension all men, into sin. The belief that women's bodies embody sin and evil led to the view that their sexuality must be regulated and controlled. This interpretive lens had far-reaching theological consequences. As Margaret Farley observes, early Christian theology often exhibited a persistent tendency to associate women with moral weakness or evil.[27] In doing so, it frequently denied women full participation in the *imago Dei*, the belief that all human beings are created in the image of God, and instead cast them as secondary or derivative beings whose identity was defined primarily in relation to men. Within this older framework, women were unambiguously positioned as inferior. Their roles were tightly controlled, subordinate, and carefully delimited, serving primarily to complement male authority rather than to express independent agency or equality. Such constructions not only reinforced hierarchical gender relations

[25] Kelly, *The Emergence of Roman Catholic Medical Ethics*, 160.

[26] Kelly, *The Emergence of Roman Catholic Medical Ethics*, 159.

[27] Margaret Farley, "New Patterns of Relationship: Beginnings of a Moral Revolution." *Theological Studies* 36, no. 4 (1975), 629. EBSCOhost.

but also contributed to enduring theological and cultural narratives that justified the marginalization of women.

To break the cycle of marginalisation of women, Farley argues that ethical reflection must begin with what she calls the "obligating features" of persons—those characteristics of human existence that generate moral claims upon us. Among these, two remain particularly significant. First are those features of human persons that bind and guide moral action, requiring that our choices and structures be accountable to the dignity of others. Second are the attitudes that fail to acknowledge the particularity and diversity of persons, reducing individuals to abstract or generalized categories and thereby overlooking what is nevertheless constant in all human beings, whether male or female.[28]

Farley ultimately identifies two fundamental features at the core of human personhood: autonomy and relationality. Autonomy entails more than mere independence; it requires that persons be respected as ends in themselves, never merely as means to another's purposes.[29] It calls for recognition of everyone's capacity for self-determination, moral agency, and participation in shaping their own lives. At the same time, relationality underscores that persons are inherently social and interdependent, formed and sustained through relationships with others. To honour relationality is to acknowledge mutual responsibility, care, and the ways in which human flourishing is bound up with the well-being of others.

Taken together, autonomy and relationality provide a moral framework that resists marginalisation. They demand both respect for individual dignity and attentiveness to the networks of relationship in which that dignity is realized. In this way, Farley's account challenges any system or practice that diminishes women by denying either their agency or their full participation in the shared life of the human community.

Characteristic to all the manuals is the fact that nearly all the writers were priests and tended to include in their works topics of pastoral and sacramental nature. Some of the included subjects, although relevant to the pastoral care of the patients, were not of immediate importance in the professional activities of nurses and doctors. In the case of Stanislas La Rochelle and Charles Fink, their *Handbook of Medical Ethics for Nurses, Physicians*, *and Priests* "discusses baptism, confession, the Eucharist, and extreme unction in the context of illness; baptism of foetuses and monsters, of the apparently dead, of unconscious persons of unknown religion, and of children of non-Catholics."[30]

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[28] Margaret A. Farley, "A Feminist Version of Respect for Persons." *Journal of Feminist Studies in Religion* 9, no. 1/2 (1993): 187. http://www.jstor.org/stable/25002208.

[29] Farley, "A Feminist Version of Respect," 187.

[30] Kelly, *The Emergence of Roman Catholic Medical Ethics*, 157.

Monsters referred to infants born with extreme deformities like anencephalic babies who are characterised by partial or total absence of the brain.[31] Such babies were baptised before they were left to die because they were not expected to live longer. Salvation of souls featured prominently in these manuals. This approach points to the understanding of the human person as a citizen of this world and the next. In other words, they considered both the physical and spiritual dimension of every patient and the need to give them the necessary attention. Treating only the physical illness may leave the patient in spiritual limbo. It must be noted that this approach fits into Catholic soteriology.

The two works of major interest in our next chapter of study are situated at both ends of the Second Vatican Council (Vatican II). Vatican II was a momentous event for the Church in the modern world regarding guidance on current fundamental subjects related to human dignity, respect for human life, and healthcare. On the pre-Second Vatican Council side Charles J. McFadden's *Medical Ethics* made significant contribution in the training and working of doctors, nurses, and seminarians. Keeping the same title and working in the post-Second Vatican Council era, Bernard Häring made huge contribution to bioethics in his work on *Medical Ethics*. One major recommendation of Vatican II was that "moral theology and moral reflection should be nourished and rooted in the Scriptures."[32] From its initial development Catholic medical ethics was largely grounded on bodily integrity, dignity of the human person, and respect for human life. In line with the Church's Magisterium, the earlier manualist of medical ethics endeavoured to defend and protect human life at every stage from wanton manipulation and unfettered abuse by both researchers and medical practitioners. The primary focus of the manualist of Catholic medical ethics was to develop tools for pedagogy, instructions, and direction on matters of human life and health. As such the manuals like the *Medical Ethics* by McFadden and Häring include the formation of conscience for doctors, nurses, and patients. Conscience endeavours to enable healthcare professionals to assume greater responsibility regarding their decisions and actions.

1.3 The Objective Character of Catholic Bioethics

After millennia of experiences, medical ethics evolved into bioethics. The term 'bioethics' was used for the first time by the oncological physician Van Rensselaer Potter in 1970.[33] Potter's proposal of bioethics has a wider meaning involving several factors that govern healthcare delivery today. Apart from physician-patient covenant, bioethics is "characterised by the need for a civil ethic or an ethic of a

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[31] "Anencephalic." *Vocabulary.com Dictionary,* Vocabulary.com, https://www.vocabulary.com/dictionary/anencephalic. Accessed 12 Dec. 2024.

[32] Pádraig Corkery, *Bioethics and the Catholic Moral Tradition* (Dublin: Veritas Publication, 2010), 12.

[33] Paulo Nuno Martins, "A Concise Study on the History of Bioethics: Some Reflections." *Middle East Journal of Business*,13 (2018), 36. DOI: 10.5742/MEJB.2018.93183.

consensual reformation of rights and obligations in the context of medical practice and healthcare."[34] That shifted an understanding that healthcare is an enterprise involving civic, social, political, economic, and environmental determinants. To that effect, Paulo Martins argues that as a subject, bioethics has developed from "four fonts namely: experimentation on human beings, new technologies, ecological ethics, and religion."[35] No doubt, atrocities committed against humanity was the major drive behind expanding the scope of healthcare and medical science. Currently, technology and the state of ecology pose major threats to the practice of medicine and the overall welfare of humanity especially the already vulnerable. This means that the scope of bioethics is expanding.

Bioethics endeavours to increase surveillance on any threats to human life and health arising from exponential development in biotechnology, environmental degradation, social and economic inequality, and justice and human rights. In agreement with Diego Gracia, bioethics proposed by Potter was "much more comprehensive and global, as the moral analysis of the equilibrium of life over earth, and the present and future of life and quality of life."[36] Technological advancements have their intention to make better the life of human persons. Without doubt, there have been lots of benefits associated with innovations in medical care. Potter's view of bioethics urges the adoption of sustainable development in order to preserve life, quality of life, now and in the future, threatened by the unsustainable overdevelopment of the global North, and undermined by the unsustainable underdevelopment of global South.[37] This model of bioethics calls for ecological equilibrium that promotes respect for human life, life in general, and nature. Potter warns as unsustainable any type of innovations that endanger and create an imbalance in the environment and in their application or use. The CST principle of universal destination of created goods must inform the development of innovations as well as the distribution of such goods. Authentic development supported by bioethics involves genuine progress of science, of man and society, and focuses on the "link between biology, ecology, medicine, and human values."[38] At its earliest stage four principles of bioethics were defined namely: non-maleficence, justice, beneficence, and autonomy. These four principles of bioethics which were developed by Tom Beauchamp and James Childress form the foundation of ethical decision-making in healthcare.[39] Each of the four principles will be given a critical consideration in this study.

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[34] Guinan, "Medical Ethics versus Bioethics," 652.

[35] Paulo Martins, "A Concise Study on the History of Bioethics: Some Reflections." *Middle East Journal of Business*,13 (2018), 35. DOI: 10.5742/MEJB.2018.93183.

[36] Diego Gracia, "History of Medical Ethics" in *Bioethics in a European Perspective*, H.A.M.J ten Have and B. Gordijn, eds. (Kluwer Academic Publishers, 2001), 17.

[37] Gracia, "History of Medical Ethics," 18.

[38] Martins, "A Concise Study on the History of Bioethics," 35.

[39] Martins, "A Concise Study on the History of Bioethics," 36 – 37.

Scholarship has revealed that bioethics is an expansion of medical ethics. In other words, it is not replacement of medical ethics. To this day, "Medical ethics guides the behaviour of physicians in treating their patients. It should be noted that although medicine has become more complex as the result of specialization, technology, and the intervention of third-party players, the traditional practice of medicine – that is a competent medical practitioner and a sick person in the classic doctor-patient relationship – remains the norm of patient care."[40] Bioethics has simply expanded the scope of medical science and healthcare practices, to include factors outside clinical settings that would either worsen or improve the onset of disease. This is where bioethics introduces "ethical considerations of health professionals and researchers as applied to healthcare, health policy, and biological and medical research."[41] No aspect of medical ethics is removed or diminished. Firmly grounded on these foundations, "bioethics general orientation is *salus populi suprema lex esto* (Let the safety [welfare/health] of the people be the supreme law."[42] Moreover, the desired behaviour of the healthcare professionals is self-regulation. And self-regulation is properly achieved from an informed guided code of conduct.

1.4 Catholic Interpretation of the Four Principles of Bioethics

This sections endeavours to deliberate on the four principles of bioethics to show that the Catholic moral tradition can enrich their concrete applications. The principles of bioethics (beneficence, nonmaleficence, autonomy, and justice) reveal that the structure of healthcare and medical sciences has moved from the narrow clinical enterprise to the broader framework of multidimensional considerations. The ascendency of an approach to bioethics centred on these four principles has seen bioethics becoming more secularized.[43] Probably so that they can be easily applicable universally. With the movement for a global ethic that is not dependent on any particular religious tradition, these principles became more acceptable. In their secular application, these principles have tended to be more individualistic. Some misconceptions have arisen that suggest that the Catholic moral tradition is in opposition to modern philosophies. To the contrary, Catholic moral tradition accepts beneficence, non-maleficence, autonomy, and justice to be fundamental principles for a well-structured healthcare delivery system, albeit with the correct interpretation.

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[40] Guinan, "Medical Ethics versus Bioethics," 651
[41] McWhirter, "The History of Bioethics," 329.
[42] McWhirter, "The History of Bioethics," 330.
[43] Cahill, *Theological Bioethics: Participation, Justice, and Change*, 17.

Catholic bioethics attaches great anthropological value to the nature of the human being. It is, therefore, fundamental that the principles of bioethics are interpreted or understood through a Christian anthropology. That the human being possesses an intrinsic value having been created *imago Dei*. Furthermore, the human person is a social being whose existence affects others and is affected by others as well. For that reason, Catholic bioethics encompasses relationships between human persons, and between humanity and the natural world. Catholic bioethics offers a foundation for historical consciousness which secular bioethics tends to change, replace, and re-invent. The desire to formulate moral terms that can be acceptable by all is leading to the change of language to suit the new approach. For instance, the language orientation is directed towards terms such as consensus against truth, ethics against morality, partner against spouse – husband or wife, choice against conscience, gender against masculinity or femininity, safe sex against chastity and virginity, global governance against national sovereignty, to mention but a few.[44] Without relenting, the Church has genuinely spoken and continues to speak to these secular principles and to show that these principles are not in conflict with the Catholic teaching on human dignity and respect for life. The four principles of bioethics cannot be properly applied without taking into consideration other fundamental principles such as human dignity, the common good, and solidarity. To rely on the four principles only presupposes isolating the individual from her/his relational context and offers a simplified understanding of justice as solely giving one her due.[45] What are the connections between the four principles of bioethics in the principles of human dignity, the common good and solidarity? What are the core values of these four bioethical principles to healthcare and medical ethics?

1.4.1 The Principle of Nonmaleficence

The fundamental claim of the principle of non-maleficence is that one should avoid causing harm. The principle of non-maleficence examines practices and policies that have the potential to harm the human person or are considered unjust. When the principle of non-maleficence is violated, it would amount to the violation of human dignity and right. This principle positively protects the patient from any form of harm from the medical expert. Martins sheds more light on this:

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[44] Marguerite A. Peeters, "The New Global Ethic: Challenges for the Church." *The Institute for Intercultural Dialogue Dynamics. http://www. laici. va/content/dam/laici/documenti/donna/filosofia/english/new-global-ethic-challenges-for-the-church. pdf* (2007).

[45] Andrea Vicini and Tobias Winright, "Environmental Ethics as Bioethics" in *Catholic Bioethics and Social Justice*: *The Praxis of Health Care in a Globalized World,* Therese Lysaught and Michael McCarthy, eds. (Collegeville, Minnesota: Liturgical Press Academic, 2018), 381.

> The healthcare professional should not harm the patient. All treatment [may] involve some harm, even if minimal, but the harm should not be disproportionate to the benefits of treatment. This principle is a version of the Latin term *primum non nocere* (First of all, do not harm the patient) which is used as a moral requirement of the medical practice. In fact, the higher the risk of causing harm, greater must be the care of the medical procedure so that it can be considered an ethical procedure.[46]

The foremost question here is 'what is harm?' Harm is any form of injury or damage to someone or something, intentionally or accidentally. Furthermore, harm is a deliberate injury to the body caused by violence.[47] Harm can be hurt, pain, evil, and insult that deliberately violates the dignity of the person. Non-maleficence is concerned with deliberate and violent harm for its moral implications. For Varkey harm includes killing, causing pain or suffering, incapacitating, causing offense, and depriving others of the goods of life.[48] Harm is also caused by violations and crimes against the dignity of the human person such as abortion, euthanasia, physical and mental torture, and undue psychological pressure.[49] From these descriptions, harm is therefore, any action that can destroy human life or diminish the dignity of human life. In the context of our research, it would be a contradiction of what medical or healthcare stands for – it is supposed to protect life, bring relief, and if possible, achieve healing.

The Catholic Church believes that the principle of non-maleficence is guided by the recognition of the inviolable dignity of the human person. The *Catechism of the Catholic Church* emphasises that "Human life must be respected and protected absolutely from the moment of conception. From the first moment of his existence, a human being must be recognised as having the rights of a person."[50] The inviolability of the dignity of the human person is the basis for the Church's teaching and advocate against the practices of abortion, euthanasia, and capital punishment. The principle of non-maleficence implores people to avoid causing harm to others either by commission or omission acts. The Irish Catholic bishops observed that harm can also be caused to someone when personal data is shared intentionally without patients' consent. The bishops explained, "Much healthcare information is stored in medical files, electronic records, healthcare databases and genetic registers. … To the extent that records identify a patient, they must be treated as confidential and should only be accessible to those in a therapeutic relationship with the patient, unless he or she has consented to further access."[51] This type

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[46] Martins, "A Concise Study on the History of Bioethics," 35.

[47] *Vocabulary.com Dictionary*, s.v. "harm," accessed November 07, 2024, https://www.vocabulary.com/dictionary/harm.

[48] Basil Varkey, "Principles of Clinical Ethics and their Application to Practice," *Medical Principles and Practice* 30, no. 1 (2021), 19. https://dx.doi.org/10.1159/000509119.

[49] Dicastery for Doctrine of the Faith. *Dignitas Infinita*: *On Human Dignity* (April 2, 2024), no. 34-46. https://press.vatican.va/content/salastampa/en/bollettino/pubblico/2024/04/08/240408c.pdf.

[50] *Catechism of the Catholic Church*, no. 2270.

[51] Irish Catholic Bishops' Conference, *Code of Ethical Standards for Healthcare*, no. 1.10.

of harm, although non-physical is equally damaging to the individual's right to privacy and confidentiality. Mishandling of data can further cause anxiety and trauma.

The practical application of non-maleficence requires that all the actions of the healthcare professionals are devoid of any physical, emotional, and spiritual harm. In physical terms, "the physician is urged to weigh the benefits against the burdens of all interventions and treatments, to eschew those that are inappropriately burdensome, and to choose the best course of action for the patient."[52] The principle of non-maleficence is a handy tool when dealing with patients on critical care especially when some dilemma arise. The guiding principles of proportionality and disproportionality treatment become very handy in such cases. These principles are "particularly important and pertinent in difficult end-of-life care decisions on withholding and withdrawing life-sustaining treatment, medically administered nutrition and hydration, and in pain and other symptom control."[53] Again, such critical situations cannot be left to the professional's good will alone. The fundamental security measure on the part of the healthcare professionals is to obtain from their patients a verifiable informed consent on the intended or ongoing intervention.

For many years, the Catholic Church has guided health professionals to weigh the burdens and benefits of difficult critical situations by applying the principles of double effect and proportional and disproportional means. Th principle of double effect is the tool proposed by the Catholic Church to handle difficult cases where harm is foreseen and tolerated in an intended beneficial intervention. The principle of double effect spells out the conditions to be applied when an evil effect can be permitted. Good should not be achieved through evil means or deeds. Should the good effect only be followed by the means of the evil effect, then evidently this latter effect must have first been willed and cannot be justified by a good end. Simultaneously, with the principle of double effect the principles of proportionality and disproportionality (ordinary and extraordinary) can be invoked. Following Gerald Kelly's understanding, "ordinary means of preserving life are all medicines, treatments and operations, which offer a reasonable hope of benefit for the patient, and which can be obtained and used without excessive expense, pain, or other inconvenience."[54] We are obliged and mandated to pursue ordinary means of preserving life. Conversely, extraordinary means of preserving life are "all medicines, treatments, and operations, which cannot be obtained or used without excessive expenses, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit."[55] Extraordinary means

[52] Varkey, "Principles of Clinical Ethics," 19.
[53] Varkey, "Principles of Clinical Ethics," 19
[54] Gerald A. Kelly, *Medico-Moral Problems* (Dublin: Clonmore and Reynolds, 1955), 129.
[55] Kelly, *Medico-Moral Problems*, 129.

of preserving life, although permitted, are not obligatory. Where resources permit to prolong life through extraordinary interventions and treatment, care must be taken that health professionals do not abuse the patients and their families for their own advantage. Full disclosure and patient's consent must be respected to ensure the protection of integrity of the patients as well as the justification of the intervention.

The truth is that even with the best effort, there must come a moment of acceptance of the impending death. The emotional and spiritual care of the patient and the family must be paramount at this stage. The patient's or the family's affordability of resources must be appreciated. At the same time the family must be helped to accept that the availability of resources does not mean application without limit especially when treatment becomes futile. The Irish Catholic Bishops reiterates the moral teachings of the church regarding the sanctity of life that "Life is sacred from conception to death, and we may never deliberately hasten death. There comes a time, however, when death ought to be accepted. The goal then is to keep patients as free of pain and other sufferings as possible so that they may die comfortably, with dignity, and at peace with God, themselves, and others."[56] At this stage the roles of the doctors and chaplains are very essential. This demonstrates again our dual citizenship and the need to pay attention to both when dealing with every human person medically.

Principles of the common good and solidarity may also be considered in dealing with the excessive application of aggressive treatment when healing is unattainable in relation to a multitude of people who could be helped if the patient were allowed to die sooner without prejudice of medical negligence. Overall, the Catholic social teaching advocates for systems and policies that prevent harm and promote the common good. For that matter the Church opposes unjust wars, exploitation, and killing of innocent lives either through abortion, euthanasia, or murder, human trafficking, environmental degradation, and inequality in healthcare. All these are meant to prevent the causing of harm to the human person.

1.4.2 The Principle of Beneficence

In close relationship with non-maleficence, is the principle of beneficence which encourages 'doing good.' That one should act in a manner that reflects God's love and the moral goodness as positive steps to help others. Beneficence is a commandment of love (John 13:34), and "You shall love your neighbour as yourself" (Mt 22:39). The principle of beneficence is grounded in the Church's belief that every person is created in the image of God (Gen 1:27). Varkey defines the principle of beneficence as

[56] Irish Catholic Bishops' Conference, *Code of Ethical Standards for Healthcare*, 25.

"the obligation of a physician to act for the benefit of the patient and supports a number of moral rules to protect and defend the rights of others, prevent harm, remove conditions that will cause harm, help persons with disabilities, and rescue persons in danger."[57] The definition encompasses the good to be done by every physician to their patients in different categories. It is important to also note that the concept of beneficence, in this case, goes beyond clinical settings into other concerns like rescuing trafficked individuals being held in bondage. For such people, the healthcare setting may be their only contact outside their environment of captivity. Clearly the principle of beneficence puts a strong obligation not only on healthcare professionals but on all others to do good.

Specifically, beneficence's value lies mainly on the integrity of the physician to promote the patients' benefits and their personal welfare. Martins explains that "The healthcare professional should act in a way that benefits the patient. For example, to prevent and remove the disease or disability, promoting the physical, emotional and mental health of the patient."[58] While doing so, healthcare professionals must protect the integrity of their patients by paying attention to issues of confidentiality and privacy. Healthcare professionals have a moral obligation to expend resources at their disposal in a way that reflects love, justice, compassion, and respect for the human dignity. That means beneficence is guided by the virtues of justice and solidarity. This is enshrined in the command: "do to others as you would have them do to you" (Mt 7:12).

Medical informed consent is key for the principle of beneficence. This means that healthcare professionals cannot impose a procedure or intervention on an unwilling patient no matter how best the treatment may be. Meaney asserts that, "Instead, it is important to explain to patients their medical situation and their different options, including the potential risks and benefits of different choices."[59] When the patient's decision turns out detrimental to their health and life, the healthcare professional has no right to proceed otherwise. Although intervention of the law can sometimes be enforced to override the patient's wishes in extreme circumstances as in the case of the patient who does not have mental capacity for a valid decision. It is important to safeguard the freedom and integrity of patients and the integrity of physicians in their execution of duties. Any minimalist approach to the application of the principle of beneficence can be detrimental to the welfare of the patient as it may border on

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[57] Varkey, "Principles of Clinical Ethics", 18. "It is worth emphasizing that, in distinction to nonmaleficence, the language here is one of positive requirements. The principle calls for not just avoiding harm, but also to benefit patients and to promote their welfare. While physicians' beneficence conforms to moral rules, and is altruistic, it is also true that in many instances it can be considered a payback for the debt to society for education (often subsidized by governments), ranks and privileges, and to the patients themselves (learning and research)."

[58] Martins, "A Concise Study on the History of Bioethics," 36.

[59] Joseph Meaney, "Different Visions of Autonomy" *National Catholic Bioethics Centre* (January 2024), 2. https://static1.squarespace.com/static/5e3ada1a6a2e8d6a131d1dcd/t/65b931e238103568cbbd75e4/17066 35746852/DifferentVisonsAutonomy.pdf.

humiliation and devaluation of their personhood. Beneficence is both an obligation for the professionals and a right for the patients. Despite strong obligations placed on the healthcare professionals, transgressions are still being committed, revealing that the anticipated self-regulation has not yet been achieved.[60]

The Church proposes the formation of conscience to assist in making informed decisions for both the patients and healthcare professionals. Conscience is the subjective authoritative guide of people's moral conduct which gives approval or disapproval to those actions completed or contemplated. Conscience refers to an inner sense of what is right or wrong in one's actions or motives. Vatican II defines conscience as an inner law which summons human beings to love the good and to avoid evil.[61] It is an intrinsic moral endowment in the human person which regulates their choices and decisions in relation to the betterment of one another in the society. This presupposition is based on the understanding that conscience bears witness to the law of knowing what is right or wrong within every person in relation to human conduct.[62] According to Richard N. Rwiza, "this makes the law an objective norm of morality while conscience becomes a subjective norm."[63] This study is concerned with healthcare professionals' ability to distinguish and do what is right and good for their patients without being monitored by any external authority. In this case, conscience "is a natural facility of reasoning that does three things: (1) Reminds us always to do good and avoid evil. (2) Makes a judgement about the good and evil of particular choices in specific situations. (3) Bears witness after the fact to the good or evil that we have done."[64] In other words, conscience works within a regulated framework. Hence, the need for the formation of conscience for all humanity and not just healthcare professionals. The Church further advocates for the right to act in conscience and freedom to personally make moral decisions.[65] The aim of the formation of conscience is so that judgement will tally with the good willed by God.

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[60] McWhirter, "The History of Bioethics," 334.

[61] The Second Vatican Council, *Gaudium et Spes* (December 7, 1965), no. 16.

[62] Richard, N. Rwiza., *Formation of the Christian Conscience in Modern Africa,* (Nairobi, Kenya: Paulines Publications Africa, 2001), 13.

[63] Rwiza., *Formation of the Christian Conscience in Modern Africa,* 13.

[64] Efeturi, A. Ojakaminor, "The Teaching of the Catholic Church on Conscience Formation and Responsibility to Society: A Social Doctrine Perspective" in *The Role of Religion in the Conscience Formation of Society: Proceedings of the Second Theology Week of the Good Shepherd Major Seminary, Kaduna*, ed. Victor Usman Jamahh, (Kaduna, Nigeria: De Crown Printing Press, 2019), 23.

[65] *Catechism of the Catholic Church*, no. 1782.

1.4.3 The Principle of Autonomy

Autonomy is probably the most evoked principle regarding any interaction of a person with others. In essence autonomy is part of the very nature of a human person. It is the fundamental characteristic of the dignity of the human person, and it distinguishes human persons from all other living creatures. By definition, "autonomy means individual freedom, the right to choose what is best for oneself."[66] In both medical ethics and bioethics, autonomy is accorded the highest priority. In general, "The philosophical underpinning for autonomy, as interpreted by some philosophers, especially Immanuel Kant (1724–1804) and John Stuart Mill (1806–1873), and accepted as an ethical principle, is that all persons have intrinsic and unconditional worth, and therefore, should have the power to make rational decisions and moral choices, and each should be allowed to exercise his or her capacity for self-determination."[67] The freedom to act and to choose are significant when it comes to matters of treatment. This teaching emphasises the capacity of rational beings to legislate moral laws for themselves through reason. They guide the conversation around who must be allowed to decide on the information made available to them regarding their conditions with the corresponding options that are available for their treatment.

Within the modern philosophical spectrum several views of autonomy have emerged. One such notion of autonomy is the claim for unfettered freedom to choose what to do with one's health and life in line with their conception of the good. When freedom distorts the person's ability to choose what is good and what is true, authentic autonomy is missing. Gregory R. Beabout warns of the danger of what he termed radical autonomy, whereby one claims the freedom both to make one's own choices and to define one's conception of the good.[68] The conception of the good and what is true cannot be defined without recourse to objective truth. One's faulty conception of the good may include destroying one's life. Hence, the need for a balanced conversation based on informed consent. This means that information should be provided by the professional regarding the case being looked at so that the patient or their representative are able to make a well-informed choice.

Contrary to the secular concept, the Catholic Church understands that autonomy does not mean complete independence and freedom from responsibility. The Church has taught that "Man has the right to act in conscience and in freedom so as personally to make moral decisions. He must not be forced to act contrary to his conscience. Nor must he be prevented from acting according to his conscience, especially in religious matters."[69] To act correctly, an individual's autonomy must be

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[66] Meaney, "Different Visions of Autonomy," 1.

[67] Varkey, "Principles of Clinical Ethics," 30.

[68] Gregory R. Beabout, "What Counts as Respect", in *Medicine, Health Care, and Ethics*: *Catholic Voices*, John F. Morris, ed. (Washington: Catholic University of America, 2007), 29.

[69] *Catechism of the Catholic Church*, no. 1782.

ordered towards moral responsibility acquired through the teaching of the Church and divine revelation. The Second Vatican Council promulgated that:

> For God has willed that man remain 'under the control of his own decisions,' so that he can seek his Creator spontaneously, and come freely to utter and blissful perfection through loyalty to Him. Hence man's dignity demands that he act according to a knowing and free choice that is personally motivated and prompted from within, not under blind internal impulse nor by mere external pressure.[70]

In relation to conscience, it means that autonomy is correctly exercised by obeying God's law which is revealed through Scripture, Tradition, and Natural Law the three fonts of the Catholic moral wisdom. Invariably, autonomy cannot be applied without limits. People need to be educated regarding the limitations of their autonomy when seeking healthcare and every association with others.

The first limitation on autonomy comes with the nature of our being. The Catholic church teaches that autonomy means acknowledging that each person's life is a gift from God, and that no person can play master over his or her own life. Each person is simply granted stewardship over his or her own life. The U. S. bishops maintain that "The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have absolute power over life.[71] By stewardship, it means "we receive God's gifts gratefully, cultivate them responsibly, share them lovingly in justice with others, and return them with increase to the Lord."[72] Every person has an obligation to accept the duty to look after their lives and to avoid habits that might harm them. This duty also comes with the obligation to contribute meaningfully to the welfare of others and the community. Therefore, the misuse of drugs and other substances cannot be part of autonomy because they undermine one's freedom and capacity to related with others.[73] Such practices contribute to the diminishing of human dignity. Instead, individuals are encouraged to adopt lifestyles and habits that promote good health for themselves, for others, and for the natural world.

Autonomy is also limited by objective morality whose source is from the Scriptures, Tradition, and Natural Law. The underlying principle of morality is the pursuit of what is good and shun what is evil. The question by the rich young man to Jesus can be a good starting point, "What good must I do to inherit the Kingdom of Heaven?" (Mt 19:16). In other words, what good must people do to achieve

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[70] The Holy See, *Gaudium et Spes* (December 7, 1965), no. 17

[71] *Ethical and Religious Directives*, Part Five, Introduction, par. 3.

[72] The USCCB, "Stewardship", https://www.usccb.org/committees/evangelization-catechesis/stewardship#:~:text=A%20Summary%20of%20the%20U.S.,1%20Pt%204%3A10).

[73] Irish Catholic Bishops' Conference, *Code of Ethical Standards for Healthcare*, no. 6.

their goal. Jesus' first recommendation to the rich young man is to keep the commandments. Autonomy is incomplete without the freedom that conforms with the moral good as dictated by God.

In addition, autonomy can be limited by human law as what happens when restrictions are imposed to protect public health. It is therefore imperative that each individual take personal responsibility to know the objective truth of morality. Beabout describes this form of autonomy as ordered since it "is the freedom to use one's power of self-determination in a responsible manner in accord with objective moral order."[74] In ordered autonomy, self-determining choices are subject to the moral law. This approach recognizes that there is an objective moral order discoverable in part by reason by every person. Ordered autonomy is also oriented towards the good of the individual and the common good. Free will recognises that acting in an orderly manner means accepting that God created human beings to choose what is true and good.[75] Within the broader teaching on human nature, "Freedom actually presupposes that the human will is 'activated' by the natural desire for the good and for the last end."[76] A person does not act in a vacuum. There is always the demand for the responsibility to search for the truth to make informed choices.

Autonomy can further be restricted by the nature of the person as a social being. Respect for autonomy demands an obligation not to intrude on another person's life/body or interfere with their choices without their permission. This form of limitation of autonomy considers the freedoms and the welfare of others. One's liberty must always enhance the autonomy of others by refraining from violating their dignity and their human rights. Therefore, someone's actions that contravene moral values or are found unsafe for other people cannot belong to ordered autonomy. Moral values are taught within a given moral context like the community to which one belongs. The Church teaches that, "The human person is capable of knowledge and of love; he is endowed with freedom, capable of entering into communion with others and called by God to a destiny that transcends the finalities of physical nature. He fulfils himself in a free and gratuitous relationship of love with God that is realized in a history."[77] By that doctrine, the Catholic church confirms that there is no complete independence and freedom of autonomy for a social being.

Individual autonomy is also checked using created things. One may not use natural resources without considering the universal destination of all created goods and that God is the master of all. The principle of the universal destination of goods means that the earth and all it contains are intended for

[74] Beabout, "What Counts as Respect", 29.
[75] Meaney, "Different Visions of Autonomy", 1.
[76] International Theological Commission, *In Search of a Universal Ethic*, no. 77.
[77] International Theological Commission, *In Search of a Universal Ethic*, no. 66.

all people and peoples.[78] Although private ownership is a fundamental right, all goods carry a social function and are always linked to the common good. All owners must consider the effects their use has on others and act in a way that benefits not only themselves and their families but also the common good.[79] Individuals are therefore, called to be responsible stewards of their possessions and to use them in ways that benefit society as a whole, while ensuring that everyone has access to the basic necessities of life. Excessive accumulation goes against fairness and solidarity.

On the global stage, individual autonomy is often constrained by various contextual factors, including national laws, gender dynamics, ethnic identity, and cultural norms. Within international economic enterprise, autonomy is being checked by inter-governmental instruments that bind all nations such as the law against genocide. In recent years, attention has been drawn to climate justice and the need to slow down the impact of global warming. The willingness to commit to the Conference of Parties (COP21) Paris Agreement by countries depends on their economic demands.[80] The cutting in carbon emission has direct implications on the economic stability of some countries. Such resistance to adopt the demands of climate justice proves that even with the obvious threats to the planet, parties' actions are shaped by a sense of belonging. Although it is true that one's life cannot be disconnected from the character of the community to which they belong, every part of the world is interconnected to others. The various unique needs and experiences are what the public debates need to know. Cahill clearly observed this fact when she stated that:

> No individual enters in disconnection from the communities of belonging and worldview formation that are constitutive for his or her particularly and agency. Institutions are patterns of social relationships that give normative definition to practices, structure experience, and shape individual character and commitments. Practices and institutions make up the infrastructure of society and are a necessary component of the public sphere.[81]

In healthcare processes, autonomy is restricted by one's dependence on others. The decision to seek healthcare, reveals the fact that by nature, the human persons cannot do everything on their own in their quest for flourishing and ultimate end. Upon the onset of disease, individuals often approach healthcare facilities for examination and prescription for treatment which requires special knowledge and skill. Ordered and true autonomy is the ability to make free choices that reflect moral responsibility that is

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[78] Pontifical Council for Justice and Peace, *Towards a Better Distribution of Land*, *the Challenge of Agrarian Reform* (November 23, 1997), no. 28.

[79] Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine*, no. 178.

[80] The Paris Agreement is a legally binding international treaty that seeks to strengthen the global response to climate change and reaffirms the goal of limiting global temperature increase to well below 2 degrees Celsius, while pursuing efforts to limit the increase to 1.5 degrees. (https://unfccc.int/process-and-meetings/the-paris-agreement).

[81] Cahill. *Theological Bioethics: Participation, Justice, and Change*, 29.

good for the welfare of all. True autonomy is also a commitment to respect the dignity of others and the duty to the common good. As much as healthcare is a basic primary good that should be provided to all, it also puts demands for every person to contribute to its realisation. The principles of the common good, solidarity, and universal destination of created goods can all be evoked to temper unfettered autonomy. Individual rights and autonomy are grounded within the broader scope of every community's well-being.

1.4.4 The Principle of Justice

While the three principles discussed above deal directly with the practice of medicine and healthcare proper, justice is concerned with the question of how to achieve adequate universal access. The principle of justice demands that benefits and resources should be fairly distributed for the sake of the common good. Within the Catholic moral tradition, justice is the "moral virtue that consists in the constant and firm will for people to give others (God and neighbour) their due."[82] In bioethical considerations, justice is a moral principle that holds that all people should have access to decent healthcare and be treated in a similar manner, whatever the religion, race, sex, economic condition, [and] social position.[83] In line with the above definitions, the Irish Catholic bishops assert that, "In any society, the State, which has responsibility for the common good, has the task for overseeing the allocation of healthcare resources in such a way that people are enabled to meet their basic healthcare needs."[84] For that matter, justice means the responsibility of society, governments, and healthcare providers to promote fairness, equity, and respect for the sanctity of human life in all policies, decisions, and systems of healthcare. The Catholic teaching emphasises the right to healthcare for all peoples. As such, it reiterates that "concern for health requires that society help [people] in the attainment of living conditions that allow them to grow and reach maturity."[85] The major take from the reflection by the Catechism is its expanded consideration of healthcare to encompass all necessary conditions.

The key word regarding justice as a principle of bioethics is distribution of resources. The principle of justice emphasises the fair distribution of healthcare resources to ensure that every human person has access to the care they need to maintain their health and well-being. Although justice applies to everyone, it has a special bias towards protecting the weak and vulnerable. As such the

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[82] *Catechism of the Catholic Church*, no. 31807.
[83] Martins, "A Concise Study on the History of Bioethics," 35.
[84] Irish Catholic Bishops' Conference, *Code of Ethical Standards for Healthcare*, no. 3.
[85] *Catechism of the Catholic Church*, no. 2288.

question of allocation of scarce resources in healthcare must favour the marginalised. The distribution of scarce resources deals with how government allocates human, material, and financial resources across all healthcare facilities in the country. Fundamentally, the State redistributes what it collects from the citizens through tax and other revenues in contributive justice. Contributive justice regulates citizens' obligations towards the larger society and government by paying of taxes. This form of justice stresses the duty of all who are capable to help create the goods, services and other nonmaterial or spiritual values necessary for the welfare of the whole community.[86] It, therefore, means that the State anchors its demands on citizens to contribute to the common welfare on commutative justice. This, in essence, is a demand by the State that burdens are shared among all citizens for the good of all members of the state.

Technically, in matters of tax, there are always people who contribute more than others. However, when it comes to distributive justice, the benefits do not necessarily commensurate with how much an individual contributed. It is a framework of "from each according to his ability, to each according to his needs."[87] That means that, "it is not about getting what I paid for, or about absolute entitlement. …Distributive justice is a balance of fairness. It balances the need of the individual at a particular time against the needs of others and the availability and most effective use of resources."[88] Distributive justice is a growing demand because of the exponential rising costs to accessing advanced diagnostic and treatment services. To determine the most deserving patients of available scarce resources is becoming an ever-growing demand for healthcare personnel. Within the health sector, the delivery of facilities, services, and treatment must always be on a fair and impartial basis, especially in front of limited resources such as limited bed spaces, organ transplants, dialysis allocations, MRI and CT scans.

The principle of Triage charges healthcare professionals with daily decisions of how to apply the available resources to cater for as many patients as possible. Anthony Nnadi sympathises with health professionals when he notes that "decisions are not easy when you stand face to face with those in need and you do not have all the necessary resources to address the problems of all of them."[89] Such scenarios are a frequent occurrence in low income and developing countries. The model of healthcare access driven by distributive justice demands decisions in favour of the preferential option for the poor,

[86] USCCB, *Economic Justice for All*, no. 71.

[87] USCCB, *Economic Justice for All*, no. 69.

[88] Irish Catholic Bishops' Conference, *Code of Ethical Standards for Healthcare*, no. 3.

[89] Nnadi, Anthony Okechukwu. *Distribution of Resources in the Nigerian Health Care System: Ethical Considerations and Proposals Applying Catholic Social Teaching* (Milton Keynes UK: Lightning Source UK Ltd, 2020), 132.

although "the language and practices of modern science, market economies, and liberal individualism are generally unreceptive to consideration of distributive justice and a preferential option for the poor."[90] In addition to the preferential option for the poor, the common good and solidarity sustain the application of distributive justice by emphasising the need for universal destination of goods.

Distributive justice is a justice of sharing that sees to the fair and equal distribution of the goods of creation so that human needs are met. This form of justice demands that the allocation of income, wealth, and power in society be evaluated considering its effects on persons whose basic material needs are unmet.[91] In Catholic bioethics, the focus must always be on the question of the needy. According to Nnadi, "a person who needs could be one who is experiencing a situation of misfortune, physically or mentally disabled, a person or persons going through an unfavourable condition consequent to a past discrimination that was not in their favour and all those classified as vulnerable."[92] Distributive justice answers to the needs of all persons. It is at this level that citizens make demands on their governments and institutions, and on each other. Overall, the principle of justice in healthcare answers to the demands for the respect for human dignity, the common good, preferential option for the poor, and solidarity.

1.5 The Objective Nature of Catholic Bioethics

The Catholic moral tradition has been a major influence in the transformation of society because it is objective, authentic, and noble. By proposing the principles of Catholic moral values to inform bioethics is not an imposition of superiority over other religious and philosophical traditions, but a desire to maintain and share a moral framework that is authentic and objective. On its journey through human history, the original influence of Catholic bioethics waned significantly due to some misconceptions about its religious foundations and in part due to new discoveries in medical sciences to which the Church needed to respond and realign its position. Another significant factor relates to the Church's encounter with knowledge from other traditions of wisdom from which it needed to learn without losing its fundamental deposit of truth. The encounter between sources of wisdom reveals points of overlap and interaction that would lead to common morality. The sources of the wisdom for moral theology are based on the event of revelation and on the experience of human persons as moral and historical agents. In other words, they are founded on theology and anthropology. To proceed, the

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[90] Cahill, *Theological Bioethics: Participation, Justice, and Change*, 22.
[91] USCCB, *Economic Justice for All*, no. 70.
[92] Nnadi, *Distribution of Resources in the Nigerian Health Care System*, 133.

next section will deal with the question of anthropology and eventually deal with theological foundations.

1.5.1 Founded on Holistic and Authentic Anthropology

Anthropology is fundamentally one of the human sciences that have a wider applicability, can easily cut across cultures, and has the human person as the object of its analysis. Anthropology has assumed prominence today mainly due to the relationship between moral theology and scientific works that impact directly on human subjects. The Congregation for the Doctrine of the Faith (CDF) noted that new biomedical techniques have brought many advantages in healing and therapeutic methods, but at the same time have had the effect of undermining the human dignity, and unjustifiably dominating procreation.[93] The role of anthropology and its affirmation of the primacy of the human person allows for the understanding of the task that ethics performs in the determination of the limits of the utilization of the scientific progress on the part of human freedom with regard to the moral good. In the wake of exponential scientific discoveries, the Magisterium has always appealed to the integral and adequate anthropology.

The nature of the human person (sound anthropology) is the key fundamental concept of the Church's teaching on all ethical deliberations including bioethics. Human nature is first and foremost understood on the level of *imago Dei*. This is the truth that every human person is created in the image and likeness of God (Gen. 1:26-27). Being created *imago Dei* means that every human person possesses intrinsic dignity that is not dependent on their health, wealth, achievements, sexual orientation or religious affiliation.[94] In addition, human nature is discoverable through Christ's work of redemption that the fallen humanity was granted glory through the incarnation and the resurrection of Jesus Christ (2 Cor 5:17; Gal 6:15). The incarnation and resurrection of Jesus Christ reveal further the dignity of the human person. It reveals that "the dignity of [human] life is linked not only to its beginning, to the fact that it comes from God, but also to its final end, to its destiny of fellowship with God in knowledge and love of him."[95] The human person adequately or holistically considered is one understood by reason informed by faith. Integral anthropology takes into account the body, mind, heart, and spirit, respectively corresponding to physical, psychological, emotional, and spiritual realities of a person. These dimensions define the identity of the human being. Richard Gula explains that the human

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[93] Congregation for the Doctrine of the Faith, *Donum Vitae*: Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation (February 22, 1987), nos. 17-20.

[94] Corkery, *Companion to the Compendium*, 15.

[95] International Theological Commission, *In Search of a Universal Ethic*, no. 20.

person is adequately considered under four fundamental dimensions: "a relational being, an embodied subject, an historical being, and a being fundamentally equal to others but uniquely original."[96] The four fundamental dimensions of being are also presented as bio, psycho, socio, and *divino*. These dimensions constitute the human person integrally considered. These dimensions imply that, the "human person is adequately considered when taken as an historical subject in corporeality who stands in relation to the world, to other persons, to the social structures, and God, and who is a unique originality within the context of being fundamentally equal with all other persons."[97] Therefore, all dimensions participate in the discovery and expression of the nature of the human person.

Humanity's bodiliness is the essential condition by which human persons exist in the world and express themselves. The spiritual/psychological dimension sets human persons apart from other created beings and distinguishes one person from another. At this same level, human beings are endowed with knowledge and freedom to choose, unlike other living creatures. The social dimension reveals the relational nature of the human person. Gula explains, "Human existence does not precede relationship, but is born of relationship and nurtured by it. To be a human person is to be essentially directed towards others. We are communal at our core."[98] With the appropriate structures, human beings sustain human dignity and the common good by upholding ethical imperatives. Being *divino* signifies that every person is sacred and dignified prior to any human achievement and standards.

Although the four dimensions contribute to a better understanding of the nature of a person, human life is more complex than these dimensions since the human person is dynamic and never static. The fundamental imperative of being in the image of God and for living in a community is to live fully according to the gifts everyone has received from God by moving out of oneself into the world of relationships. Destiny explores the ultimate end of human life. That means human activities map out an individual's journey to the final goal. The nature and destiny of the human person shape our understanding of human beings and their place in the universe. This is what John Morris meant when he narrowed down the understanding of the human person to two central tenets: "(1) each human being is created in the image and likeness of God; and (2) the life of each human being is given as a free gift from God. These two points give rise to an obligation to respect all human life."[99] The inviolability and the inherent dignity of every human person form the fundamental principle of moral deliberations. This

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[96] Richard M. Gula, *Reason Informed by Faith*: *Foundations of Catholic Morality* (New York: Paulist Press, 1989), 67.

[97] Gula, *Reason Informed by Faith*, 67.

[98] Gula, *Reason Informed by Faith,* 67.

[99] John F. Morris, ed., *Medicine, Health Care, and Ethics: Catholic Voices* (Catholic University of America Press, 2007), 128. ProQuest Ebook Central, http://ebookcentral.proquest.com/lib/nuim/detail.action?docID=3135061.

is affirmed by the Catholic hierarchy in the Irish Church. The Irish Catholic Bishops' Conference teaches that "the starting point of all ethical thinking is the question 'who are we?'"[100] And this question points to human dignity as the fundamental aspect of human nature. Our dignity is intrinsically who we are regardless of our physical appearance or status.

The Declaration *Dignitas Infinita* states that "every human person possesses an infinite dignity, inalienably grounded in his or her very being, which prevails in and beyond every circumstance, state, or situation the person may ever encounter."[101] This document (*Dignitas Infinita)* by the Dicastery for the Doctrine of Faith (DDF) presents four types of dignity namely ontological dignity, moral dignity, social dignity, and existential dignity. Ontological dignity "belongs to the person as such simply because he or she exists and is willed, created, and loved by God. This is the first and the most important of all. Ontological dignity is indelible and remains valid beyond any circumstances in which the person may find themselves."[102] This dignity underlines the enduring teaching of the Church that every person possesses an inherent value and worth that is not dependent on any human standards, and it is never earned. Above all, this dignity can never be lost because it is part of human nature.

During dehumanizing conditions occasioned by the rise of capitalism, the Church, through Leo XIII's *Rerum Novarum*, called attention to a non-negotiable value which cannot be sacrificed in the name of economic progress, the inalienable and inviolable dignity of every human person.[103] From Leo XIII's deliberation we note that any situation or practice that dehumanises the nature of the human person is an afront to the dignity of human life. Although Pope Leo was referring to the conditions of the working class, threats to human dignity have been manifesting in different forms, at various stages of human life and at different epochs of human history. This explains why the principle of the human dignity is of the utmost importance to both Catholic social teaching and bioethics. John Paul II proclaimed that human persons' dignity does not come from the work they do, but from the persons they are.[104] It follows, therefore, that since dignity defines a person, it must not be violated either by reducing the person to a mere thing or as a means to an end. In dealing with any human being, their dignity can only be enhanced but never destroyed.

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[100] Irish Catholic Bishops' Conference, *Code of Ethical Standards for Healthcare* (Dublin: Veritas Publications, 2018), 20.

[101] Dicastery for the Doctrine of Faith (DDF), *Dignitas Infinita* (April 2, 2024), no. 1.

[102] DDF, *Dignitas Infinita*, no. 7.

[103] Pope Leo XIII, *Rerum Novarum* – On the Rights and Duties of Capital and Labour (London: Catholic Truth Society, 1983), no. 20.

[104] Pope John Paul II, *Centesimus Annus*: On the 100th Anniversary of *Rerum Novarum* (London: Catholic Truth Society, 1991), no. 11.

Unlike ontological dignity, the other forms of dignity enumerated by the DDF in *Dignitas Infinita* can be lost or diminished. With regards to moral dignity, human persons lose it when they behave in an undignified manner and cause evil. Nevertheless, moral dignity can be restored upon the person's repentance and conversion. Social dignity is characterised and influenced by the quality of a person's living conditions.[105] On one hand, inhuman conditions can deny and contradict the inalienable and inherent dignity of the human person. This can be manifested when one lives in a situation akin to slavery. It is generally agreed that extreme poverty can deny people to live according to their ontological dignity. On the other hand, better conditions do enhance the dignity of the person. Lastly, existential dignity expresses the uniqueness of every person in terms of his/her aspirations and contributions to human flourishing. Existential dignity further refers to the ever-existing tension between the unpleasant situations and satisfactory conditions through which a person hopes to find meaning for life. For example, one may be experiencing severe failure in personal health while enjoying lots of wealth. On the other hand, people may manage to live in peace, joy, and hope amid severe depravity. It is therefore incumbent on every person and every institution to promote and protect human dignity in all its spheres.

The violations of human dignity have been identified in many spheres of life. Attempts have been made to distort the meaning of human dignity arising in arguments regarding the sanctity of life from conception to birth, and physical appearance to quality of life in terms of functionality. This is exemplified in the arguments for or against abortion, stem cells research, euthanasia and other medical procedures that involve some level of tampering with the human person in medical practice and biotechnology. For instance, "stem cell research has faced substantial opposition from various cultural and religious groups around the world regarding the beginnings of life, the moral status of the embryo, and the ethical implications of manipulating human cells."[106] These objections are stemming from safeguarding the dignity of the human person from conception to natural death. The growing distinction between the sanctity of life and the quality-of-life has become increasingly noticeable when dealing with medical interventions regarding patients in "comatose/vegetative state" or end-of-life care. Once again, it is important to emphasis the church's magisterial teaching that the most fundamental aspect of human dignity is the respect for the sacredness of life or the sanctity of life throughout its natural cycle from conception to natural death.

[105] Pope Francis, *Dignitas Infinita*, no. 8.

[106] Louis A Cona, "Stem Cell Research Controversy: A Deep Dive," *DVCSTEM*, (5 June 2024), https://www.dvcstem.com/post/stem-cell-research-controversy# Accessed November 16, 2024.

Sanctity of life is the Catholic Church's foundational teaching on the dignity of human life. Sanctity or sacredness means that which has an absolute value, is unreachable compared to other things, or is absolutely transcendental. This means that human life is set apart (separated and pure) from all other created beings. The Church's understanding of the sanctity of life is grounded in its basic theological conviction that God is the author of life. It is on the fundamental doctrine of the sanctity of life, that the right to life is affirmed.[107] Sanctity of life should therefore be respected as a natural characteristic of every human person.

The principle of the quality-of-life differs with the sanctity of life because of its utilitarian approach to human life. According to the World Health Organisation (WHO), six aspects describe the quality-of-life: Physical status – that is people's ability to do things by themself; psychological status – self-assertiveness; level of independence – mobility; social relations – social usefulness; environment - accessibility to health services; and personal faith – conviction in line with life.[108] Overall, the above conditions connect with WHO's own explanation of health and healthcare as "a state of physical, mental and social well-being, not merely the absence of disease and infirmity."[109] WHO's considerations for a quality-of-life differs from the Church's understanding because of its emphasis on changeable factors which can easily be relativised. A further existing threat to the sanctity of life is the modern criteria of the quality-of-life – an emerging concept involving the assessment whether a particular human life is worthy allowing to exist.

In addition, the DDF pays attention to the dangers involved in attempting to emphasise personal dignity as against human dignity. DDF sees this as another threat to the sanctity of life. The promotion of the concept of personal dignity arises from an understanding that a person is one who is capable of reasoning – with capacity for knowledge and freedom. This means that those who fall short of such characteristics lack the dignity of personhood. Such understanding of the human person would not consider the unborn, comatose, mentally disabled as persons.[110] John Kavanagh amplifies the threats to the sanctity of human life when he observed that "today human foetuses are described as blobs of protoplasm or tissue; criminals as vermin; profoundly damaged patients are vegetables."[111] The employment of selected factors to measure the worthiness of life, threatens prenatal life, the gravely

[107] Brendan Sweetman, "Two Arguments Against Euthanasia" in *Medicine, Health Care, and Ethics: Catholic Voices*, John F. Morris, ed. (Catholic University of America Press, 2007), 176.

[108] World Health Organisation (WHO), *WHOQOL User Manual* (Geneva: WHO Division of Mental Health and Prevention of Substance Abuse, 1998).

[109] WHO, *WHOQOL User Manual*.

[110] DDF, *Dignitas Infinita*, no. 24.

[111] John Kavanagh, "Wounded Humanity and Catholic Health Care" in *Medicine, Health Care, and Ethics: Catholic Voices,* John F. Morris, ed. (Catholic University of America Press, 2007), 19. ProQuest Ebook Central, http://ebookcentral.proquest.com/lib/nuim/detail.action?docID=3135061.

sick, the elderly, and every human life in general. In medical interventions, quality-of-life considerations have "implications for both judging the appropriateness of using life-sustaining treatments and for determining death."[112] Studies have shown that the quality-of-life approach presents a very simplistic way of allowing people to die by withdrawal of intervention, feeding or otherwise.

The criteria for judging who qualifies for medical intervention because they enjoy quality-of-life must take into account a more robust procedure that includes the principles of proportionate and disproportionate treatment. Nobody knows who determines the parameters and criteria of quality-of-life, unlike sanctity of life which is protected by an authentic anthropology. Those who support quality-of-life argue that full personhood is achieved only when one possesses the ability to act to full conscious desires, self-knowledge, and with a sense of responsibility that mark adult humans as moral agents. Supporters of quality-of-life criteria believe that personhood can be achieved and lost according to human standards. This study accepts Kavanagh's argument that "when human worth is reduced to subjective attitude or external performance, no one is valued any longer for his or her own sake. No single person will hold intrinsic value."[113] This is not good for the society. It creates unequal treatment of people based on certain perceived deficiencies.

Pope Francis has warned of a throwaway culture and every threat to human life. Wastefulness which the Pope normally associated with food has evolved into the wastefulness of throwing away the "not yet useful unborn babies," the "no longer needed elderly," and the devalued poor and disabled.[114] The attitude of discarding others further finds expression in racism which is more and more proving that the much-proclaimed social progress is in fact a mere façade.[115] Discarding others also involves hostility against migrants where children, women, and men live in conditions akin to slavery because they are being treated as objects through coercion, deception, and physical and psychological duress.[116] These social factors deny many people from enjoying the quality-of-life. All the above actions demonstrate in a subtle way that "many forms of injustice that persist in the society, fed by reductive anthropological visions and by profit-based economic model that does not hesitate to exploit, discard, and even kill human beings."[117] Richard McCormack, made an interesting observation when he stated that the sanctity of life "focuses our attention on our obligation to preserve life and avoids degrees of discrimination in quality-of-life criteria," at the same time, quality-of-life implies "that not all lives are

[112] Gula, *Reason Informed by Faith*, 67.
[113] Kavanagh, "Wounded Humanity and Catholic Health Care," 18.
[114] Pope Francis, *Fratelli Tutti* (October 3, 2020), no. 18.
[115] Pope Francis, *Fratelli Tutti*, no. 20.
[116] Pope Francis, *Fratelli Tutti*, no. 24.
[117] Pope Francis, *Fratelli Tutti*, no. 22.

equally good or equally deserving of protection."[118] Christian anthropology indicates that being *imago Dei* means that human beings are endowed with rights and duties. Prominent among the rights is the right to life as promulgated in the United Nations in 1948, which implies dignity, equality, and mutual respect among all humanity.[119] When healthcare practice is built on such universal pillars of our common humanity, it works for the common good by protecting the dignity of every human person. This is necessary because the principle of quality-of-life creates inequalities in access to adequate healthcare. It is important to state that "all offenses against life, such as murder, genocide, abortion, euthanasia, and wilful suicide must be recognised as contrary to human dignity."[120] All these grave offenses work against human dignity because they involve the intentional destruction or violation of human life, which is intrinsically valuable.

Moreover, it is no longer news that those living extreme poverty experience unequal treatment in the distribution of goods and services meant for all in the society. The dignity of the poor is often in jeopardy because they lack the necessary resources to meet their basic needs. This results in some level of being treated with contempt when attempting to access healthcare.[121] It must be noted that poverty is not a state of life people bargained for, as such they should be accorded the respect every human being deserves in every sphere of life. In addition, "all violations of the integrity of the human person, such as mutilation, physical and mental torture, undue psychological pressure, also infringe upon our dignity."[122] Other human actions including war, human trafficking, sexual abuse, and violence against women also negatively impact on human dignity. Justice demands that there must always be presumption in favour of the vulnerable where resource allocation is concerned. This should be the approach to healthcare practice for the good of our humanity.

1.5.2 The Catholic Moral Tradition and Its Dialogical Relevance in Bioethics.

The Catholic moral tradition engages with contemporary ethical questions, especially in bioethics, through its foundational sources: Sacred Scripture, Sacred Tradition, and Natural Law. Pope John Paul II encapsulated these sources by affirming that Catholic doctrine "is based upon natural law and upon the written word of God, is transmitted by the Church's Tradition and taught by the ordinary and

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[118] Richard A. McCormick, "The Quality of Life, The Sanctity of Life" in *The Hastings Centre Report*, Vol. 8, No. 1 (Feb. 1978), 35. https://www.jstor.org/stable/3560325.

[119] United Nations, *Universal Declaration of Human Rights*, Article 3.

[120] DDF, *Dignitas Infinita*, no. 34.

[121] DDF, *Dignitas Infinita*, no. 36.

[122] DDF, *Dignitas Infinita*, no. 34.

universal Magisterium."[123] These sources function not as isolated authorities but as interrelated tools of moral reflection, each aimed at safeguarding human dignity and the sanctity of life, while also fostering dialogue with other moral traditions.

Sacred Scripture**,** comprising the Old and New Testaments, is foundational as the inspired Word of God. While it should not be read as a rigid rulebook,[124] it provides the theological and moral narrative through which Catholics interpret life, grounding principles such as the ontological dignity of the human person, of every individual being created *imago Dei* (Gen 1:26–27). Scripture nourishes personal conscience, theological reflection, and ecclesial teaching. The Second Vatican Council reaffirmed Scripture's centrality by stating that it is the soul of theology and the source of all moral truth.[125] However, the Church also emphasizes the importance of hermeneutics, recognizing the human authorship and historical conditioning of biblical texts, which necessitates careful interpretation, especially in morally complex areas such as bioethics.[126] While the Church upholds the primacy of God's Word, it does not diminish the essential role of human reason, particularly in mediating between revealed truth and the realities of human experience.

Sacred Tradition complements and coexists with Scripture as the living transmission of divine revelation. Rooted in apostolic teachings and animated by the Holy Spirit, Tradition encompasses doctrines, liturgical practices, and moral teachings passed down through generations. One of the fundamental characteristics of doctrine is its capacity for ongoing development; in this regard, Sacred Tradition is rightly described as *dynamic and living*.[127] The Church has preserved and transmitted values across generations, not as static or finalized truths, but as realities continually open to deeper understanding through the light of the Gospel. This dynamic nature of Tradition enables the Church to revisit and engage questions that may have once been considered closed, such as the ordination of women, in the context of new insights and evolving circumstances. The Gospel is thus more effectively applied through a discerning reading of the "signs of the times." Nevertheless, it is essential to distinguish between authentic doctrinal development, which deepens the Church's understanding of the faith, and deviations that compromise its integrity. Tradition also functions as a source of unity, ensuring that legitimate diversity in expression contributes to the richness of faith rather than to division or fragmentation.[128] The *Sensus fidei*, or the spiritual intuition of the faithful, plays a crucial

[123] John Paul II, *Evangelium Vitae* (March 25, 1995), no. 65.
[124] Corkery, *Bioethics and the Catholic Moral Tradition*, 12.
[125] Second Vatican Council, *Optatam Totius* (October 28, 1965), no. 16.
[126] Second Vatican Council, *Dei Verbum* (November 18, 1965), nos. 7-10.
[127] Corkery, *Bioethics and the Catholic Moral Tradition*, 29.
[128] International Theological Commission, *Sensus Fidei in the Life of the Church* (2014), no. 67.

role in preserving Tradition, especially in the face of cultural pressures and public policy challenges in healthcare. Theologians, therefore, must resist capitulating to secular agendas and instead offer a prophetic, theologically grounded witness that upholds human dignity.

Natural Law, which is the rational participation of the human person in God's eternal law,[129] provides the Catholic moral tradition with a universal ethical language that resonates beyond ecclesial boundaries. Pope John Paul II, in *Veritatis Splendor*, articulates natural law as an objective and universal moral order grounded in human nature. He asserts that natural law is inscribed in the human heart and discernible through reason, thereby possessing normative authority that applies to all people, regardless of context.[130] The Holy Father further emphasized that natural law represents the manifestation of God's eternal law, inscribed within human nature, and serves to direct individuals toward the realization of their ultimate purpose.[131] Rooted in human nature and accessible to reason, natural law articulates moral principles such as the preservation of life, the good of procreation, the pursuit of truth, and the demands of justice. It serves as a common moral ground for dialogue with other traditions and ethical systems, functioning as a bridge between faith and reason. Violations of natural law, whether through relativism, utilitarian ethics, or disregard for human dignity, are seen as actions contrary to reason and divine order.[132] Pope John Paul II emphasized that certain acts are intrinsically evil, regardless of circumstances, reinforcing the objective character of moral truth.[133] This natural law framework is particularly relevant in healthcare ethics, where human dignity must never be subordinated to technological advancement, economic gain, or political agendas. As Benedict Ashley warns, modern tendencies to reconstruct nature, through practices like genetic engineering or artificial reproductive control, can erode respect for the human person.[134] True moral action in healthcare must respect both the natural moral order and the autonomy of the individual, exercised not as unrestrained freedom, but as the capacity to choose the good.

In conclusion, the Catholic moral tradition, through Scripture, Tradition, and Natural Law, offers a cohesive, reasoned, and theologically grounded framework for addressing bioethical challenges. These sources not only guide internal moral discernment but also enable respectful and

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[129] *Summa Theologiae*, I-II, q. 91, a. 2; and q. 93.

[130] John Paul II, *Veritatis Splendor* (August 6, 1993), no. 51.

[131] John Paul II, *Veritatis Splendor*, no. 72.

[132] J. Budziszewski, "Why Natural Law is for Everyone." *The National Catholic Bioethics Quarterly* 23, no. 4 (Winter 2023), 568.

[133] John Paul II, *Veritatis Splendor*, no. 80.

[134] Benedict M. ASHLEY and Kevin D. O'ROURKE, *Health Care Ethics*: *Theological Analysis* (Washington, D. C.: Georgetown University Press, 1997), 224.

fruitful dialogue with other moral traditions. Ultimately, they affirm the universality of human dignity and the moral responsibility to protect and promote life in all its stages.

1.5.3 Convergence with the Wisdom of Other Traditions

Catholic moral teaching resonates deeply with the moral insights of other religious and philosophical traditions. The Catholic Church does not claim an exclusive monopoly over moral truth but understands itself as one among several wisdom traditions that have significantly contributed to the development of universal moral principles. At the same time, the Church acknowledges that while there are areas of profound convergence with other traditions, there also remain points requiring continued dialogue and critical engagement to foster deeper mutual understanding. The dynamic interaction between moral traditions, marked by overlap, resonance, and agreement in ethical principles, is often referred to as convergence. The *Pontifical Biblical Commission* describes convergence as an openness to the values of diverse cultures and traditions, facilitating movement toward a shared ethical universalism.[135] This principle highlights the meeting points of moral agreement between the Christian moral tradition and other cultural and religious systems.[136] Convergence plays a pivotal role when Catholic moral principles, particularly in the field of bioethics, are brought into public discourse. This section explores how foundational elements of Catholic bioethics align with the moral teachings found in other traditions, including Judaism, Hinduism, Buddhism, African Traditional Religions, and Islam—demonstrating the Church's commitment to respectful dialogue and shared moral reasoning in the pursuit of the common good.

The foundational and most firmly held principle within the Catholic moral tradition is the sanctity of human life. This core tenet affirms that every human person possesses inherent dignity and must be treated with respect at all stages of life. Notably, this principle finds resonance across a wide range of global wisdom traditions, each of which upholds the sacredness of human life in its own theological and moral framework. In the Hebrew Scriptures, the concept of *imago Dei*, that every human being is created in the image of God (Gen 1:27), serves as the fundamental source of human dignity. This theological conviction underpins both Christian and Jewish ethical traditions, particularly in matters related to life, justice, and healthcare. Similarly, Islamic ethics holds life in the highest regard. As one scholar notes, "Islam holds life in the highest esteem to the extent that the duty to

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[135] Pontifical Biblical Commission, *The Bible and Morality*: *Biblical Roots of Christian Conduct* (Vatican City: Libreria Editrice Vaticana, 2008), no. 93.

[136] Corkery, *Bioethics and the Catholic Moral Tradition*, 21.

preserve life forms one of the core principles in *maqāṣid al-sharīʿah*."[137] This commitment to the sanctity of life informs Islamic prohibitions against murder, suicide, and, except in narrowly defined circumstances, abortion. Across these and other traditions, there is a shared moral conviction: that all healthcare processes, medical practices, and frameworks of social justice must be grounded in a commitment to safeguard the intrinsic dignity of the human person. This convergence underscores the universality of respect for human life as a foundational ethical principle.

Justice is another central moral principle that the Catholic moral tradition contributes to public discourse, and it finds significant resonance with the values upheld in other moral wisdom traditions. Theologically, justice is one of the four cardinal virtues, alongside prudence, temperance, and fortitude, and serves as a foundational imperative for ethical and moral life. As a cardinal virtue, justice obliges individuals and communities to render to others what is due to them, ensuring right relationships and the equitable distribution of goods, opportunities, and protections. According to Pope Benedict XVI, justice consists in rendering to the other what is rightfully theirs—what is owed to them by virtue of their inherent dignity or by reason of their actions.[138] Catholic teaching on justice is deeply rooted in Sacred Scripture, particularly in the Old Testament, where the moral obligation to defend and uplift the poor is consistently emphasized. The Book of Proverbs encourages just conduct and care for the vulnerable (cf. Prov. 22:17–24), while the prophet Amos offers a powerful critique of systemic injustice. In Amos 8:4–6, he condemns merchants who exploit the needy through dishonest practices, calling instead for economic and social structures grounded in fairness and integrity. For Amos, justice entails not merely the absence of wrongdoing, but proactive action to ensure equity, redress inequalities, and safeguard the dignity of all people—especially the marginalized. Justice, in this prophetic vision, demands concrete action rather than empty rhetoric, and it is inseparably linked to compassion and solidarity.

A closer examination of major world wisdom traditions reveals a consistent moral pattern: the commendation of good and the condemnation of evil. Across cultural and religious diversity, there emerges a shared moral intuition encapsulated in the maxim, "*One must do good and avoid evil*."[139] This foundational principle of Catholic moral theology finds resonance in many traditions, reflecting a universal ethical impulse. Likewise, the so-called "Golden Rule" is widely echoed: "*And what you hate, do not do to anyone*" (Tob. 4:15) and "*In everything, do to others what you would have them do*

[137] Ramizah Wan Muhammad, et al., "The Doctrine of Sanctity of Life from the Islamic Perspective." *Al-Shajarah* 21, no. 1 (2016), 23. https://www.researchgate.net/publication/318760857.

[138] Benedict XVI, *Caritas in Veritate* (June 29, 2009), no. 6.

[139] International Theological Commission, *In Search of a Universal Ethic*, no. 39

to you" (Mt. 7:12). These expressions suggest that the human person, by nature, is oriented toward the good, a disposition that undergirds the pursuit of the universal common good. While such convergences do not eliminate the specific moral and cultural differences among traditions, they indicate a shared recognition that there exists a "correct" or "wise" way to live and act.[140] Further, the Pontifical Biblical Commission notes, this convergence points to an ethical universalism that is not imposed, but discovered through reason, experience, and dialogue. These cross-cultural engagements reveal that many forms of conduct are widely esteemed across diverse societies as embodying the highest expressions of human flourishing. Traits such as courage in adversity, perseverance through suffering, compassion toward the vulnerable, temperance in the use of material resources, ecological responsibility, and a commitment to the common good are consistently upheld as virtues that reflect the fullness of human dignity and moral excellence.[141] The dynamic interplay between doing good and avoiding evil is thus not merely an abstract ideal, but a moral foundation for social harmony, justice, and peace in diverse societies.

While the Catholic moral tradition brings a rich reservoir of ethical values to public discourse, it does so not from a position of dominance, but through a posture of dialogue and mutual respect. This approach aligns with what David Hollenbach terms "intellectual solidarity", a mode of engagement rooted in deliberation, reciprocity, and civility. Hollenbach emphasizes that authentic dialogue must avoid alienating or marginalizing any group. He describes intellectual solidarity as:

> An orientation of the mind that regards differences among traditions as stimuli to intellectual engagement across religious and cultural boundaries. It is an orientation that leads one to view differences positively rather than with a mindset marked by suspicion or fear. It starts from a posture that welcomes foreign or strange understandings of the good life into one's mental world in a spirit of hospitality, rather than standing on guard against them.[142]

At the heart of this approach lies the principle of listening—granting each participant the opportunity to both learn from and contribute to the exchange. Engaging in intellectual solidarity presupposes that each party brings something valuable to the dialogue. Hollenbach maintains that the Christian community's primary contribution to the public sphere is its foundational religious conviction.[143] The vision of the good life offered by Christian teaching holds significance not only for Christians but also for the broader society. Moreover, Catholic moral tradition contributes deeply rooted principles, such

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[140] International Theological Commission, *In Search of a Universal Ethic*, no. 23.

[141] International Theological Commission, *In Search of a Universal Ethic*, no. 36.

[142] David Hollenbach, *The Common Good and Christian Ethics* (Cambridge: Cambridge University Press, 2002), 138.

[143] Hollenbach, *The Common Good and Christian Ethics*, 137.

as the dignity of the human person, the moral insights of natural law, and the ethical wisdom of Sacred Scripture. These principles resonate with those found in other major wisdom traditions across the globe, offering a basis for meaningful convergence and shared moral reasoning in the public square.

1.6 Conclusion

This chapter has shown that Catholic bioethics is not only theoretically significant but also practically capable of grounding and guiding the pursuit of universal healthcare under conditions of economic and structural limitation in line with its transformation into a more contextually engaged approach. The Catholic moral tradition offers a set of principled ethical values that not only possess normative force within its own theological framework but also resonate with other global wisdom traditions. These principles have been thoughtfully articulated to safeguard human dignity, particularly within healthcare and broader bioethical contexts. At the heart of this tradition lies the anthropological affirmation that every human being is endowed with intrinsic dignity. This foundational claim, rooted in the Church's teaching that each person is created *imago Dei*, grounds the universality of human equality. Such dignity is not contingent upon health status, economic standing, accomplishments, sexual orientation, or religious affiliation.

This inherent worth, referred to as ontological dignity, arises from the very fact of being human. It is a dignity that, as affirmed by Church teaching, "remains valid beyond any circumstances."[144] Ontological dignity asserts that every individual, by virtue of being born into the human family, deserves unconditional respect. While this foundational dignity can be influenced by moral, social, or existential factors, such as personal behaviour (moral dignity), socio-economic conditions (social dignity), or life circumstances (existential dignity), its core reality is never nullified.[145] Though these dimensions may affect how dignity is experienced or expressed, they do not negate the fundamental worth of the human person.

The Catholic moral tradition upholds an objective moral standard grounded in three foundational sources of wisdom: Natural Law, Sacred Scripture, and Tradition. Natural law, in particular, is regarded as universal, immutable, and absolute. It is universal because it is rooted in human nature and thus applies to all people; immutable because it is not subject to change, repeal, or exemption; and absolute because it obliges adherence under all circumstances. As one scholar explains, "natural law is universal because, being based on human nature, it binds all men [and women]; it is

[144] Dicastery for the Doctrine of the Faith, *Dignitas Infinita*, no. 7.
[145] Dicastery for the Doctrine of the Faith, *Dignitas Infinita*, no. 7.

immutable, because it is not subject to change, abrogation, or dispensation; [and] it is absolute because man must observe it at all costs."[146] While Sacred Scripture and Tradition are distinctively Christian in origin, their ethical content often converges with the teachings of other moral and cultural traditions. For instance, the ethical maxim known as the 'Golden Rule', as stated in "And what you hate, do not do to anyone" (Tob 4:15) and "In everything, do to others what you would have them do to you…" (Mt. 7:12), articulates a universal moral principle that finds expression in diverse religious and philosophical traditions. These scriptural imperatives advocate for a universal ethic of relational responsibility: to avoid harming others and to actively pursue the good.

This ethos finds practical expression in the core principles of bioethics—non-maleficence, beneficence, justice, and autonomy, all of which align with the overarching maxim to "do no harm." These principles ensure respect for the autonomy and integrity of patients, equitable treatment of individuals, and fair distribution of limited healthcare resources. Furthermore, they provide an ethical framework for resisting violations of ontological dignity, such as abortion, murder, euthanasia, suicide, war, human trafficking, and physical or psychological torture.

The next two chapters will examine, respectively, the classical tradition of medical ethics and the evolving landscape of bioethics as informed by Catholic Social Teaching. The first will explore how foundational ethical principles have shaped medical practice, while the second will consider how Catholic Social Teaching can guide bioethics in responding to the ethical challenges posed by rapid technological advancements and systemic healthcare inequalities. Particular attention will be given to how these principles can safeguard human dignity and support the pursuit of universal healthcare.

[146] Cahill. *Theological Bioethics: Participation, Justice, and Change*, 15.

CHAPTER TWO

THE SIGNIFICANCE OF CHARLES MCFADDEN AND BERNARD HÄRING'S CONTRIBUTIONS TO MEDICAL ETHICS

2.0 Introduction

This chapter examines the development of Catholic moral theology beyond the manualist tradition through the contrasting yet complementary contributions of these two figures. It situates their work within the broader transformation of Catholic bioethics into a more historically conscious and contextually responsive discipline. In doing so, the chapter explores the extent to which this evolution has reshaped bioethics into a framework capable of grounding and guiding the pursuit of universal healthcare. The contributions of Charles McFadden and Bernard Häring to the development of medical ethics as a distinct field of study and practice are significant for the transitional role they play in its evolution. These scholars have been specially selected for interlocution in this chapter because of their unique positioning in the development of medical ethics and their contributions to the Second Vatican Council's (Vatican Council II) considerations of moral theology including medical ethics. The Pre-Vatican II *Medical Ethics* by Charles McFadden was a teaching manual for nurses and doctors and a reference guide for decision making in medical practice. The post-Vatican II *Medical Ethics* by Bernard Häring represents the initial efforts to respond to the council's recommendations on new approach to theology emphasising renewal and more engagement with the modern world. The spirit of the Vatican Council II to renew and adapt to the changing world, while preserving the essential truths of the faith promoted acquired an Italian name *aggiornamento*, meaning 'bringing up to date.' Bernard Häring immediately sought to respond to a call for the Church to be both faithful to its traditions and relevant to the contemporary world, adapting its methods and expressions while upholding its core beliefs. These works are also representative of the start and the end of the manualists' era. This chapter attempts to answer the question: What are the contributions of McFadden and Häring in the development of medical ethics and how has that shaped the argument regarding universal healthcare?

2.1 The Significance of Charles McFadden's Medical Ethics

This section explores Charles J. McFadden's fundamental principles for *Medical Ethics* which became a manual that was generally accepted as a guide for nurses and medical practitioners. It has been

revised and updated several times to respond to the new developments in the practice of medicine.[1] The manual went through a number of revisions to incorporate new topics and to adjust some in consonant with new developments in medical science.[2] Revisions broadened the scope of the manual from its narrow Christian character to a universal and wider coverage. McFadden could not conceal the Catholic Christian identity in the earlier editions of his *Medical Ethics* because of his Christian theological background. This observation was well reflected in some medical ethics scholarship. For example, Kevin Meagher observed that:

> Many new medical techniques and procedures have been introduced, new drugs have been discovered, new responsibilities have been laid upon medical art by the social and political sciences. Moreover, there have been numerous Papal pronouncements upon these matters, and moralists have been busy speculating upon the problems brought to light by the advances of medicine and investigating the implications of the various utterances of the Holy See. The new editions of Father McFadden's work which have appeared over this period required extensive revision to keep them up to date.[3]

Meagher's observation shows that McFadden was aware of the changes in medical science and the need to be abreast with new emergent challenges. However, the revisions never affected his original purposes to uphold and safeguard the dignity of the human person in medical care and biomedical research and practice. With accelerated development and increased discoveries in health sciences, clarifications, confirmations, and corrections became inevitable. More importantly the manual presents key principles of medical ethics. For the purposes of this study, this section will focus on natural law, the protection of human life and the respect for human dignity, and the pursuit of the common good.

2.1.1 Natural Law as a Rational and Universal Guide

Medical Ethics, in McFadden's conception, is anchored on natural law. It emphasises that every reality in the universe has a goal and purpose for its existence given by the Creator. And is governed and directed by law, which every creature must observe to reach the goal of its existence. McFadden avers

[1] Charles McFadden was born in Philadelphia in 1909. He was ordained a priest of the order of St. Augustine in 1935. He had been professor of philosophy at Villanova University and instructed nurses in medical ethics at various Catholic Colleges. Father McFadden was a member of the American Association of University Professors. His works include *Medical Ethics, Philosophy of Communism*, and *The Dignity of Life*. His career of teaching and writing spanned over 35 years. *The Dignity of Life* highlights the fact that "in this time of accelerated development, those concerned with the defence of moral standards must be fully informed on the scientific and legal nature of today's medical advances." McFadden endeavoured to use the language that is understandable to all when writing his books.

[2] The first edition appeared with the title *Medical Ethics for Nurses* in 1946. A significantly revised and enlarged second edition with the shortened title *Medical Ethics* was published in 1949, together with a reference manual for teachers. Subsequent editions appeared in 1953, 1961, and 1967, each revised and updated.

[3] Kevin Meagher, "MEDICAL ETHICS. 5th Edition by Charles J. McFadden." *Blackfriars,* Vol. 43, No. 508 (October 1962), 441. https://www.jstor.org/stable/43816517.

that, "the sum total of the requirements which each species must obtain in order to grow and develop is simply the law which it must obtain in order to progress toward its perfection and the goal of its existence."[4] This means that each creature is expected to act in obedience to the provided conditions on which its growth and development depends. McFadden identifies various conditions for the growth and development of different creatures and species."[5] According to him, the requirements for growth form an indispensable law that must be observed, and failure to obey it amounts to violation of the very essence of progress. When all physical laws governing other creatures below the human being such as soil, water, food, light, and air are present, their reality is in harmony with their nature.[6] All other creatures are essentially conditioned to these requirements without choice. When lesser beings or creatures are denied the needed conditions, they die, unless they are moved to suitable conditions that allow their flourishing.

Like other creatures, human beings require proper conditions and requirements that support their growth to full potential for the achievement of their purpose in life. However, while the human person shares most physical needs with all living creatures, she/he is not conditioned to these physical laws, but they remain essential to good health. Human beings are uniquely set apart from animals because of their rationality. While animals are governed by instincts to meet their needs, human beings use their rationality and freedom to shape their destiny.[7] What is true is that an inclination to self-preservation is shared by all creatures. In addition, an inclination to reproduce and raise off-spring is also common to all animals and to the human person. However, an inclination to acquisition of knowledge (reason) is peculiar to human beings. Knowledge is one of the seven basic goods of natural law.[8] These goods are considered self-evident, universal, and objective; others are life, friendship,

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[4] McFadden, *Medical Ethics* (London: Burns & Oates, 1961), 13.

[5] McFadden, *Medical Ethics*, 13.

[6] McFadden, *Medical Ethics*, 14.

[7] Many years later Richard Gula makes the categorisation of the interrelationship and distinctions between all creatures: "The first inclination to the good is common to all created reality. It is the tendency to preserve in being. Preserving and protecting life as a basic value belongs to the natural law on the basis of this inclination. The second inclination to the good is generic to animals. Insofar as human beings are animals, what nature has taught all animals belongs to natural law. Included here is the tendency toward the procreation and education of offspring. The third inclination to the good is specific to humans. Insofar as humans are rational, whatever pertains to reason belongs to the natural law. This includes the tendency toward truth and cooperating with one another in social existence" (Richard M. Gula, *Reason Informed by Faith*: *Foundations of Catholic Morality* (New York: Paulist Press,1989), 225-226).

[8] Terence Kennedy lists knowledge as a primary good and a starting point of reasoning to what is to be done. The complete list of goods is as follows: "1. Life: vitality in all its aspects from self-preservation and healthcare to the transmission of life by procreation; 2. Knowledge; 3. Play: a performance simply for its own sake and the joy it gives; 4. Aesthetic experience: beauty and its appreciation; 5. Sociability: from a minimum of peace and harmony to friendship in its fullness; 6. Practical reasonableness: to shape one's life, character, and destiny by intelligence; 7. Religion: an ultimate order of things that reaches beyond death and refers all to its origin and end, God." [Terence Kennedy, "John Finnis' Conception of the Natural Law." *Readings in Moral Theology* 7: *Natural Law and Theology*, eds. Charles Curran and Richard McCormack (New York: Paulist Press, 1991), 129].

aesthetic experience, practical reasonableness, and religion.[9] Basic goods of law serve as guides for individuals and communities to pursue what is good and true.

Reason or intellect formed McFadden's major distinction between human beings and other creatures. Being composed of matter and spirit, the human being requires moral or spiritual laws over and above the physical laws to progress towards the eternal destiny.[10] The moral or spiritual law can be possessed through the use of intellect which also aids the human person "to acknowledge the existence of a Supreme Being."[11] The knowledge of the existence of God has profound implications for the human person in terms of choices and actions.[12] The whole life of the human person, therefore, revolves around participation in these values through the human person's commitments, actions, and decisions that make up one's destiny.

Through intelligent reasoning human beings have built up a body of moral ideals founded on natural law. McFadden maintains the traditional definition of natural law as the human person's "participation in the eternal law – the Divine wisdom guiding all creatures to their proper ends."[13] Therefore, natural law is an inescapable aspect of human nature. In line with the Church teaches that natural law is universal and is written in the heart of each man, and manifests in every just law.[14] The Divine wisdom enjoins upon the rational creature the duty to live in harmony with her/his nature. Natural law has three enduring characteristics, namely universal, immutable, and absolute. McFadden highlighted these characteristics by elaborating that natural "is universal because, being based on human nature, it binds all men. It is immutable, because it is not subject to change, abrogation, or dispensation. It is absolute because man must observe it at all costs."[15] It follows, therefore, that every human person is obliged to conform to the universal order willed by God recognised through the use of reason. However, it is acknowledged that access to the demands of natural law may be limited in those who have no actual use of their reason or lack sufficient experience, such as infants and mentally challenged persons. Below are some concrete contributions by McFadden.

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[9] International Theological Commission, *In Search of a Universal Ethic*, no. 113.

[10] McFadden, *Medical Ethics*, 14.

[11] McFadden, *Medical Ethics*, 15.

[12] The implications of acknowledging the existence of God: "Once man recognises the fact of God's existence, he realises immediately that he owes his Supreme Being a fitting love, honour, and worship. Once man recognises the fact that he is endowed with a spiritual soul and an immortal destiny, he knows that he must subject the desires of his lower nature to the interests of his spiritual nature. Once man recognises that his fellow men are endowed with a nature and destiny similar to his own, he understands that they possess certain rights which he is morally obliged to respect. Once man recognises that he was created by God with a social nature and destined to live in society with fellow man, he realised that the State is therefore indirectly of divine origin and that its just laws should be respected and obeyed" (McFadden, *Medical Ethics*, 15).

[13] McFadden, *Medical Ethics*, 15.

[14] The Holy See, *Catechism of the Catholic Church* (Dublin: Veritas Publications, 1994), no. 1955.

[15] McFadden, *Medical Ethics*, 15.

McFadden opens his argument by affirming that natural law serves as the grounding for universal ethical standards. The doctrine of natural law establishes universal moral standards that transcend cultural, legal, and religious differences. This universality is especially vital in today's globalized context, where medical ethics must navigate diverse cultural, political, economic, and social environments. At the heart of McFadden's teaching on natural law is the conviction that "All men should have at their disposal from the beginning of their rational life all those truths which will help them develop themselves spiritually and make a constant progress toward their final spiritual destiny."[16] This underscores natural law as both the foundation and primary source of moral law. In defending the moral law as understood in Christianity, McFadden asserts that "It is found in Tradition, in Sacred Scripture, and in the teaching of Christ's infallible Church."[17] His claim that moral law is most perfectly preserved within Catholic teaching positions it as a valuable contribution to global moral discourse, an ideal the Church proposes, rather than imposes, for imitation by other traditions and states. Accordingly, civil legislation must not contradict the principles of natural law. The International Theological Commission affirms this, stating that natural law provides a framework to guide moral behaviour and inspire legal structures that uphold human dignity.[18]

McFadden also explores natural law in its twofold expression: affirmative obligations and negative prohibitions. Natural law, fundamentally, is the moral order discernible by human reason and rooted in human nature, directing individuals to pursue good and avoid evil.[19] Negative natural law prohibits morally evil acts and actions that harm the body or human dignity. It is characterized by its absolute nature—binding at all times without exception.[20] This includes intrinsic evils such as abortion, euthanasia, homicide, genocide, mutilation, physical and mental torture, slavery, human trafficking, arbitrary imprisonment, and subhuman living conditions. As a cornerstone of Catholic moral teaching, negative natural law provides unequivocal prohibitions that serve as essential guides for the formation

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[16] McFadden, *Medical Ethics*, 16.

[17] McFadden, *Medical Ethics*, 16.

[18] International Theological Commission (ITC), *In Search of a Universal Ethic*: *A New Look at Natural Law* (2009), no. 9: "Aware of what is currently at stake in the question, we would like, in this document, to invite all those pondering the ultimate foundations of ethics and of the juridical and political order, to consider the resources that a renewed presentation of the doctrine of the natural law contains. This law, in substance, affirms that persons and human communities are capable, in the light of reason, of discerning the fundamental orientations of moral action in conformity with the very nature of the human subject and of expressing these orientations in a normative fashion in the form of precepts or commandments. These fundamental precepts, objective and universal are called upon to establish and inspire the collection of moral, juridical, and political determinations that govern the life of human beings and societies. They constitute a permanent critical instance of them and guarantee the dignity of the human person in the face of the fluctuations of ideologies. In the course of its history, in the collaboration of its own ethical tradition, the Christian community, guided by the Spirit of Jesus Christ and in critical dialogue with the wisdom traditions it has encountered, has assumed, purified, and developed this teaching on the natural law.

[19] *Summa Theologiae* I-II, 94.2.

[20] McFadden, *Medical Ethics*, 225.

of conscience, moral decision-making, and the development of just laws and policies. In contrast, affirmative natural law imposes positive moral obligations.[21] It encourages individuals to engage in actions that promote personal flourishing and social well-being. These include worshiping God, respecting human life, seeking truth and knowledge, developing one's talents, promoting the common good, caring for one's family, educating children, and aiding those in need. These obligations affirm the human person's dignity and direct society toward justice, solidarity, and the common good. While negative natural law is prohibitive and protective, affirmative natural law is prescriptive and directive. Both aspects are essential and mutually reinforcing. In healthcare, they correspond to the foundational bioethical principles of non-maleficence (do no harm) and beneficence (promote the good), which demand that healthcare professionals act in the best interests of patients while avoiding harm.

Lastly, McFadden emphasizes the moral boundaries that must govern medical interventions. The moral limits of medical interventions are grounded in the dignity and integrity of the human person, the nature of the medical act, and its intended purpose—namely, the promotion of the patient's overall well-being, both physical and psychological. Interventions may be morally justified when aimed at repairing defects or sacrificing a part of the body for the benefit of the whole. However, all such acts must conform to the demands of both natural and divine law. McFadden's critique of artificial insemination illustrates how natural law sets ethical boundaries on medical procedures. He argues that technical success does not negate moral concern. Despite the possibility of conception through artificial means, such procedures raise unresolved ethical questions regarding the dignity of the child and the integrity of marriage, especially in cases involving donor sperm or surrogate arrangements.

The Church teaches that not all technically feasible procedures are morally permissible. John Paul II's affirms this principle: "every medical procedure performed on the human person is subject to limits: not just the limits of what is technically possible but also limits determined by respect for human nature itself."[22] Healthcare professionals, therefore, must not participate in practices contrary to public morality or human dignity, that is, "any practice which is contrary to public policy, injurious to the welfare of society, or destructive to the true dignity of marriage."[23] At the same time, McFadden acknowledges that medical professionals are moral agents whose consciences must be respected,

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[21] McFadden, *Medical Ethics*, 225.

[22] John Paul II, "Address to the 18th International Congress of the Transplanting Society" (August 29, 2000), no. 2.

[23] McFadden, *Medical Ethics*, 58.

especially when faced with procedures that conflict with deeply held ethical or religious convictions. The right to conscientious objection is an essential component of professional integrity.

Pope John Paul II reinforces the importance of moral discernment in medicine, stating: “Every medical procedure performed on the human person is subject to limits: not just the limits of what is technically possible but also limits determined by respect for human nature itself.” Medical interventions must therefore be evaluated not only for their feasibility but also for their impact on human dignity and the sanctity of life. For instance, in end-of-life care, the continued use of life-sustaining technologies, when there is no reasonable hope of recovery, can cross ethical boundaries by artificially prolonging suffering. Allowing natural death, in such cases, respects both the dignity of the person and the moral boundaries of care. Science and technology must always be applied with an awareness of their social, psychological, legal, and moral implications.

In summary, natural law, both in its affirmative and negative forms, serves as a comprehensive moral compass in guiding medical practice. It ensures that technological advances are used ethically and that the sanctity and dignity of human life remain central in all healthcare decisions.

2.1.2 Respect for Human Life

Grounded in the doctrine of natural law, medical ethics upholds the sanctity and inviolability of human life as a foundational principle. Every medical decision must take into account its impact on human dignity, ensuring that no action undermines the inherent worth of the person. This is particularly pertinent in ethically complex areas such as abortion, euthanasia, organ donation, end-of-life care, and medical experimentation. Catholic teaching, drawing from natural law and divine revelation, consistently advocates for the protection of human life from conception to natural death. Human life is most vulnerable at its inception, requiring deliberate ethical attention and protection. McFadden, consistent with the Catholic natural law tradition, maintained that marriage is the appropriate and divinely instituted context for the generation and nurturing of life. He affirms that “matrimony was the divinely appointed means for the propagation and conservation of the human race,” emphasizing that the institution of marriage serves both biological and moral purposes by ensuring that children are welcomed and raised in conditions that respect their dignity and potential.[24] While acknowledging the socio-economic challenges posed by rapid population growth, McFadden recognized the need for responsible fertility regulation. However, he firmly rejected practices that directly attack human life or undermine its dignity, such as abortion, sterilization, and contraceptive methods. In his view, the foetus

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[24] McFadden, *Medical Ethics*, 41 & 46.

is to be regarded as a human person from the moment of conception, a position supported by both ethical reasoning and biological science. Thus, any medical or social intervention at this stage must align with the protection and promotion of nascent human life.

McFadden also paid attention to the ethical implications of organ donation and mutilation. The conservation of life extends throughout the individual's lifetime, including practices such as organ donation and surgical interventions that result in mutilation. Both actions are ethically evaluated through the lens of the principle of totality, which holds that interventions on parts of the body are morally permissible only when they are necessary for the well-being of the whole person.[25] Organ donation, particularly when performed altruistically, can be a profound act of solidarity. However, McFadden emphasized that such donations must never jeopardize the life or dignity of the donor, thereby safeguarding the lives of individuals. Living donors require stringent ethical safeguards, while cadaveric donations must also uphold the dignity of the deceased, avoiding any manipulation that artificially extends life solely to preserve organs for transplantation.[26]

Mutilation, defined by McFadden as the removal or disabling of a body part, is morally permissible only when the organ in question poses a serious threat to the life or overall health of the person.[27] In such cases, the principle of totality prioritizes the preservation of life over the retention of a particular bodily function. It is important to recognize that any alteration to an individual's body may result in significant psychological and spiritual challenges; therefore, those affected require comprehensive and holistic support.

In medical ethics, a critical distinction is drawn between ordinary and extraordinary means of preserving life. Ordinary means refer to treatments and interventions, such as hydration, nutrition, and standard medical care, that offer a reasonable hope of benefit and do not impose excessive burden on the patient or caregivers.[28] Every individual has a moral obligation to make use of such means when they are available and effective. Extraordinary means, by contrast, are those interventions that entail excessive burden, cost, or pain and do not offer proportional benefits.[29] Emphasis must be made here that decisions to forgo extraordinary means must be carefully discerned, ideally with the input of

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[25] John Paul II, *Evangelium Vitae* (March 25, 1995), no. 86: "Over and above such outstanding moments, there is an everyday heroism, made up of gestures of sharing, big or small, which build up an authentic culture of life. A particularly praiseworthy example of such gestures is the donation of organs, performed in an ethically acceptable manner, with a view to offering a chance of health and even of life itself to the sick who sometimes have no other hope." Further emphasis is made that commercialisation of any human organ is inadmissible as every donation is to be considered an act of love, which does not expect any reward in return.

[26] McFadden, *Medical Ethics*, 136.

[27] McFadden, *Medical Ethics*, 259.

[28] McFadden, *Medical Ethics*, 227.

[29] McFadden, *Medical Ethics*, 227.

multiple professionals, in order to avoid misjudging the value or quality of a patient's life. Importantly, McFadden argued that deliberate omission of appropriate care is not permissible since it leads directly to the patient's death.[30] Hence, the application of treatments, especially in terminal cases, must be guided by prudence, the principle of double effect, and a commitment to preserving human dignity without needlessly prolonging suffering. Respect for human life demands special attention at its most vulnerable stages, particularly at the end of life.

Medical progress depends significantly on research and experimentation, which must be conducted within moral boundaries that uphold the dignity and autonomy of all participants. McFadden acknowledged that experimentation, whether on animals, cadavers, or living humans, is an essential component of advancing medical knowledge. However, he strongly emphasized that procedures involving human subjects must be governed by informed and verifiable consent.[31] Historically, unethical experimentation—such as the Nazi atrocities and the Tuskegee syphilis study—highlighted the dangers of coercion, deception, and disregard for human welfare. Such violations are condemnable, underscoring the need for transparency, respect, and the minimization of risk. More importantly, the motivation for medical experimentation must be rooted in the pursuit of scientific knowledge or the well-being of the patient, rather than driven solely by professional advancement or institutional self-interest. Therefore, the right to withdraw from a study, adequate disclosure of risks, and the proportionality between potential benefit and risk are all essential ethical conditions. Moreover, knowledge gained from research involving human subjects must not remain the private property of researchers or institutions but should serve the common good, reflecting the Church's principle of the universal destination of goods.

2.1.3 The Pursuit of the Common Good

The chapter on "Property Rights" in McFadden's *Medical Ethics* highlights the ethical imperative of prudent stewardship over material goods, particularly within healthcare. In his discussion, McFadden insists that healthcare professionals must balance the use of resources in ways that serve both the immediate needs of patients and the operational sustainability of medical institutions. He asserts that "God, as a generous Creator, has placed a bountiful nature at the service of the human race," and that human beings have a "strict moral obligation to use this creation to maintain [their] health and life."[32] While this assertion does not explicitly reference the principle of the universal destination of goods, it

[30] McFadden, *Medical Ethics*, 227.
[31] McFadden, *Medical Ethics*, 249.
[32] McFadden, *Medical Ethics*, 343.

implicitly affirms it. According to this principle, all resources of the earth are divinely intended for the benefit of the whole of humanity, thereby placing moral limits on the exclusive control or consumption of such resources.[33] Even when hospitals are privately or corporately owned, they function as communal institutions. Accordingly, all staff bear a profound responsibility for stewardship, refraining from theft, waste, or any form of unjust damage to resources entrusted to their care. McFadden affirms the legitimacy of private property, acknowledging that individuals may rightfully own and utilize nature's resources for personal benefit, through use, profit, exchange, or sale.[34] However, he simultaneously underscores the moral constraints that accompany such rights. He extends this analysis to corporate entities and the State, which may also possess and manage goods within legitimate boundaries. Central to McFadden's argument is a distinction between the right to ownership and the moral use of property. He notes that "a person may have the right ownership over many things, but the use of these things is always subject to very definite and rigid limitations."[35] In doing so, McFadden echoes a key tenet of Catholic social teaching: the right to private property, though real and protected, is not absolute. It is subordinate to the universal destination of goods, which mandates that ownership must always be exercised with regard to the common good and the equitable distribution of resources.[36] Collectively, these values and principles advance the realization of the universal destination of created goods, a foundational concept in this study underpinning the ethical argument for universal healthcare.

[33] Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, no. 172.
[34] McFadden, *Medical Ethics*, 343.
[35] McFadden, *Medical Ethics*, 343.
[36] John Paul II, *Laborem Exercens*, no. 14.

2.2 The Contribution of Bernard Häring to Contemporary Medical Ethics.[37]

Bernard Häring's contribution to the principles of medical ethics also focus on the sanctity of human life and the promotion of human dignity. Häring is an iconic contributor to medical ethics and moral theology in general, who made his impact both pre-Second Vatican Council and post-Second Vatican Council (Vatican Council II). His major works include the three-volume *The Law of Christ* written before and during Vatican Council II. This three-volume book became the manual for teaching moral theology in general. *The Law of Christ* was preceded by his work on the specific subject of genetics entitled *Manipulation*. With *Free and Faithful in Christ*, Häring stepped up to put into motion the reforms proposed by Vatican II. In *Free and Faith in Christ*, Häring endeavoured to move beyond a legalistic rule-based morality to one that is rooted in love, personal responsibility, and the call to discipleship. He promoted an understanding of morality as not simply complying with rules, but actively discerning God's will in one's life. Convinced that medicine creates its own health problems, Häring worked on the new manual aimed at protecting the integrity of human life at every stage, with his work entitled *Medical Ethics*.[38] The immediate shift of this work was to comprehensively present bioethics subjects for the wider audience including doctors, nurses, the *Magisterium*, theologians, and the patients. Häring's approach was pedagogical, instructive, and directive on matters aimed at protecting human life from conception to natural death. This section examines his contributions to theology in general and to medical ethics in particular.

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[37] MacEoin, Gary. "Conversation With Bernard Häring." *Worldview* 15, no. 8 (1972): 22. DOI: https://doi.org/10.1017/S0084255900014509: "Bernard Haring is probably the best-known writer on moral theology (Christian ethics) in the Roman Catholic Church. He was a priest belonging to a religious congregation known popularly as the Redemptorists. He was a lecturer at the Accademia Alfonsiana, a college for graduate studies in moral theology in Rome, and a visiting professor of the Joseph and Rose Kennedy Institute for the Study of Human Reproduction and Bioethics. Häring's pre-Vatican II three-volume manual of Moral Theology called *Das Desetz Christi* (The Law of Christ) was the first of his significant works. The volume was translated into most modern ethical and modern languages and was highly being hailed as a breakthrough in ethical and moral teaching, taking into account as it did contemporary sociological and psychological scholarship. It is important to note that this volume, although focused on the law as the title suggests, represents the beginning of the change of ethical and moral teachings. Häring's second three-volume manual of theology entitled *Faith and Free in Christ* written after the Second Vatican Council truly confirms the shift in moral teaching. It shows a movement from actions based on the fear of the law and punishment, to actions in response to God influenced by freedom and responsibility. Haring wrote numerous books, of which two are of particular interest to students of medical ethics. These are *Medical Ethics* and *Manipulation*. *Medical Ethics* is concerned with the ethics of medical practice. It covers the whole field of medicine and views its subject matter from the point of view of the Christian faith. *Manipulation*, which has the subtitle *Ethical Boundaries of Medical Behavioural and Genetic Manipulation*, is more limited in its scope. The word 'manipulation' denotes a wide variety of activities. It can be used of manufacture, whether literally by hand, or by machine; or it can be used, by analogy, of the 'Medical Ethics. Sometimes these activities are undoubtedly morally good: for example, most forms of surgery, but at other times they are morally doubtful, or, as in the case with torture and brainwashing, certainly wrong. Advances in biology, medicine and psychology have increased the range of manipulative activities which are possible now or which might become possible in the future. Haring's study concentrates on manipulation in this field in an effort to determine the criteria of right and wrong both in general and in particular cases (Brendan Soane. "The Literature of Medical Ethics: Bernard Haring", *Journal of Medical Ethics*, 1977, 3, 85-92). https://jme.bmj.com/content/medethics/3/2/85.full.pdf.

[38] Häring, *Medical Ethics* (Slough: St. Paul Publications, 1972), 3.

2.2.1 Bernard Häring's Theological Contribution

Häring integrated biblical sources into medical ethics to signify a shift towards a personalist and scripture-based approach to the evaluation of moral behaviour. The Sacred Scriptures reveal that God is love and this truth inspires respect for every person and for all created things. Häring states that "*Belief in One God, Creator of all things*, is a call to co-responsibility."[39] This teaching implies that because God created everything, we have a shared duty to care for creation and work towards the common good. This responsibility is not limited to individual actions but extends to one's relationships with God, others, and the entire creation. It is a call to be stewards of creation by caring for the earth and its resources. This stewardship involves both protecting the environment and promoting the well-being of all people, especially the poor and vulnerable.

The belief in the transcendent God evokes certain attitudes and dispositions in every religious individual. Such attitudes include using the earth's resources responsibly and sustainably with consideration for the future generations. Taking responsibility for the stewardship of human life and all earth's goods is a noble duty for every person. As such Häring reiterates Christian anthropology for an understanding of the human person when he stated that: "for the Christians, the importance and dignity of the body is paramount, ordained as it is to become more and more a visible image of God's goodness, mercy, and purity."[40] In Christian anthropology, the human person assumes the role of a co-creator, at the same time, one whose nature cannot be complete without the story of Redemption realised through the Incarnation and the Resurrection of Christ.[41] The act of redemption puts a demand of authentic discipleship on Christians. First, there is need for a complete awareness that there is no separation of the physical from the spiritual in the human person. Emphasising the Christian view of the human person, Häring observed that "the Christian vision is directed towards man in his wholeness. The whole man has his origin in God; the whole man falls into the stream of sinfulness and is subjected to the vanity of sin. So also, is the whole man redeemed and called to holiness, able to conquer the powers of sin."[42] Secondly, authentic discipleship demands that Christians live out the mandate of witnessing to the whole world. Häring placed Jesus and his teaching at the centre in his moral reflection as he explains "Christian faith and theology centre in Christ through whom (the creative Word) and for whom (the incarnate Word) all things are made."[43] Human beings can now share Jesus' sonship in God by being-in-Christ through imitating him. By discipleship, the believer is free from the law and is under the new law of Christ

[39] Häring, *Medical Ethics*, 11.
[40] Häring, *Medical Ethics*, 50.
[41] Häring, *Medical Ethics*, 50.
[42] Häring, *Medical Ethics*, 50.
[43] Häring, *Medical Ethics*, 11.

(Romans 8:2, 6:14; 1 Corinthians 9:20; Galatians 6:2, 5:18). Here the emphasis is on human freedom and autonomy that come from the new law from the interior, not imposed by any other laws. This approach promotes a morality deeply rooted in the lived experience of individuals guided by a well-formed conscience.

Christians are called to respond to Jesus' command "to proclaim the kingdom of God and to heal the sick (Luke 9:2). And urgently so. This command was part of the overall mission of Jesus to liberate and heal (Lk. 4: 16 – 22; Mt. 11: 2 – 6). Healing was an essential part of Christ's mission. He often suffered accusations of breaking the Law by healing on the Sabbath because his healing work was endless, timeless, and limitless. The determination of Jesus to heal on the Sabbath also demonstrated the urgency of wanting to restore human life to its vocation. The real Sabbath is the release of every person from any form of incapacitation and restriction of freedom. The action by Jesus also symbolised the dawn of the messianic age. The prophets described the messianic age as one of peace and healing of the sick (cf. Is. 61: 1-3; Mich. 4: 1-4; Jer. 33: 6). True Sabbath as the person's response and peace in God has a healing quality that brings about liberation and redemption from any form of infirmity and incapacitation.

Healing also involves the acceptance of death. During those moments, the patient and the physician are called to turn to the Paschal Mystery of the suffering, death, and resurrection of Jesus. As illustrated, "illness seen in the light of the Paschal Mystery prevents both the patient and the doctor from focusing one-sidedly on suffering. The mystery of redemption draws the doctor to the Redeemer and Healer, for his curative efforts are directed towards the restoration and development of the patient's freedom and increasing altruistic love and service."[44] Here, freedom includes freedom from fear of death. Simply put, healing must always be physical and spiritual. The doctor's decisions and attitudes, and the patient's response in the face of illness must be governed by Christ's redemptive event. Therefore, the patient's acceptance of healing is both liberating and redeeming.

2.2.2 Integrated Catholic Anthropology and the Preservation of Life in Bernard Häring's Medical Ethics

Bernard Häring highlighted the persistent risks in medical care stemming from rapid scientific advancements and a reductive view of the human person that prioritizes the physical and biological over the spiritual and existential.[45] He insisted that a correct and holistic understanding of human anthropology is essential for healthcare professionals to fulfil the true purpose of medicine. Häring's

[44] Häring, *Medical Ethics*, 165.
[45] Häring, *Medical Ethics*, 2.

medical ethics are grounded in Catholic Christian anthropology, which affirms that every human being originates in God and possesses inherent dignity.[46] Though Häring does not explicitly use the phrase "created in the image of God," his idea conveys this belief by emphasizing the divine design of human nature. Human nature must always be interpreted as dynamic (being by becoming) and as having an intrinsic orientation toward growth and fulfilment, aided by God's grace and personal relationships.[47] He stresses the dual physical and spiritual unity of the person, critiquing medicine's tendency to either reduce the person to their body or abstract them as a disembodied soul. This fragmented view, shaped by Zeitgeist and prevailing worldviews, misses the integrated reality of the human person.[48] Philosophically, human nature includes rationality, self-awareness, love, and sociality. Human flourishing is realized through relationships and a response to God's call.[49] Medicine, therefore, must adopt an integrated approach that acknowledges both body and soul, recognizing that the ultimate goal of healthcare is not merely biological survival but holistic well-being.

Häring emphasizes that while hospitals may be privately owned, their function is communal. Thus, the stewardship of life and health resources falls on various actors, including physicians, patients, families, institutions, and communities. Catholic teaching upholds the sanctity of life from conception to natural death, with the prohibition of unjust killing forming a central moral principle. Every person is a steward of their life, entrusted by God for the good of others.[50] Physicians occupy a crucial role as direct stewards of life. Each patient encounter demands individualized assessment, acknowledging that a person's understanding of life and death evolves. A Christian understanding sees life as a divine gift, not a private possession, and this perspective must inform all medical decisions. Healthcare, therefore, requires ongoing, reflective collaboration between patients and practitioners on the meaning of health and suffering. A case-by-case evaluation can also uncover broader social determinants of health and potential societal failures, such as neglect or injustice.[51] Healthcare requires a continually renewed commitment between physician and patient, grounded in mutual reflection on the meaning of health, illness, and the human condition.

In addition, Häring addresses the diverse factors that pose significant risks to the preservation of life. At the beginning of life, threats include assisted procreation, contraception, and abortion. The Catholic position, affirmed by Häring, holds that life must be protected from the moment of

[46] Häring, *Medical Ethics*, 50.
[47] Häring, *Medical Ethics*, 48.
[48] Häring, *Medical Ethics*, 33.
[49] Häring, *Medical Ethics*, 46.
[50] Häring, *Medical Ethics*, 66.
[51] Häring, *Medical Ethics*, 65.

conception, as such abortion and infanticide are condemned as direct violations of life.[52] While acknowledging complex medical scenarios, Häring distinguishes between direct and indirect abortion, the latter being morally permissible under grave conditions, such as saving a mother's life in cases like ectopic pregnancy.[53] Infanticide, often rooted in gender bias, deformity, or eugenics, is another grave threat.

Modern medicine's ability to artificially prolong life raises further ethical challenges. Häring cautions against expensive or futile treatments that impose hardship on families, arguing for a balance between care and the patient's or family's welfare.[54] While genuine concerns about the potential economic burden on a family resulting from the prolongation of a patient's life are valid, they must not override the fundamental ethical obligation to preserve life. Decisions should be guided by whether a medical intervention imposes undue suffering on the patient or reflects a sincere and compassionate effort to allow the patient adequate time to prepare for death. The key ethical measure is whether treatment honours the person's dignity and prepares them for death without undue suffering. Euthanasia presents a major ethical temptation under critical care. Häring recalls the original sense of euthanasia as palliative care—relieving suffering without hastening death.[55] However, its redefinition as active, direct killing undermines the dignity of life and targets vulnerable groups, including the aged, disabled, and mentally ill. Medically assisted death, or assisted suicide, reflects this shift and raises serious moral concerns about the devaluation of life.

In conclusion, Häring's medical ethics advocate a Christian, holistic view of the human person. Medicine must serve life in all its dimensions, respecting its divine origin, communal character, and ultimate destiny. Life is not a possession to be manipulated but a gift to be stewarded with love, responsibility, and reverence.

2.2.3 Conscience and Innovation in Bernard Häring's Medical Ethics

Bernard Häring places the concept of conscience at the heart of moral decision-making in medical ethics. While firmly rooted in the teachings of the Church, Häring emphasizes that conscience is not merely a passive recipient of doctrine but an active agent in discerning moral truth. He argues that individuals have a duty to form their consciences in line with ecclesial teaching, but also to follow their consciences responsibly in concrete situations, especially in the face of complex ethical dilemmas

[52] Vatican II, *Gaudium et Spes*, no. 51.
[53] Häring, *Medical Ethics*, 115.
[54] Häring, *Medical Ethics*, 140.
[55] Häring, *Medical Ethics*, 144.

posed by modern medicine. Häring's contribution is particularly salient in the context of rapid technological advancement in healthcare. He underscores the physician's obligation to engage critically with innovation rather than to fear or reject it.[56] According to Häring, the Church's desire to protect life should not position technological progress as an adversary; rather, it should view such advancements as allies in addressing the multifaceted challenges of illness. Häring affirms that modern physicians possess knowledge, tools, and procedures that were unimaginable a century ago. Despite the ethical complexities these technologies may introduce, he advocates for a pathway of rigorous evaluation and continued refinement, rather than blanket condemnation.

In this regard, Häring promotes sustained collaboration between the Magisterium, theologians, and medical professionals. He writes: "The teaching office of the Church (the Magisterium) and moral theologians have their special tasks, which can be fulfilled only in continuous dialogue and cooperation with physicians and other experts in related fields."[57] This collaborative model reflects Häring's conviction that medicine cannot be isolated from the influence of innovation, and that the Church must remain open to new insights arising from scientific and clinical developments. Theologians, therefore, play a mediating role, translating the experiences and insights of healthcare professionals for the Magisterium while helping to shape ethically sound responses to emerging issues.

Häring insists that the application of conscience must take precedence over its theoretical exposition. According to Häring, all human beings possess an intrinsic awareness of moral good and evil and feel compelled to act accordingly. The ideal process of sound decision making is premised on the understanding that all human beings possess an inner conviction of what is right and wrong and that they feel compelled to act in accord with that judgement.[58] Belief alone in the existence of inner convictions is not sufficient for habitual acting. Each person must make an effort to form their conscience. He views the physician's conscience as a vital safeguard against potential harm when engaging with new technologies. A well-formed conscience enables the physician to discern what promotes human dignity and life, even in the absence of clear magisterial guidance. Thus, the physician's responsibility lies not only in receiving moral norms but also in contributing experiential knowledge to the Church's ethical reflection.

Importantly, the conscience of the physician should not be displaced by doctrinal authority. While Church teachings remain essential, they cannot always provide immediate solutions to novel medical challenges. In urgent situations lacking clear directives, Häring encourages physicians to act in

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[56] McFadden, *Medical Ethics*, 26.
[57] McFadden, *Medical Ethics*, 35.
[58] Second Vatican Council, *Gaudium et Spes* (December 7, 1965), no. 16.

conscience after obtaining the best available information. Patient autonomy must also be respected: physicians are required to offer clear and comprehensive information to enable informed decision-making. If a patient refuses an intervention, that decision must be honoured unless it is demonstrably irrational or harmful. In life-saving situations involving children, however, the physician may be compelled to act in defence of life even against parental objections, particularly where legal frameworks prioritize the child's right to medical care.[59] Häring also emphasizes that physicians must not withhold treatment based on moral judgments about the cause of illness. Providing care is not a reward for moral behaviour but a fundamental obligation rooted in the sanctity of life.[60] Similarly, the conscience of the physician must be respected by patients and society alike. Häring's model recognizes the Magisterium's indispensable role in shaping moral doctrine but insists that its function is to aid the formation of conscience, not replace it. He stresses the distinction between official Church teachings and the process of personal moral reasoning.[61] While the Magisterium offers authoritative guidance, ultimate moral responsibility rests with the individual conscience, which must be educated through engagement with Scripture, tradition, reason, and contemporary moral experience.

Häring notes a shift in modern society from moral guidance rooted in religious custom and community norms toward a legalistic framework. While acknowledging the importance of legislation in pluralistic societies, he warns that law alone cannot be the final arbiter of moral judgement. Instead, conscience, informed by the Gospel and other moral sources, must continue to guide ethical decision-making. In this context, Häring calls on the Church and humanist ethicists to promote the development of mature consciences. Given that legislation often reflects prevailing public opinion, efforts to influence moral reasoning must include strategies for engaging civil discourse.[62] Through dialogue and partnerships with those outside the Church, shared ethical goals, especially concerning the protection of human life, can be more effectively advanced.

Häring ultimately presents conscience not as a private instinct, but as a disciplined and dialogical moral faculty, shaped by tradition, experience, and cooperation. In the evolving field of medicine, the physician's conscience serves both as a moral compass and as a partner in the Church's ongoing ethical reflection. Every innovation is, in this light, not merely a technical opportunity but a moment for theological discernment and shared moral growth.

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[59] McFadden, *Medical Ethics*, 39.
[60] McFadden, *Medical Ethics*, 37.
[61] McFadden, *Medical Ethics*, 117.
[62] McFadden, *Medical Ethics*, 117.

2.2.4 Healthcare as a Christian Ethical Commitment

Healthcare, at its core, is grounded in the Christian imperative to love and serve others. As a social good and ethical responsibility, it demands engagement from both the State and society. Bernard Häring asserts that "the protection of people's health and adequate healthcare are basic social concerns," emphasizing the need for every individual to cultivate a robust ethical outlook toward health-related challenges.[63] While all members of society share responsibility, healthcare professionals bear a particular duty to heal in ways that uphold the dignity and autonomy of the patient. Häring offers a comprehensive view of health, stating: "Human health includes the greatest possible harmony of all man's forces and energies, the greatest possible spiritualization of man's bodily aspect, and the finest embodiment of the spiritual."[64] Though idealistic in tone, this definition underscores a shift toward holistic health, moving beyond a narrow focus on physical well-being. While physical fitness remains a vital component, it cannot serve as the sole criterion for health. Häring warns that in a utilitarian age, there is growing temptation to define health merely in terms of work capacity or physical efficiency, an approach that reduces human worth to measurable output.[65] This reductionist view is ethically dangerous. A person cannot be reduced to their physical or cognitive abilities, achievements, or functional roles. The human person is an integrated being whose psychological, social, and spiritual dimensions must be recognized and respected in clinical care. A holistic approach to health affirms the inherent dignity of the patient, emphasizing not only cure but the nurturing of conscience, values, and self-realization.

Historically, medicine has concentrated on physical, psychological, and spiritual care, often neglecting social and environmental determinants of health. Häring, however, highlights these broader factors, stating: "Health has a social finality [involving] cooperation and interdependence in areas such as nourishment, housing, prenatal care, education, and the shaping of the environment."[66] This perspective calls for a more integrated and justice-oriented understanding of health.

Nevertheless, Häring acknowledges that modern medical practice may hinder the physician's vocation. He identifies key concerns: diminishing personal contact between doctor and patient, overreliance on technological systems, and the commodification of care.[67] Despite the efficiency afforded by diagnostic tools and institutional structures, there is a risk that the patient becomes a record rather than a person. Moreover, physicians operating within insurance-driven systems may prioritize

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[63] Häring, *Medical Ethics*, 35.
[64] Häring, *Medical Ethics*, 154.
[65] Häring, *Medical Ethics*, 153.
[66] Häring, *Medical Ethics*, 153.
[67] Häring, *Medical Ethics*, 29-31.

quotas over meaningful care. In such settings, genuine interaction, a prerequisite for effective treatment, is sacrificed.

Häring also critiques economic barriers to care. Some patients are denied services because they cannot pay, thereby undermining the physician's ethical commitment to treat all who suffer. Institutional policies may prevent medical professionals from honouring their vocation to serve life indiscriminately. Yet Häring acknowledges the medical community's efforts to raise awareness of healthcare as a basic human right: "The medical profession itself has done much to alert the public to the fact that all men [and women] have a right to medical care."[68] Few experiences are more disheartening for healthcare professionals than being unable to provide adequate care due to a lack of essential resources.

To address these systemic challenges, Häring proposes greater State involvement in healthcare provision.[69] While he cautions against governmental monopoly, he also recognizes the benefits of public systems that fund care through pensions, insurance, and subsidies. By alleviating financial restrictions, governments empower healthcare professionals to serve all patients equally. Ultimately, this is a call for universal healthcare, one that is grounded in justice, equity, and the Christian moral vision of human dignity.

2.3 Core Principles of Universal Healthcare from McFadden and Häring.

Charles McFadden and Bernard Häring have each made substantial and enduring contributions to the field of medical ethics. While their respective approaches reflect distinctive emphases, there exists considerable convergence in their ethical perspectives. This section seeks to critically examine key elements within their thought, with particular attention to the foundational principles they offer in support of universal healthcare, principles that are especially pertinent to the present study.

2.3.1 Respect for the Sanctity of Human Life

McFadden's medical ethics converges significantly with that of Bernard Häring, particularly in their shared commitment to the protection and preservation of human life. Both thinkers ground their perspectives in Christian anthropology, which affirms the inviolability of the human person as one created in the image of God and redeemed through Christ.[70] Central to this vision is the safeguarding of

[68] Häring, *Medical Ethics*, 29.
[69] Häring, *Medical Ethics*, 29.
[70] Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, 196.

the fundamental rights of every patient, which includes not only the right to life but also the dignity of informed medical decision-making. Respect for the patient requires obtaining informed consent prior to treatment, clearly communicating the nature of the illness and associated risks, and offering disclosure in cases of incurable disease or imminent death.[71] When human subjects are involved in research, experimentation, or clinical trials, the knowledge and benefits gained must be recognised as part of a communal trust, a shared good that reflects a broader social responsibility.

A key concern for Häring was the avoidance of fragmented or reductive descriptions of the human person. He insists that the question "What is man?" forms the necessary point of dialogue between moral theology, medicine, and the behavioural sciences.[72] This anthropological foundation guards against the tendency of any single discipline to narrow human identity to one particular dimension. Both doctors and patients, must resist the compartmentalisation of life, recognising that the various dimensions of human existence, physical, psychological, spiritual, and social, are interdependent and co-constitutive of the whole person.

Brendan Soane supports this view, observing that Häring regarded reductionism as one of the greatest obstacles to a comprehensive understanding of the human person.[73] Reductionism, in this context, refers to any epistemological framework that limits the human being to a single aspect, such as denying the reality of free will or spiritual values. Such distortions, can lead to an erosion of moral concern for the most vulnerable members of society, including the unborn, those with profound disabilities, and patients with severe brain damage. From the standpoint of Christian ethics, human worth cannot be measured by subjective sentiment or external functionality, as doing so threatens the intrinsic value of life at every stage—beginning, middle, and end.

Häring's philosophical anthropology, as summarised by Soane, emphasises the distinctiveness of the human person situated between nature and culture.[74] The human vocation involves being a wise steward of nature, which serves as the medium through which human flourishing is realised. While anthropological medicine seeks a holistic understanding of the person, clinical practice often privileges the physical body, given the physician's primary concern with diagnosing and treating bodily illness. Nevertheless, the medical profession increasingly recognises the importance of addressing the spiritual dimension of health. Soane observes that past medical models paid little attention to the foundations of

[71] Healy and Ferriols, "Review of *THE CRUCIAL ISSUE*," 325.
[72] Häring, *Medical Ethics*, 6.
[73] Brendan Soane, "The Literature of Medical Ethics: Bernard Häring." *Journal of Medical Ethics*, 3, (1977), 85.

[74] Soane, "The Literature of Medical Ethics," 86.

'spiritual' aspects such as reason, will, religious sentiment, and emotional life—areas where modern medicine has significantly advanced.[75] Häring himself acknowledges this development, affirming that a comprehensive understanding of the human person is essential to medicine's proper aim: the restoration of the person's capacity to live and function as a fully integrated human being.[76]

2.3.2 Medical Advancements and the Ethical Demands of Conscience

The original intent of Charles McFadden's *Medical Ethics* was to provide sound moral instruction for Catholic nurses. However, rapid advancements in medical science and technology soon necessitated successive editions to guide both physicians and nurses in applying traditional moral principles to emerging scientific developments. The framework of these guiding principles was grounded in natural law. As Hamel observes: "The old approach to moral theology, typically taken in standard textbooks used in seminaries, tended to be highly philosophical (employing a form of natural law reasoning), concerned with the application of universal and unchanging principles to particular actions and situations in a deductive manner, preoccupied with judgments of the rightness or wrongness of actions, committed to the integrity of biological processes in a virtually absolute way, and divorced from concrete human experience."[77] While the habitual application of such principles, natural law, moral merit, respect for the dignity of life, and an essentialist understanding of health, was foundational in protecting and promoting human life, it became increasingly evident that not all cases could be resolved by rigid adherence to traditional norms. The iterative revisions of McFadden's manual reflected an ongoing attempt to keep pace with evolving medical realities. Yet even the most current editions often lagged behind the speed of medical innovation, requiring future editions to address emerging questions retrospectively. In practice, unresolved or ambiguous issues were frequently referred to bishops and priests, whose guidance, though sometimes reliant on the manual itself, was considered authoritative. While *Medical Ethics* largely articulated the official position of the Church on a broad spectrum of moral questions, McFadden's commitment to frequent updates distinguishes him from the rigidity often associated with manualist approaches. His work served both as a pedagogical resource and a practical tool for shaping the ethical character and professional conduct of healthcare practitioners.

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[75] Soane, "The Literature of Medical Ethics," 86.

[76] Häring, *Medical Ethics*, 1.

[77] Ron P. Hamel, "On Bernard Häring: Constructing Medical Ethics Theologically." *Second Opinion* (October 1991), 108+. *Gale Academic OneFile*. https://link-gale-com.may.idm.oclc.org/apps/doc/A11474674/AONE?u=nuim&sid=bookmark-AONE&xid=af4ff732.

Bernard Häring, however, marked a significant transition in the discipline of moral theology. Moving beyond fixed propositions, Häring appealed to personal responsibility and broadened the scope of moral discernment beyond medical professionals to include all moral agents. While remaining rooted in the core traditions of Catholic moral thought, Häring emphasized the role of the individual conscience, urging believers to engage in the formation of conscience to enable sound prudential judgment. Building on Häring's perspective, Soane contends that moral law should not be treated as a rigid code to be followed uncritically, especially when such adherence may cause harm. Rather, it should be seen as a guiding framework that directs individuals toward a life of moral and human flourishing.[78] This shift from rule compliance to moral formation represents a profound reorientation in Catholic healthcare ethics. The Christian vocation is not merely about observing precepts but about cultivating virtue and moral character.[79] Emphasizing the primacy of conscience and human freedom, Häring acknowledged that medical and ethical challenges often evolve rapidly, and that virtuous discernment, rather than rigid adherence to pre-existing norms, is required to prevent harm. As Hamel notes, Häring's moral theology is distinguished by its structure and focus: "Haring's ethics is religious in structure (word-response), biblically and theologically influenced in conception and content (an ethics of discipleship and of Christian freedom), person-centred rather than principle-centred, and more concerned with good character than with right action."[80]

Häring also recognized the comprehensive nature of medical care, observing that "medicine and its prophylactic measures accompany the human person from the moment of conception to the hour of death."[81] The rapid pace of medical discoveries and technologies has significantly enhanced the effectiveness and efficiency of treatment, yet the allure of such innovations can sometimes overshadow necessary ethical reflection. The excitement among healthcare professionals over diagnostic and therapeutic breakthroughs may, unintentionally, diminish the depth of moral scrutiny applied to these practices. Indeed, the increasing influence of biomedical technologies has reshaped the vision, methods, and ethical responsibilities of modern medicine. One of Häring's central contributions was his insistence that conscience must remain an active moral compass in navigating new medical frontiers. Healthcare professionals and patients alike are called to form their consciences responsibly and to exercise that conscience in morally complex situations, especially where new technologies introduce novel ethical considerations. Häring's vision calls for a moral framework that integrates faith,

[78] Soane, "The literature of medical ethics," 92.

[79] Patrick T. McCormack and Russell B. Connors, *Facing Ethical Issues*: *Dimensions of Character*, *Choices*, *and Community* (New York/Mahwah, N.J.: Paulist Press, 2002), 16.

[80] Hamel, "On Bernard Häring," 108.

[81] Häring, *Medical Ethics*, 1.

reason, and compassion—one that protects human dignity without retreating into inflexible moralism. In this regard, Marty rightly states: "For Häring, the person outranked even the application of divine law and certainly of human law."[82] In cases where no clear directive exists concerning the use of new technologies, the moral obligation remains to prioritize the well-being of the patient. Equally, informed consent is essential, both as a right of the patient and as a recognition of their moral agency within society. Looking forward, Häring argued that the physician-patient relationship must transcend the individual encounter to incorporate a broader "social-collective responsibility."[83] In this model, the ethical practice of medicine is not only personal but communal, intertwined with the health of society as a whole.

2.3.3 Stewardship of Property in Pursuit of the Common Good.

One pertinent contribution in McFadden's *Medical Ethics* is his clear and realistic treatment of private property, particularly in relation to the universal healthcare. While unique to McFadden, this discussion is especially relevant to the present study's concern with the universal destination of goods. His chapter on "property rights" distinguishes between the right to private ownership and the obligation toward common use. Importantly, the right to ownership is always subordinate to the demands of the common good, thus affirming the principle of the universal destination of created goods. In today's context, the category of created goods has expanded to include rapidly evolving knowledge, technologies, and skills with global impact.[84] In practice, when such goods emerge through collaborative efforts, such as research, experimentation, and clinical trials, the knowledge and skills produced form part of the community trust and cannot be entirely privatized. McFadden insists that responsible stewardship of goods, whether privately or publicly owned, is essential to promoting the common good. At the same time proper management of resources ensures efficiency and effectiveness in healthcare services delivery.[85] In healthcare, this entails that all staff members avoid unjust damage, misuse, or theft of resources entrusted to their care. McFadden observed that theft remains the most frequent violation of the right to private property. He cautioned hospital personnel that the informal tolerance of taking minor items, such as adhesives, should not be mistaken for a legitimate entitlement.[86]

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[82] Martin E. Marty, "Medical Ethics and Theology: the Accounting of the Generations." *Second Opinion* 17, no. 4 (April 1992) 70+. *Gale Academic OneFile*. https://link-gale-com.may.idm.oclc.org/apps/doc/A12137176/AONE?u=nuim&sid=summon&xid=f8b0eb34.

[83] Häring, *Medical Ethics*, 3.

[84] Corkery, *Companion to Compendium*, 72.

[85] McFadden, *Medical Ethics*, 351.

[86] McFadden, *Medical Ethics*, 344.

2.3.4 Healthcare as a Fundamental Right

Bernard Häring's unequivocal affirmation of the right to healthcare stands as one of the foundational tenets of his moral theology.[87] This right carries profound implications not only for individuals but also for families, societies, and states. Recognizing healthcare as a fundamental human right imposes a moral obligation on all stakeholders, governments, healthcare providers, institutions, and civil society, to ensure that healthcare is affordable, accessible, and of high quality for all. Healthcare provision can no longer be viewed as a private interaction solely between physician and patient; rather, it demands a collective, interdisciplinary response. Häring strongly argues that the responsibility for addressing the ethical challenges posed by contemporary medicine must be assumed by the entire human community.[88] These issues, he contends, must not be treated within a narrow, individualistic framework but must be approached from a standpoint of global social responsibility, one that includes concern for both humanity and the broader ecological environment.

2.4 Conclusion

This chapter has shown that the contributions of Charles McFadden and Bernard Häring occupy a pivotal transitional place in the development of Catholic medical ethics beyond the manualist tradition. In their respective approaches, both McFadden and Häring affirm a shared commitment to guiding healthcare professionals and patients through the ethical complexities inherent in medical practice, with the protection and promotion of the sanctity of human life as their principal aim. Together, they helped to consolidate core values in medical ethics—natural law, divine revelation, human dignity, conscience, autonomy, and the pursuit of the common good—while addressing a wide range of critical issues, including artificial insemination, contraception, sterilization, abortion, critical care, and euthanasia within a coherent moral framework. Building on this foundation, the chapter has argued that the development of Catholic moral theology has reshaped bioethics into a more contextually responsive discipline, raising the further question of which resources within Catholic Social Teaching can be most effectively leveraged to support the pursuit of universal healthcare under conditions of economic and structural constraint.

Each scholar responded to the ethical challenges posed by technological advancement in distinct but complementary ways. McFadden revised and updated his ethical manuals to incorporate new medical data and correct outdated positions, an effort that, while concrete and practical, risked lagging behind the rapid pace of innovation. In contrast, Häring responded by emphasizing the

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[87] Häring, *Medical Ethics*, 4.
[88] Häring, *Medical Ethics*, 5.

cultivation of personal responsibility and the formation of conscience. For Häring, the moral agent, whether healthcare professional or patient, must be guided by a well-formed conscience, shaped by Scripture and theological reflection. Conscience, for him, is not a loophole for moral relativism but the mature exercise of freedom anchored in a commitment to values, belief, and the common good.

One enduring insight from both McFadden and Häring is that medicine accompanies the human person from conception to natural death. In a world where medical technologies continue to extend both lifespan and quality of life, the moral imperative is to ensure that all persons have equitable access to lifesaving and life-enhancing care. McFadden rightly identified healthcare as a common good, thereby rejecting any form of inequality in its provision.[89] In alignment with this, Häring argued that every healthcare system must guarantee treatment for all individuals within a given society, affirming that "the right to proper medical care is part and parcel of the most fundamental human rights."[90] This conviction demands that healthcare remains affordable, accessible, and of high quality for all, regardless of social or economic status.

Häring's invocation of the *zeitgeist*, the spirit of the time, points to a growing global consensus: the shift toward universal healthcare coverage is both ethically necessary and politically urgent, especially in developing countries where such systems are increasingly non-negotiable.[91] Moreover, a broader vision of healthcare is taking shape—one that recognizes health as a holistic and collective concern, transcending the traditional physician-patient binary. This holistic vision understands the human person in an integrated way—as a unity of body, mind, and spirit. Accordingly, contemporary healthcare must address not only biological conditions but also the social, psychological, and spiritual dimensions of the human experience. Each of these facets reveals distinct health-related needs, none of which can be adequately addressed in isolation. It is not an overstatement to regard Häring as one of the early architects of this paradigm shift, from a narrowly clinical medical ethics to the broader, interdisciplinary landscape of modern bioethics.

This emerging multidimensional framework, ethically robust, socially responsible, and theologically grounded, provides the foundation for the discussion in the following chapter, which further explores the implications of holistic healthcare ethics in contemporary practice.

[89] McFadden, *Medical Ethics*, 343
[90] Häring, *Medical Ethics*, 4.
[91] Häring, *Medical Ethics*, 4

CHAPTER THREE

THE NATURE OF THE EMERGING APPROACH TO BIOETHICS

3.0 Introduction

This chapter examines the shift within Catholic bioethics toward more historically conscious and contextually responsive modes of moral reflection. Moving beyond the limitations of earlier frameworks, it explores how this emerging approach engages concrete social, economic, and cultural realities in shaping ethical discernment. In this context, an important follow-up question arises: which resources within Catholic Social Teaching can be leveraged to help Zambia achieve universal healthcare? By foregrounding this question, the chapter situates bioethics not merely as a theoretical discipline, but as a practical moral framework capable of informing just and sustainable healthcare systems.

Lisa Sowle Cahill, in *Theological Bioethics: Participation, Justice, and Change*, and Therese Lysaught and Michael McCarthy, in *Catholic Bioethics and Social Justice: The Praxis of US Health Care in a Globalized World*, have been instrumental in advancing the integration of Catholic Social Teaching into the policies and practices of bioethical healthcare. The manualist era laid a foundational framework for modern Catholic medical ethics, which subsequently evolved into contemporary bioethics in response to the emergence of new medical technologies and the increasingly complex ethical issues they presented. While the manualist tradition provided essential principles, such as the sanctity of life and the dignity of the human person, that remain central to Catholic bioethical discourse, modern bioethics has expanded to incorporate insights from secular ethical theories, interdisciplinary scholarship, and broader social concerns.[1]

The transition from a primarily clinical, rules-based approach to more contextual and socially informed bioethics reflects an important paradigm shift. Contemporary bioethics now recognizes that healthcare is embedded in intricate social, cultural, environmental, and ethical contexts that shape both practice and policy. Though this shift introduces conceptual and methodological challenges, they are not insurmountable. As Roland Grant Nutter observes of Cahill's contributions, "She recognizes the difficulties and challenges of working to bring about such a paradigm shift in ethical discourse. But she

[1] Pontifical Academy for Life, IX General Assembly - Concluding Communiqué on the "Ethics of Biomedical Research. For a Christian Vision" (February 26, 2003), no. 5.

also sees victories in incremental movements and activism at the local level and the social changes that have been brought about because people choose to make a difference."[2]

The ongoing effort to align bioethics more closely with the justice-oriented commitments of Catholic social teaching has gained considerable momentum, with numerous theologians making significant and impactful contributions. Before engaging in a detailed analysis of the works by Cahill, Lysaught, and McCarthy, this section will first outline the concept and development of emerging bioethics within its broader ethical and theological context.

3.1 The Changing Landscape of Bioethics

Contemporary bioethics presents a complex and evolving landscape that both resonates with and challenges Catholic moral teachings, particularly in areas such as medical ethics, end-of-life care, and reproductive technologies. The Catholic Church's ethical framework remains firmly grounded in the principles of the sanctity of human life and the inherent dignity of every person—principles that continue to serve as the cornerstone of its moral evaluation of biomedical research and clinical practice. These foundational values demand consistent respect across all areas of healthcare and scientific advancement.[3] Lisa Sowle Cahill has made sustained efforts to uphold and promote these guiding principles in her theological bioethics, demonstrating that ethical reflection rooted in Catholic tradition remains both relevant and constructive in contemporary discourse. It is important to emphasize from the outset that Catholic bioethics has not been severed from its roots in classical medical ethics, but rather, it has evolved in response to new challenges while remaining anchored in its foundational moral commitments.

The emerging approach to bioethics marks a clear departure from the traditional clinical model, which tended to emphasize the biological or physical dimension of the human person. According to Roland Grant Nutter, Lisa Sowle Cahill maintains that "theological bioethics needs to be more than just theory; it must be about engagement."[4] Such engagement entails a collaborative and multidisciplinary involvement in healthcare processes, bringing together healthcare professionals, policymakers, social scientists, ethicists, and religious leaders to address the complex ethical, social, environmental, and cultural dimensions of medical practice. In this view, theological bioethics shifts its primary concern

[2] Ronald Grant Nutter, "Theological Bioethics: Participation, Justice, and Change (Moral Traditions Series) – Lisa Sowle Cahill." *Reviews in Religion & Theology* 13, no. 4 (September 1, 2006): 572. doi:10.1111/j.1467-9418.2006.00316_2.x.

[3] Congregation for the Doctrine of the Faith, *Dignitas Personae* (September 8, 2008), no. 1.

[4] Nutter, "Theological Bioethics," 570.

from isolated individual medical decisions to broader questions of social ethics. This expanded perspective incorporates a wide range of ethical, legal, and cultural issues that arise from advancements in biomedical science and technology. These social dimensions of bioethics are deeply interwoven with core principles of Catholic social teaching, including human dignity, justice, option for the poor, and the common good. Contemporary bioethics, therefore, must attend to issues such as equitable access to healthcare, solidarity among communities, respect for cultural diversity, environmental sustainability, and responsible engagement with emerging technologies.

A holistic approach to healthcare necessitates the involvement of diverse stakeholders, including researchers, healthcare professionals, economists, social scientists, spiritual leaders, and political actors. Andrea Vicini emphasizes that the realization of an effective healthcare system requires "collaborative efforts that promote multidisciplinary participation and aim at offering realistic and appropriate solutions to complex problems."[5] His proposal for a multifaceted and interdisciplinary strategy includes "continuing to invest in research and offering healthcare services to every citizen, particularly those who are more vulnerable; to secure jobs while extending unemployment benefits and providing economic support to individuals, families, and struggling economic activities."[6] This broader understanding acknowledges that numerous factors contributing to health and well-being lie outside the clinical setting. For example, secure employment is directly linked to access to adequate nutrition, housing, and healthcare. Thus, a comprehensive model of bioethics and healthcare delivery must incorporate attention to the social determinants of health, factors often overlooked when care is confined strictly to biomedical interventions.

Given that a comprehensive approach to bioethics is oriented toward the shaping of public policy, it places significant emphasis on advocacy. Catholic advocacy in support of universal healthcare is deeply grounded in the Church's commitment to key social principles: the inherent dignity of the human person, the universal destination of created goods, the common good, and the preferential option for the poor. The multiplicity of voices engaged in contemporary bioethical discourse has broadened the scope of lobbying efforts and intensified the collective responsibility toward achieving the common good. As Shuman rightly observes, "Finding common ground with others who advocate for a more just and compassionate public policy is certainly a legitimate expression of that

[5] Andrea Vicini, "Global Public Health and the Promotion of the Common Good," *Ethical Challenges in Global Public Health: Climate Change, Pollution, and the Health of the Poor*, Philip J. Landrigan and Andrea Vicini, eds. (Eugene, Oregon: PICKWICK Publications, 2021), 3.

[6] Vicini, "Global Public Health and the Promotion of the Common Good," 3.

commitment."[7] Effective advocacy platforms must seek to expose and challenge patterns of social sin and structural injustices that undermine the health and well-being of individuals and communities. In this context, Lisa Sowle Cahill affirms: "The approach proposed here will be critical of disproportionate social valuing of individual choice and of scientific progress, sceptical about whether technological 'advancements' are truly beneficent, politically engaged on behalf of a 'preferential option for the poor' and of gender equity, and confident about the possibility and potential of concerted action for change."[8] This vision of advocacy underscores the role of bioethics as not merely theoretical but as an instrument for transformative social engagement rooted in justice and solidarity.

The emerging approach to bioethics emphasizes public health and participatory engagement, promoting long-term health outcomes through sustained investment in knowledge dissemination, behavioural change, and community-based practices. These practices are often transmitted and reinforced within families and communities, making them powerful vehicles for promoting sustainable health. A key component of long-term healthcare initiatives is the empowerment of individuals and families with the knowledge and skills necessary to manage non-complicated health conditions more effectively and independently. This initiative includes comprehensive health education and skills training programs designed to encourage lifestyle modifications and behavioural changes that can prevent illness and promote overall well-being. Healthcare facilities, in this expanded framework, are envisioned not only as sites for clinical care but also as agents of social reform and public health advocacy. They can serve as strategic platforms for addressing broader social issues, such as gun violence, human trafficking, and substance abuse, through interdisciplinary and victim-sensitive interventions. These efforts reflect a holistic understanding of health that extends beyond clinical treatment to address the social determinants and structural conditions that impact human flourishing.

Two key scholarly works selected to illustrate the integration of Catholic Social Teaching (CST) with contemporary bioethics are *Theological Bioethics: Participation, Justice, and Change* by Lisa Sowle Cahill, and *Catholic Bioethics and Social Justice: The Praxis of US Health Care in a Globalized World*, edited by Therese Lysaught and Michael McCarthy. These texts were chosen for two principal reasons. First, they represent some of the most comprehensive and critical engagements with the intersection of bioethics and social justice within a Catholic framework. Second, they provide a robust foundation for both theoretical reflection and practical application and were among the most

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[7] Joel James Shuman, "Theological Bioethics: Participation, Justice, Change – By Lisa Sowle Cahill." *Modern Theology* 24, no. 3 (July 1, 2008), 510. Doi: 10:1111/j.1468-0025.2008.00474.x.

[8] Lisa Sowle Cahill, *Theological Bioethics*: *Participation, Justice, and Change* (Georgetown University Press, 2005), 4.

accessible and relevant resources during the initial formulation of this research. Both works demonstrate sustained efforts to articulate how CST can meaningfully inform and transform the ethical practice and structural reform of healthcare in a globalized and pluralistic context.

3.2 Cahill's Participatory Theological Bioethics

This section examines *Theological Bioethics: Participation, Justice, and Change* by Lisa Sowle Cahill, which advances a distinctive methodological framework known as participatory theological bioethics. A defining feature of this approach is its capacity to "operate simultaneously in many spheres of discourse and activity," thereby influencing the social structures and relationships that shape healthcare delivery.[9] One of the key strengths of participatory bioethics is its inclusivity, it broadens the field of engagement to encompass a wide array of stakeholders, including families, communities, religious institutions, political organizations, schools, sports associations, and professionals across diverse disciplines. In exploring Cahill's contribution to bioethical discourse, this section will be organized around four central themes: the public sphere, participation, justice, and change.

3.2.1 The Concept of the Public Sphere

The public sphere, as articulated in participatory theological bioethics, is conceived as an inclusive and multifaceted platform that brings together representatives of diverse stakeholder groups and individuals, irrespective of their religious, philosophical, or ideological convictions. This inclusive model enhances resilience in community health outcomes and fosters the sustainability of public health initiatives. One of the most commendable features of the public sphere is its deliberate incorporation of perspectives from all sectors of society, particularly those of vulnerable and marginalized populations. Fundamentally, the public sphere aims to transcend rigid categories and identities that often amplify divisions, emphasizing collective action over abstract debate. Lisa Sowle Cahill critiques the prevailing tendency to reduce the public sphere to a site of intellectual contestation, noting that "it is a mistake to think that the 'public sphere' is a sphere of argument and debate rather than action," and warning against the assumption that public discourse is only legitimate when it adheres to detached, secular, and

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[9] Lisa Sowle Cahill, *Theological Bioethics: Participation, Justice, and Change* (Washington D. C: Georgetown University Press, 2005), 23. Note: Lisa Sowle Cahill is Professor at Boston College, where she has taught theological ethics since 1976. She is a past president of the Catholic Theological Society of America (1992-93), and the Society of Christian Ethics (1997-98), and is also a fellow of the American Academy of Arts and Sciences. She received her Ph.D. in theological ethics from the University of Chicago Divinity School, where she studied under James Gustafson. Her works include *Sex, Gender, and Christian Ethics* (Cambridge University Press, 1996); *Theological Bioethics*: *Participation, Justice, and Change* (Georgetown University Press, 2005).

empirically verifiable reasoning.[10] In contrast, Cahill envisions the public sphere as an intersection of faith, ethics, and public life that promotes the common good, inclusivity, solidarity, and justice. Importantly, the public sphere is not confined to physical locations; rather, it encompasses various modes of social interaction, print, digital media, and face-to-face dialogue, through which members of society deliberate on shared concerns and coalesce around common values.[11] As such, it functions as a vital arena for identifying, articulating, and addressing issues of collective interest. Engagement within this sphere requires particular ethical dispositions, including humility, openness, mutual respect, and a commitment to justice-oriented action.

Participants in the public sphere must exercise discernment and sensitivity, particularly in distinguishing between religiously grounded arguments and arguments presented by individuals who happen to be religious. This distinction is critical in maintaining the neutrality and inclusivity that define the public sphere. The same level of attentiveness applies to non-religious or secular contributors, whose philosophical or ideological commitments may equally shape their perspectives. The public sphere, by its very nature and character, is designed to be a neutral, pluralistic space, one that accommodates diverse worldviews while seeking common ground in the pursuit of the common good. Lisa Sowle Cahill underscores the inherent vulnerability of the public sphere to misrepresentation or domination by particular voices or modes of discourse. She cautions that participants bear a serious responsibility to engage with integrity, openness, and accountability. Deliberation within this space demands a high level of ethical commitment and the constant recognition that the legitimacy of public discourse depends on inclusivity, mutual respect, and the willingness to engage across differences without collapsing into partisanship or exclusion.

3.2.2 The Public Sphere: A Neutral Platform Beyond Sectarian Traditions

Cahill acknowledges that the public sphere is not tradition-generated, worldview-oriented, or value-driven in a strictly confessional sense.[12] Rather, it operates within the bounds of legal traditions and is significantly shaped by public consensus and popular opinion, with a strong emphasis on autonomy and informed consent in the decision-making process. This reliance on legal proceduralism and public sentiment, however, introduces the risk of legitimizing policies that may lack normative moral force but are nonetheless adopted due to their popularity. To mitigate this, there must be safeguards that

[10] Cahill, *Theological Bioethics*, 23.
[11] Cahill, *Theological Bioethics*, 25.
[12] Cahill, *Theological Bioethics*, 18.

balance the neutrality of the public sphere with mechanisms to critically assess the ethical implications of proposed policies, without imposing any particular religious doctrine on participants of differing beliefs.[13] Although the public sphere is designed to avoid the dominance of any single tradition or worldview, certain ethical principles can attain broad, if not universal, resonance when articulated through a shared moral language. For instance, the four principles of bioethics, beneficence, nonmaleficence, autonomy, and justice, are widely accepted as foundational for protecting individual rights and freedoms. However, a deeper and more ethically coherent interpretation of these principles arises when they are situated within the broader context of the common good and mutual responsibility. Autonomy, for example, is not absolute; it must be exercised within the constraints of the moral order and the rights of others. Ordered autonomy presumes that self-determined choices are accountable to objective moral norms, discernible, at least in part, through reason, and may rightly be restricted when those choices threaten the well-being or safety of others. This integrative perspective fosters a more holistic and ethically sustainable application of autonomy within the public sphere.

Furthermore, certain principles introduced into the public sphere by various world wisdom traditions may possess a universal or cross-cultural character. One such example is the Catholic Church's articulation of natural law, which it regards as having universal applicability. While the concept of natural law is rooted in the Catholic intellectual tradition, its foundational claims, grounded in reason and human nature, can transcend specific religious or cultural frameworks. Lisa Sowle Cahill affirms this possibility, noting that "context-generated moral insights and proposals can gain a public hearing if they can prove themselves relevant and useful in various contexts that together make up the common good of interest to the public in question."[14] In practice, public discourse and decision-making related to healthcare and human life can be significantly enriched when principles such as the sanctity of human life and the inherent dignity of the human person, central to Catholic moral teaching, are integrated into the deliberative process. Crucially, these principles need not be tied exclusively to their religious origins; rather, they can be articulated in a way that resonates with widely shared ethical intuitions and rational moral reflection. For instance, the principle of human dignity, although theologically grounded in Christian anthropology, can also be justified through secular philosophical reasoning, making it accessible and relevant in pluralistic societies. Thus, while the public sphere avoids privileging any single tradition, it remains open to moral contributions that serve the common good and uphold universally intelligible human values.

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[13] Cahill, *Theological Bioethics*, 16.

[14] Cahill, *Theological Bioethics*, 19.

For purposes of ethical integrity and practical implementation, Lisa Sowle Cahill contends that resolutions emerging from the public sphere should be guided by five interrelated modes of discourse: ethical, policy, prophetic, narrative, and participatory. These modes offer a framework that not only facilitates deliberation but also grounds it in a holistic moral and theological vision. Ethical discourse directs participants to discern what is good, what is right, and how one ought to act in particular circumstances. It involves a rigorous engagement with questions of rights, duties, obligations, and justice, all interpreted in light of both divine revelation and the human telos. Central to this discourse is the commitment to act in accordance with moral truth and integrity. Policy discourse identifies and analyses the opportunities and challenges embedded in existing practices, institutions, and resource distributions. It aims to prioritize and defend values such as the sanctity of human life, the dignity of the person, and the moral obligation to advocate for the most vulnerable and marginalized. This discourse translates ethical principles into actionable strategies within healthcare systems and broader social institutions. Prophetic discourse emphasizes the theological imperative to prioritize certain values, such as justice, solidarity, and compassion, over others. It operates from an eschatological vision of a more equitable society, one inspired by the love of God and neighbour. As Cahill notes, prophetic discourse "holds up a vision of a more equitable society characterized by the virtues of solidarity and compassion and of justice inspired by the love of God and neighbour."[15] Such ideals, while aspirational, serve a dual function: they guide those striving for transformative change and simultaneously reveal the moral shortcomings of minimal or complacent responses.[16] Biblical narratives such as the Parable of the Last Judgement (Mt. 25:31–46) and the Good Samaritan (Lk. 10:25–37) serve as scriptural foundations for this discourse. Narrative discourse emphasizes the formative power of stories in shaping communities and moral agents. Narratives convey shared values and cultivate moral vision by shaping how individuals and communities interpret the world and respond to ethical challenges. As Cahill observes, "narratives shape the ethos of the community and the moral character of participants so that they construe the world and envision appropriate action in ways that are suitable to the narratives."[17] They engage imagination and emotion, revealing what is truly at stake in particular moral decisions and ways of life. Finally, participatory discourse is where all other forms of discourse are integrated and actualized. Without participatory engagement, the other modes risk remaining abstract, limited to ideals, concepts, or theological assertions. Participatory discourse

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[15] Cahill, *Theological Bioethics*, 36.

[16] Cahill, Lisa Sowle. "Toward Global Ethics." *Theological Studies* 63, no. 2 (2002), 336. https://link-gale-com.may.idm.oclc.org/apps/doc/A87080333/AONE?u=nuim&sid=summon&xid=c9fd26a6.

[17] Cahill, *Theological Bioethics*, 37.

grounds theological and ethical reflection in real-life practices, emphasizing action, collaboration, and concrete implementation.[18] It embodies the practical outcomes of theological commitments and affirms the necessity of lived engagement with the moral imperatives articulated in the other discourses.

3.2.3 Challenges and Theological Engagement in the Public Sphere

The public sphere, while envisioned as a space of inclusive and democratic discourse, is not without its challenges. Among the most pressing issues are the marginalization of religious voices, the emergence of abstract or diluted language, and the influence of financial interests on research agendas. Although the public sphere is founded on principles of non-discrimination and open participation, Lisa Sowle Cahill notes a growing tendency to isolate or diminish religious convictions. This contradiction undermines the very ethos of inclusivity, as it implicitly demands that participants bracket their beliefs and identities to gain legitimacy. Cahill argues that no one enters public discourse devoid of their social formation, values, or communal affiliations, be they religious, ethnic, political, or professional.[19] A genuinely neutral public sphere, therefore, is one that protects diversity and allows all perspectives, especially those of marginalized groups, to be voiced and respected.

Joel Shuman asserts that Cahill challenges the artificial distinction between "thick" private discourse and "thin" public discourse, arguing that this dichotomy leads to a dualism that fragments the integrity of individuals.[20] Jeremy Shepherd critiques this dualism as the false separation of life into "sacred" and "secular" realms, a division that ultimately undermines the authenticity of participants in both spheres.[21] In effect, the so-called neutrality of liberal public space is itself value-laden; all discourse carries implicit assumptions about the nature of reality and the moral order. In this contested space, theologians have a critical role. They do not merely translate religious commitments into secular language but serve as mediators between ecclesial tradition and the broader public, particularly in areas such as biomedical ethics. Their task is both prophetic and pastoral: to articulate the Church's vision for justice, the common good, and human dignity in a way that speaks to contemporary issues while remaining grounded in theological principles.[22] Theologians often serve communities and institutions that depend on the Church's moral teachings for conscience formation and ethical guidance in a rapidly

[18] Cahill, *Theological Bioethics*, 38.

[19] Cahill, *Theological Bioethics*, 26.

[20] Joel James Shuman, "Theological Bioethics: Participation, Justice, Change – By Lisa Sowle Cahill." *Modern Theology* 24, no. 3 (July 1, 2008), 508. Doi: 10:1111/j.1468-0025.2008.00474.x.

[21] Jeremy Shepherd, "Christian Dualism." Dallas Baptist University. https://www3.dbu.edu/naugle/pdf/Paideia%20College%202004/Christian_Dualism.pdf

[22] Cahill, *Theological Bioethics*, 18.

evolving world. Cahill underscores the theologian's vocation to raise a prophetic voice, especially in public health discourse.[23] While the ideal of free and equitable healthcare for all may be aspirational, the moral imperative remains to pursue it through incremental reforms and redistributive policies. In the face of market-driven individualism, theologians offer a counter-narrative rooted in solidarity, participation, and a preferential option for the poor. They are called not to dilute their commitments into generic abstractions but to enrich public dialogue through deep engagement, thus strengthening existing practices and expanding the moral vocabulary of care and justice across religious and civic contexts.

3.2.4 The Emergence of Abstract and Diluted Language

Lisa Sowle Cahill draws critical attention to the dominant language shaping public bioethical discourse, noting its strong emphasis on universal, rational, and secular terminology. This trend is especially evident in the privileging of principles such as autonomy, beneficence, nonmaleficence, and justice.[24] While these principles are foundational in contemporary bioethics, they are often expressed in abstract terms that align with the language of modern science, market economies, and liberal individualism, frameworks that are generally unreceptive to concepts such as distributive justice or the preferential option for the poor. Yet these very principles are essential for the realization of universal healthcare and for advancing the common good.

In his review of *Theological Bioethics: Participation, Justice, and Change*, Shuman observes that "in the wake of this shift (to participatory bioethics), theologians working at the intersection of their discipline with medicine and bioethics felt pressured to abandon explicitly theological language, which was deemed too particular, or 'thick,' and hence unsuitable for the so-called 'public sphere,' where public policy was crafted."[25] However, Cahill challenges this dichotomy, asserting that the conflict is not between "thin" and "thick" moral languages, but rather between competing "thick" worldviews, each with its own understanding of sin, salvation, moral practices, and ultimate meaning.[26] She contends that sidelining theological perspectives in favour of a falsely neutral language undermines the richness and depth required for genuine moral reflection.

Indeed, the public language of ethics has in many cases shifted from truth to consensus, from morality to ethics, and from virtue-based relationships (e.g., spouse, husband, wife) to contractual partnerships. Concepts such as chastity and conscience are replaced by terms like "safe sex" and

[23] Cahill, *Theological Bioethics*, 36.
[24] Cahill, *Theological Bioethics*, 17.
[25] Shuman, "Theological Bioethics: Participation, Justice, Change," 508.
[26] Cahill, *Theological Bioethics*, 20.

"choice," while global governance is increasingly emphasized at the expense of national sovereignty.[27] In response to this linguistic and ideological drift, the prophetic role of theologians becomes indispensable. Cahill insists that theologians must remain theologically grounded, unapologetically committed to their faith convictions, while also seeking common ground and developing a shared language with others committed to healthcare justice.[28] Despite efforts to marginalize religious voices, the current multidimensional framework of bioethics offers theological bioethicists a renewed opportunity to engage the public sphere, ensuring that broadly accepted ethical principles are interpreted in ways that uphold human dignity and the common good. Their contributions are not only integral to the Church's mission but also vital to the moral and spiritual development of society. By remaining faithful to the Gospel while participating in public discourse, theologians help illuminate the path toward a more just and compassionate world.

3.2.5 The Influence of Financial Interests on Research Agendas

This section examines the ethical implications of research funding and underscores the imperative of prioritizing the common good in biomedical innovation and public health policy. The allocation of financial resources in medical research carries significant ethical implications, particularly when funding agencies are positioned to unduly influence the agenda of the public sphere. The power that accompanies financial support can shift research priorities away from urgent social needs toward areas that promise prestige or profit. Moreover, in some instances, research funding may be misallocated, expended on projects of marginal societal benefit while critical public health needs remain underfunded or neglected. Thus, not all heavily funded research efforts serve the common good or generate equitable outcomes for humanity.

Lisa Sowle Cahill raises urgent and ethically charged questions in this context: "Does it serve the common good, even in the United States, to provide new genetic treatments for the privileged, while so many go uninsured? Does it serve the global common good to devote billions to new genetic inventions while more basic health needs are so dire and while great gaps in other basic needs such as

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[27] Marguerite A. Peeters, "The New Global Ethic: Challenges for the Church." *The Institute for Intercultural Dialogue Dynamics. http://www. laici. va/content/dam/laici/documenti/donna/filosofia/english/new-global-ethic-challenges-for-the-church. pdf* (2007), 2. "No sooner was the cold war over that the UN organized an unprecedented series of intergovernmental conferences. The purpose of the *conference process* was to build a new integrated world vision, a new world order, a new global consensus, on the norms, values and priorities for the international community in the new era: education (Jomtien, 1990); children (New-York, 1990); the environment (Rio, 1992); human rights (Vienna, 1993); population (Cairo, 1994); social development (Copenhagen, 1995); women (Beijing, 1995); housing (Istanbul, 1996); and food security (Rome, 1996). The conferences were conceived as a *continuum*, and the global consensus as a *package* integrating all the new paradigms within a new cultural and ethical synthesis (The New Global Ethic", 5).

[28] Cahill, *Theological Bioethics*, 18.

food, housing, education, and clean water bring early death to many?"[29] These questions underscore deep concerns about distributive justice, calling attention to the growing disparity between the few who can afford high-cost, cutting-edge therapies and the many who lack access to basic, life-saving medical care.

Cahill advocates for bioethics that evaluates research priorities through the lens of justice, particularly in light of the urgent needs of underserved populations. For instance, funding research aimed at combating malaria, a disease that affects millions globally, may have greater ethical justification than investing in profit-driven projects designed to serve a wealthy minority. She critiques the current structures of genetic research, noting that the interests of nations, corporations, individual researchers, investors, and consumers are often aligned toward profit rather than the service of humanity.[30] In this system, prestige and financial return frequently outweigh concern for the public good. Cahill emphasizes that institutions, such as biotechnology companies and research universities, must be critically assessed in light of their formative role in shaping practices and influencing societal values. These institutions are not morally neutral; they structure experiences and commitments and play a pivotal role in defining the contours of the public sphere.[31] Therefore, they bear a responsibility to ensure that their contributions to medical research are aligned with the common good.

Moreover, research that promises high financial returns often involves restrictive patenting practices, which can further limit access to medical innovations and exacerbate inequalities. It is incumbent upon the public sphere to act as an ethical counterbalance, advocating for more equitable distribution of knowledge, treatments, and resources. This advocacy aligns with the Catholic social teaching principle of the universal destination of goods, which asserts that the benefits of creation, including scientific advancement, must be shared fairly among all people. The Church teaches that the common good, defined as the social conditions that enable individuals and communities to flourish, must guide all social, economic, and scientific activity. Medical research, accordingly, should be evaluated not merely by its technical achievements or profitability, but by its capacity to address health disparities and promote the well-being of all, particularly the most vulnerable.[32] In this light, expensive and advanced medical research is morally justified only when it demonstrably serves to improve public health outcomes and contributes to a more just and inclusive healthcare system.

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[29] Cahill, *Theological Bioethics*, 215.
[30] Cahill, *Theological Bioethics*, 28.
[31] Cahill, *Theological Bioethics*, 26.
[32] Pope Francis, General Audience – Catechesis: Healing the World (September 9, 2020), no. 6.

3.2.6 Engagement with Catholic Social Teaching

Catholic Social Teaching (CST) serves as a critical framework for identifying and challenging patterns of social sin and systemic injustice, particularly within the healthcare sector. Its foundational principles, including human dignity, the preferential option for the poor, the common good, and subsidiarity, offer a moral compass for shaping equitable and inclusive healthcare systems. These principles not only affirm the sanctity of life but also underscore the ethical obligation to ensure the fair distribution of resources in ways that promote affordability, accessibility, availability, universality, and equity in healthcare delivery.[33] Participatory bioethics integrates these CST values as guiding norms for navigating complex ethical issues in healthcare, such as financing, delivery models (public or private), medical research, conscience protections, patient rights, and standards of care.[34] This section will draw on Lisa Sowle Cahill's central themes of participation, justice, and change to examine how CST can inform and transform healthcare practice and policy.

For Cahill, participation is inherently practical, defined by one's tangible contribution to societal well-being. In bioethics, this means the active involvement of diverse stakeholders, patients, healthcare workers, researchers, ethicists, and the broader community, in shaping healthcare policy and practice. Participatory bioethics aims to integrate scientific knowledge with the lived values, beliefs, and needs of affected communities. Shuman underscores that theological language, like scientific discovery, is only valuable when it contributes meaningfully to the flourishing of people, especially the marginalized.[35] Participation fosters inclusivity, shared responsibility, transparency, and education, particularly for vulnerable groups. The Christian ethic of solidarity emphasizes mutual interdependence, and participation becomes a tool for empowerment: individuals, especially the poor, develop leadership skills, contribute through service, and become agents of their own liberation. Thus, bioethics must act as a mediator among grassroots movements, religious and philosophical worldviews, institutional actors, and policymakers across all levels.[36] This inclusive model responds more effectively to ethical complexities in medicine by ensuring universal healthcare access through both financial and non-financial contributions—such as community hygiene, disease prevention, and promoting peace.

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[33] Anthony Okechukwu Nnadi, *Distribution of Resources in the Nigerian Health Care System* (Milton Keynes UK: Lightning Source UK Ltd., 2020), 133.

[34] Karen Shields Wright, "The Principles of Catholic Social Teaching: A Guide for Decision Making from Daily Clinical Encounters to National Policymaking", *The Linacre Quarterly* 84, no. 1 (2017), 10-22. https://dx.doi.org/10.1080/00243639.2016.1274629.

[35] Shuman, "Theological Bioethics: Participation, Justice, Change," 509.

[36] Cahill, *Theological Bioethics*, 69.

Justice in bioethics demands equitable distribution of healthcare resources, protection of human rights, and prioritization of the vulnerable. Cahill defines social justice as the integration of relationships and institutions that serve the common good.[37] Her bioethical reflections, on euthanasia, access to healthcare, reproductive ethics, and biotechnology, highlight how justice-oriented interventions can address moral complexity. Cahill argues that the issue in debates over euthanasia is not autonomy or sanctity of life per se, but the lack of a "social ethos" that affirms decline and dependency as part of the human condition.[38] Justice, therefore, entails expanding access to palliative and hospice care, not normalizing physician-assisted death. Compassionate models such as the Hospice Movement, the Catholic Health Association, and the Sant'Egidio Community offer powerful alternatives.[39] Justice also calls for proactive social intervention to support women facing difficult pregnancies and to care for long-term and terminally ill patients. These efforts prevent unnecessary loss of life while cultivating a sustainable, community-based healthcare system. Cahill further aligns social justice with contributive justice, which the U. S. bishops define as the moral duty of each person to use their skills, talents, and capacities for the common good.[40] Justice is thus both systemic and personal, requiring central authorities to harness and coordinate community resources for equitable healthcare.

Cahill calls for bioethics to be a force for transformative change, rooted in action rather than theory. Emerging in response to historical abuses like the Tuskegee Study and Nuremberg trials, bioethics must now challenge structural inequalities in global healthcare. For Cahill, theological bioethics should empower the poor, foster solidarity, and challenge systems that exclude.[41] Effective change transcends debates over terminology and instead emphasizes moral action, what is good, just, and life-affirming. Theological discourse gains value when it supports inclusion, justice, and solidarity, particularly for the socially and economically marginalized.

Cahill affirms that Christianity bears a distinctive responsibility to catalyse such change through advocacy, community organizing, and healthcare reform. While theologians bring moral insight grounded in the Christian tradition, real change occurs through collaborative engagement with other disciplines and institutions. This collaboration ensures that religious voices contribute constructively to policy negotiation, always emphasizing the preferential option for the poor.[42] Finally, social change in healthcare must prioritize justice—locally and globally. Theological bioethics calls for the

[37] Cahill, *Theological Bioethics*, 47.
[38] Cahill, *Theological Bioethics*, 117.
[39] Cahill, *Theological Bioethics*, 73.
[40] USCCB, *Economic Justice for All*, no. 71.
[41] Cahill, *Theological Bioethics*, 2.
[42] Cahill, *Theological Bioethics*, 45.

transformation of systems shaped by market interests into inclusive structures that guarantee universal health coverage. Although reform may be gradual, every act of advocacy, however small, contributes to a broader movement toward a just and compassionate healthcare system.

3.3 Bioethics and Social Justice

Therese M. Lysaught[43] and Michael McCarthy[44] are co-editors of *Catholic Bioethics and Social Justice: The Praxis of US Health Care in a Globalized World*. The volume comprises a series of thematically interconnected chapters that seek to integrate Catholic Social Teaching (CST) with contemporary bioethical discourse. The central argument is that healthcare, shaped by complex social, cultural, and ethical dynamics, demands active participation from all stakeholders, policymakers, healthcare providers, and patients alike. In highlighting this, the work critiques the narrow scope of traditional bioethics, which has often been confined to clinical concerns at the beginning and end of life or limited to pharmaceutical interventions, without sufficient regard for the broader social and economic realities of patients.[45] Classical bioethical frameworks have tended to be overly individualistic, primarily focused on prescriptive norms and clinical decision-making, often neglecting the structural injustices embedded in the communities served by Catholic healthcare institutions.[46] As a result, patients discharged from care are frequently returned to the very social conditions that precipitated their illness or injury, perpetuating a cycle of poor health outcomes.

This oversight underscores the urgent need for healthcare systems that consider not only the medical and clinical needs of patients but also the wider social determinants of health. Without addressing these determinants, such as housing, education, income inequality, and environmental degradation, efforts at comprehensive healthcare remain incomplete and ineffective.

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[43] M. Therese Lysaught, PhD, is professor at the Neiswanger Institute for Bioethics & Healthcare Leadership at Loyola University Chicago Stritch School of Medicine and Loyola's Institute of Pastoral Studies. Her first book, *Gathered for the Journey: Moral Theology in Theological Perspective* (Eerdmans, 2007). She is also the co-editor of the classic text *On Moral Medicine: Theological Perspectives in Medical Ethics*, 3rd edition (Eerdmans, 2012, co-editor Joseph Kotva), and author of *Caritas in Communion: Theological Foundations of Health Care Ethics* (Catholic Health Association, 2014). See Lysaught, M. Therese, Michael P. McCarthy, and Lisa Sowle Cahill. Quoted from *Catholic Bioethics and Social Justice*: *The Praxis of US Healthcare in a Globalised World* (Collegeville, Minnesota: Liturgical Press Academic, 2018), 427.

[44] Michael McCarthy is assistant at the Neiswanger Institute for Bioethics and Healthcare Leadership at Loyola University Chicago Stritch School of Medicine. Dr. McCarthy codirects the Physicians' Vocation Program, which seeks to ground the formation of medical students in the *Spiritual Exercises* of St. Ignatius Loyola. His research focuses on integrating liberation philosophy and theology as an epistemological approach for understanding the task of bioethics, the importance of spirituality in patient care and medical education, the intersection of the humanities with the formation of the "well-rounded" physician, and clinical ethics. See *Catholic Bioethics and Social Justice*, 427.

[45] Lysaught and McCarthy, *Catholic Bioethics and Social Justice*, 2-3

[46] Lysaught and McCarthy, *Catholic Bioethics and Social Justice*, 2.

This section explores the multidimensional approaches to bioethics presented in *Catholic Bioethics and Social Justice*, which emphasizes the integration of CST principles into healthcare delivery. The volume provides a valuable resource for bridging the gap between clinical practice and social justice, with particular focus on three foundational elements: the starting point for ethical reflection, the transformation of social structures, and the principle of integral ecology. Together, these offer a holistic and justice-oriented vision for healthcare reform.

3.3.1 Changing the Starting Point

Lysaught and McCarthy advocate for a methodological shift in bioethics by redefining its starting point. They argue that bioethical reflection and action must begin with the lived realities and concerns of the most vulnerable and marginalized populations, as well as the environments in which they encounter healthcare.[47] This reflects an approach grounded in Catholic social learning. The concept of Catholic social learning entails a strategy that prioritises local knowledge, available resources, and participatory decision-making to build resilience from the ground up. Rather than imposing external frameworks, it emphasises attentiveness to lived realities and the wisdom embedded within communities themselves. As Susan Mulligan posits, Catholic social learning "captures the idea that the social doctrine must learn from the experiences of the poor, the weak, [and] the displaced."[48] In this sense, learning is not a one-directional process but a reciprocal engagement in which doctrine is deepened and refined through encounter with those most affected by injustice and vulnerability.

The purpose of Catholic social learning, therefore, is to avoid importing ideas and systems that are asymmetrical to local needs and contexts. It resists one-size-fits-all solutions that disregard cultural, social, and ecological particularities. This concern is echoed by Pope Francis, who warns that "the imposition of a dominant lifestyle linked to a single form of production can be just as harmful as the altering of ecosystems."[49] Such a statement underscores the ethical imperative to respect both human and environmental diversity, recognising that harmful forms of uniformity can undermine sustainable development and social justice.

Accordingly, generated ideas and proposals must be aligned with Community-Based Adaptation (CBA), an approach that values local agency, traditional knowledge, and collective participation. By integrating these principles, Catholic social learning fosters context-sensitive

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[47] Lysaught and McCarthy, *Catholic Bioethics and Social Justice*, 7.

[48] Mulligan, Suzanne. "Pope Francis and the Migrant Crisis: Reflection on Hospitality, Vulnerability, and Accompaniment." *The Furrow* 74, no. 11 (November 2023), 579.

[49] Pope Francis, *Laudato Si*, 144.

responses that empower communities to articulate their own needs and solutions. It thereby strengthens resilience not only by addressing material conditions but also by affirming dignity, cultural identity, and the capacity of communities to shape their own futures.

This approach is rooted in the principle of the preferential option for the poor, which they interpret broadly to include any form of systemic violence against the vulnerable, such as disparities in healthcare access, unsafe living conditions, and gender-based discrimination. Beginning with vulnerability as the primary lens enables bioethicists and healthcare practitioners to identify the often-overlooked structural inequalities embedded within healthcare systems. This reorientation moves bioethics beyond its traditional clinical boundaries, often shaped by institutional power and medical authority, and repositions it within a framework grounded in social justice. As the authors note, the discipline must be "grounded in the preferential option for the poor, who in bioethical parlance are referred to as vulnerable populations."[50] Crucially, this reframing challenges the reductive view of the poor as merely passive recipients of care or aid. Instead, it recognizes them as active collaborators and essential participants in shaping healthcare policies and practices that affect their lives. Such a participatory ethic enhances both the legitimacy and the effectiveness of healthcare interventions.

Shifting the starting point also necessitates attentive listening to those most intimately acquainted with the social determinants of health, especially frontline healthcare workers. Engaging these voices ensures that policy decisions are informed by real-life experiences rather than abstract assumptions. Furthermore, prioritizing the participation of marginalized communities strengthens ownership and sustainability, two essential components of successful community-based health initiatives. Local leadership, expertise, and resources must be acknowledged as central to any ethically sound and socially responsive healthcare system.

3.3.2 Transforming Structures

One of the key social determinants of health emphasized in emerging bioethical discourse is public health, particularly the imperative to protect populations by ensuring safe environments in which people live, learn, work, and play.[51] Among the most pressing threats to public health, especially within vulnerable communities in the United States and globally, is gun violence. This form of violence disrupts everyday activities such as exercise, shopping, and social interaction, all of which are essential

[50] Lysaught and McCarthy, *Catholic Bioethics and Social Justice*, 7.

[51] Michelle Byrne et al., "Health Care Providers on the Frontline: Responding to the Gun Violence Epidemic" in *Catholic Bioethics and Social Justice*: *The Praxis of US Health Care in a Globalised World*, edited by M. Therese Lysaught and Michael McCarthy (Collegeville, Minnesota: Liturgical Press Academic, 2018), 35.

for physical and mental well-being. Byrne and others have observed that when gun violence becomes entrenched in communities already burdened by systemic injustice, it disproportionately affects those on the margins, individuals lacking adequate resources and opportunities.[52] In such settings, gun violence not only causes physical harm but also fosters cycles of abuse, erodes familial and communal bonds, and diminishes hope in homes, schools, and neighbourhoods.

Victims of gun violence offer a critical entry point for addressing the crisis. However, a tragic reality persists: many survivors are discharged from hospitals only to return to the same violent environments that led to their injuries, where outdoor rehabilitation is nearly impossible and freedom of movement is severely restricted. Particularly devastating is gang-related violence, where victims and perpetrators often exchange roles in an ongoing cycle of retribution and harm. Addressing gun violence requires more than standard medical treatment. It demands a holistic, community-based healing process that engages not only victims and healthcare providers but also perpetrators, community workers, and law enforcement agencies. Byrne and colleagues argue that the epidemic of gun violence cannot be resolved solely through individual clinical care or criminal justice measures.[53] Instead, a coordinated, multi-sectoral approach is essential, one that aims to heal entire communities and restore social cohesion, justice, and peace.

Another critical social determinant of health, shaped by complex structural injustices, is human trafficking. Fundamentally, human trafficking constitutes a grave violation of human rights, defined as "the unlawful act of transporting or coercing people in order to benefit from their work or service, typically in the form of forced labour or sexual exploitation" (Dictionary.com). Victims of human trafficking are stripped of their dignity and autonomy, treated as commodities, that means being bought, sold, and exploited for profit. Their value is assessed solely in terms of utility, and when deemed no longer useful, they are often discarded without regard for their humanity or wellbeing. This dehumanization not only inflicts profound physical and psychological harm but also underscores the urgent need for healthcare systems to recognize and respond to the structural conditions that enable such exploitation.

Human trafficking, driven by a convergence of vulnerability, psychological and emotional trauma, socio-political instability, and coercive mechanisms such as violence, threats, deception, and debt bondage, has become an almost insurmountable global crisis.[54] At the heart of this phenomenon

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[52] Byrne et al., "Health Care Providers on the Frontline," 38-39.

[53] Byrne et al., "Health Care Providers on the Frontline," 37

[54] Alan Sanders, Kelly H. Herron, and Carly Mesnick, "Catholic Bioethics and Invisible Problems: Human Trafficking, Clinical Care, and Social Strategy" in *Catholic Bioethics and Social Justice*: *The Praxis of US Health Care in a*

lies poverty, often the primary factor that pushes individuals into exploitative situations under the illusion of economic opportunity and escape from hardship. Many victims are lured with false promises of better lives, only to find themselves entrapped in exploitative systems from which escape is nearly impossible. The complexity of human trafficking is exacerbated by the silence it enforces. Victims, and even bystanders aware of the crime, often remain silent due to fear of retaliation or criminal prosecution, particularly in cases involving immigration violations.[55] The legal system frequently assumes that trafficked individuals may have willingly participated in or colluded with traffickers, failing to account for the pervasive manipulation and deception most victims endure. This silence, whether forced or chosen, contributes to the entrenchment of human trafficking as a form of social or structural sin. As Joseph Oppong explains, social sin comprises three interrelated elements: (1) structural systems that oppress, violate human dignity, and impose gross inequalities; (2) environments that enable and normalize individual acts of selfishness; and (3) the complicity of individuals who refuse to take responsibility for ongoing injustice.[56] Human trafficking embodies all these dimensions, with the individual and societal levels reinforcing one another.

Like gun violence, human trafficking cannot be eradicated through criminal justice alone. It requires a multidimensional response involving legal reform, social transformation, public health engagement, and moral accountability. Only through integrated efforts aimed at structural change and empowerment of vulnerable populations can this complex injustice be meaningfully addressed

A pertinent question that may arise is how gun violence and human trafficking constitute public health issues. While both are criminal acts that can rightly addressed through the criminal justice system, with the prosecution of offenders being commendable, it is important to recognize their broader societal impacts. In some instances, the successful prosecution of individuals involved in gun violence has inadvertently contributed to a cycle of retaliatory violence. Gun violence qualifies as a public health issue because it undermines the safety and well-being of communities, restricting individuals' ability to engage in health-promoting activities within a secure environment.[57] The consequences are especially severe for those who are injured, as gunshot wounds can lead to long-term physical disabilities and psychological trauma. Many victims, often familiar with their attackers, experience ongoing fear and emotional distress, which may deter them from participating in necessary

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Globalised World, edited by M. Therese Lysaught and Michael McCarthy (Collegeville, Minnesota: Liturgical Press Academic, 2018), 48.

[55] Sanders, Herron, and Mesnick, "Catholic Bioethics and Invisible Problems," 52.

[56] Joseph Oppong, *An Assessment of David Hollenbach's Contribution to the Debate on Human Rights and Its Future Promise* (Pittsburgh, Pennsylvania: Duquesne University, 2010), 11. https://dsc.duq.edu/cgi/viewcontent.cgi?article=2012&context=etd.

[57] Byrne et. al., "Health Care Providers on the Frontline," 35.

rehabilitation or even leaving their homes.[58] In such contexts, it is crucial to adopt a holistic public health approach that emphasizes the rehabilitation of not only individual victims but also the affected community as a whole.

Human trafficking is also a significant public health concern. Victims often lack social support networks, delay seeking medical attention, and suffer from a range of physical and psychological health issues, including trauma, abuse, neglect, and inadequate housing.[59] Due to their marginalized and often undocumented status, trafficked individuals frequently remain invisible within healthcare systems. They may be unable to access basic medical services or complete treatment for infectious diseases because of restricted mobility and limited contact with others. Even when alone with healthcare providers, many victims are too fearful to disclose their circumstances due to threats, manipulation, or mistrust. Given these conditions, a key priority must be the safe and effective rescue of victims from environments of exploitation and harm. In all interventions, the protection and safety of trafficked individuals must be paramount. Ensuring safety involves preventing re-trafficking, shielding victims from potential retaliation, and avoiding any return to the circumstances that led to their exploitation.[60] Addressing human trafficking as a public health issue calls for an interdisciplinary response that combines healthcare, legal protection, social services, and long-term rehabilitation strategies.

3.3.3 Healing as Justice: Moving Beyond the Act of Rescue

In light of the complex and often traumatic conditions they endure, trafficked individuals and victims of gun violence undeniably require intervention. While rescue remains a critical and necessary function of law enforcement, *Catholic Bioethics and Social Justice* emphasizes the deeper and more enduring imperative of healing. This distinction reflects a broader ethical framework in which healthcare providers are not merely responders to immediate crises but are also agents of long-term recovery and restoration. Although freedom, safety, and peace are vital to the healing process, the emphasis on healing arises from the unique role and environment healthcare settings offer. Medical professionals are often positioned to provide victims with private, confidential spaces where they may speak openly, sometimes for the first time, about their experiences.[61] This trusted relationship allows healthcare providers not only to initiate physical and psychological care but also to collect valuable information that can contribute to safe and effective rescue efforts. Thus, healing and rescue are not opposing

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[58] Byrne et. al., "Health Care Providers on the Frontline," 31.
[59] Sanders, Herron, and Mesnick, "Catholic Bioethics and Invisible Problems," 56 – 57
[60] Sanders, Herron, and Mesnick, "Catholic Bioethics and Invisible Problems," 56.
[61] Sanders, Herron, and Mesnick, "Catholic Bioethics and Invisible Problems," 60.

strategies but interdependent processes, with healing forming the cornerstone of any sustainable response to such deep-seated social harms.

Above all, healthcare institutions and providers are uniquely positioned to lead efforts in transforming the structural conditions that perpetuate social evil. In accordance with their social responsibility to "advocate for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable."[62] Healthcare centres are therefore called to serve and advocate for those whose social circumstances render them particularly vulnerable. One significant advantage of healthcare institutions is their capacity to engage in evidence-informed advocacy, grounded in their direct and often intimate knowledge of victims' circumstances. For many trafficked individuals or victims of gun violence, the clinical encounter may be the only moment of privacy, thereby offering a crucial opportunity for disclosure and intervention.

The data and insights gathered within healthcare settings can serve as a vital resource for multidisciplinary collaborations involving social workers, legal professionals, law enforcement, and policymakers. While healthcare providers may take the lead in this collaborative response, dismantling structures of social sin necessitates a multifaceted strategy. This includes education, interdisciplinary engagement within clinical settings, enhanced utilization of community resources, and advocacy both *for* and *with* victims.[63] Effective advocacy must also aim to strengthen the prosecution of traffickers, remove punitive legal measures against victims, particularly in relation to prostitution or immigration violations, and expand state-level education efforts targeted at healthcare professionals.

Legal reforms should ensure that genuine victims of trafficking are protected and empowered to act as whistle-blowers without fear of prosecution for immigration-related offenses. Similarly, healthcare professionals, given their experience with the human consequences of violence, are well-positioned to advocate for responsible gun law reforms, emphasizing the primacy of community well-being over the unrestricted exercise of individual autonomy.[64] Importantly, personal autonomy must be interpreted in light of relationality and social responsibility. True autonomy is not the capacity to act in isolation but the freedom to act for the common good.

While criminal prosecution of perpetrators is essential, healthcare institutions must also play a central role in promoting community healing and peacebuilding, especially in contexts where legal processes risk exacerbating violence.[65] Reconciliation between victims and perpetrators, where

[62] Sanders, Herron, and Mesnick, "Catholic Bioethics and Invisible Problems," 52.
[63] Sanders, Herron, and Mesnick, "Catholic Bioethics and Invisible Problems," 58.
[64] Byrne et al., "Health Care Providers on the Frontline," 38.
[65] Byrne et al., "Health Care Providers on the Frontline," 45.

appropriate and safe, must be pursued alongside clinical care. Healing the community is as critical as treating the individual, it is only through such integrated approaches that sustainable transformation can be achieved.

3.3.4 Integral Ecology in Healthcare

Chapter Four of *Catholic Bioethics and Social Justice* presents integral ecology as an ethical framework linking environmental, social, and personal well-being. Rooted in Catholic social teaching, it affirms that environmental degradation, such as pollution, climate change, and resource depletion, directly undermines human health, especially among the most vulnerable. Pope Benedict XVI argued that how humanity treats the environment reflects how it treats itself, urging a shift from consumerist lifestyles toward ecological responsibility.[66] Pope Francis expands this vision, defining integral ecology as the recognition of the interdependence of all creation and calling for an "economic ecology" that integrates environmental stewardship with the pursuit of the common good.[67] In the context of healthcare, integral ecology challenges institutions to address not only clinical concerns but also the environmental and social determinants of health. By embracing this interconnected vision, Catholic healthcare can advance justice, protect creation, and promote the conditions necessary for human flourishing.

Vicini and Winright deepen the discussion on human relationships with the environment by observing that "humankind shares the living conditions on the planet with many other living beings and things, from animals to plants, soil to stones, water, and gases and air."[68] Even elements often overlooked, such as stones, can host micro-organisms that contribute to the intricate web of life. They propose three stages through which humanity might cultivate a respectful engagement with nature in all its richness: contemplation, appreciation, and action.[69] *Contemplation* involves recognising that human beings are part of a vast and diverse community of life, and acknowledging the profound vulnerability of humanity in the face of natural forces.[70] This awareness of fragility, they argue, should serve as a moral impetus to act decisively in favour of environmental protection.

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[66] Benedict XVI, *Caritas in Veritate*, no. 51.

[67] Pope Francis, *Laudato Si*, no. 5.

[68] Andrea Vicini and Tobias Winright, "Environmental Ethics as Bioethics" in *Catholic Bioethics and Social Justice*: *The Praxis of US Health Care in a Globalised World*, edited by M. Therese Lysaught and Michael McCarthy (Collegeville, Minnesota: Liturgical Press Academic, 2018), 377.

[69] Vicini and Winright, "Environmental Ethics as Bioethics," 377.

[70] Vicini and Winright, "Environmental Ethics as Bioethics," 379.

Of particular importance is that an integrated approach to bioethics fosters the principle of integral ecology, as an ethic of comprehensive engagement in protecting the environment. Integral ecology recognizes that human activity is among the primary drivers of climate change. As Peppard observes, “for the first time in the history of the earth—indeed, the universe—human beings are now a prominent decisive force that co-determines the earth’s environmental state; furthermore, some of these changes may be permanent.”[71] The prospect of human influence rivalling natural causes in shaping the climate is deeply concerning, particularly given the accelerating pace of anthropogenic impacts. Yet, unlike natural forces, human-induced factors remain within our capacity to mitigate or even eliminate.

Human actions at the local level can exert a positive influence on the climate. Conversely, when the local environment is degraded, the consequences often extend beyond the immediate area, contributing to broader climatic changes, reinforcing interdependence. Activities known to damage the environment include “industrial waste, the burning of fossil fuels, unrestricted deforestation, and the use of certain types of herbicides, coolants, and propellants.”[72] These forms of environmental degradation have been shown to affect most severely the quality of air and water—resources that are indispensable to human life and are entrusted to all in accordance with the principle of the universal destination of created goods.

Key health risk factors affecting individuals and communities often signal a distortion of integral ecology. Mitchell, Andreoni, and Hatchett identify poverty, food insecurity, and chronic disease as primary concerns, noting that “the most significant is the lack of access to quality food and a safe environment in which to live, work, and play.”[73] Food security encompasses not only sufficient quantities of food but also its nutritional quality, both of which are essential for achieving and sustaining good health. Yet, food justice is frequently framed as a purely economic matter, divorced from its connections to social capital, social support, and social cohesion.[74] In reality, food insecurity is the most telling indicator of poverty and social deprivation, with consequences that extend far beyond hunger. Its sequelae include increased rates of cardiovascular disease, stroke, diabetes, substance abuse, poor mental health, and diminished educational outcomes among youth.[75] Unemployment and low wages remain primary drivers, underscoring how inequities in food access often reflect broader societal

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[71] Christiana Z. Peppard, “Commodifying Creation?” in Schaefer, Jame, and Winright, Tobias, eds. *Environmental Justice and Climate Change: Assessing Pope Benedict XVI's Ecological Vision for the Catholic Church in the United States* (Blue Ridge Summit: Lexington Books/Fortress Academic, 2013), 86. Accessed December 11, 2024. ProQuest Ebook Central.

[72] Peppard, “Commodifying Creation?,” 85.

[73] Mitchell, Andreoni, and Hatchett, “Integral Ecology in Catholic Health Care,” 78.

[74] Mitchell, Andreoni, and Hatchett, “Integral Ecology in Catholic Health Care,” 82.

[75] Mitchell, Andreoni, and Hatchett, “Integral Ecology in Catholic Health Care,” 80.

policies that determine the distribution of privilege and opportunity. As a critical determinant of health, food justice must be addressed through coordinated action at the individual, family, institutional, and societal levels.

Factors contributing to food insecurity include unemployment, illness, and the impacts of climate change, the latter of which continues to disrupt food production in many regions of the world. Food insecurity can no longer be viewed solely as an individual or family economic issue; external forces frequently undermine even the most diligent efforts to grow or obtain adequate food. Addressing food justice therefore requires coordinated action at the individual, family, institutional, and societal levels, guided by solidarity and compassion rather than merit alone. Within the framework of integral ecology, "everything is interconnected, and genuine care for our own lives and our relationships with nature is inseparable from fraternity, justice, and faithfulness to others."[76] This perspective underscores the profound interdependence of human, social, and ecological systems. Catholic social teaching offers foundational principles for advancing food justice, particularly the common good, solidarity, and the preferential option for the poor. In collaboration with other stakeholders, Catholic healthcare should prioritize programmes that promote food cultivation, storage, production, preparation, and equitable sharing.

Integral ecology calls for a steadfast commitment to the common good, solidarity, subsidiarity, and the preferential option for the poor. In relation to the common good, both the built environment, human-designed spaces for living, recreation, trade, and commerce, and the natural environment, the created natural order, should foster employment opportunities, strengthen social relationships, and advance food justice and health for all. The common good recognizes that individuals experience food justice differently and that their capacity to respond is often shaped by factors such as unemployment and low wages. The preferential option for the poor invites a critical examination of integral ecology to identify breaches in equitable interconnectedness within the community.[77] In assessing food insecurity, priority should be given to those who are undernourished, malnourished, or deprived of safe drinking water.

In conclusion, *Catholic Bioethics and Social Justice* serves as an essential resource for understanding the intersection of Catholic social teaching and bioethics, demonstrating that ethical healthcare must be grounded in the broader framework of social justice. Notably, the text moves beyond theoretical reflection to practical application, positioning social justice as the central principle of bioethical practice. It critically examines structural injustices in healthcare, such as disparities in

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[76] Mitchell, Andreoni, and Hatchett, "Integral Ecology in Catholic Health Care," 84.
[77] Mitchell, Andreoni, and Hatchett, "Integral Ecology in Catholic Health Care," 89.

access, systemic inequities, and the legal challenges faced by victims of gun violence and human trafficking, while offering concrete, multidisciplinary recommendations for reform. For example, in addressing human trafficking, the authors advocate for an approach centred on education and healing rather than solely on prosecution. The book's accessible structure and diverse authorship make it a valuable tool for policymakers, healthcare providers, ethicists, and law enforcement professionals seeking to integrate Catholic social teaching into ethical decision-making.

3.4 Conclusion

Lisa Sowle Cahill has made a significant contribution to bridging the gap between theology and lived ethical concerns by integrating Catholic Social Teaching (CST) with bioethics. Her work challenges the dominance of individualistic, secular approaches by advancing a richer, more communal and justice-oriented vision of healthcare ethics. Drawing on principles such as participation, justice, human dignity, solidarity, subsidiarity, the common good, and especially the preferential option for the poor, Cahill reframes bioethics as a moral call to transformative action rather than a merely technical or procedural discipline.

Central to her approach is the preferential option for the poor, understood not as a rhetorical slogan but as a structural and epistemological commitment that prioritizes the experiences and agency of marginalized persons. Cahill critiques assumptions that privileged actors are best positioned to determine the needs of the poor, instead emphasizing the development of leadership and moral agency among those directly affected by injustice. Authentic justice, in this view, requires enabling the poor to become protagonists of their own futures. Equally significant is her emphasis on the universal common good, which she argues is undermined by persistent global inequalities despite technological and communicative advancement. For Cahill, solidarity is not merely a virtue but a moral imperative necessary for sustaining the moral imagination required to realize the common good, which in turn demands structural commitments to equitable access to basic goods such as healthcare, food, and water.

In other words, Cahill's theological bioethics offers a compelling vision that situates healthcare justice within a broader moral and theological horizon, affirming CST as essential rather than peripheral to bioethical reflection and practice. This concern leads directly to an important follow-up question: which resources within Catholic Social Teaching can be leveraged to help Zambia achieve universal healthcare? For more than a century, the Catholic Church has developed a rich body of social doctrine that has shaped global policy debates. Yet, as *Catholic Bioethics and Social Justice* observes, this tradition remains insufficiently integrated into bioethics. The resulting lack of rapprochement

between Catholic bioethics and CST represents a significant gap that limits the practical application of bioethical reasoning in healthcare contexts. As Therese Lysaught and Michael McCarthy note, Catholic bioethics "rarely incorporates resources, categories, or concepts of the Catholic social tradition, beyond occasional reference to the common good or a focus on human dignity." This siloed approach has left the intersection of social realities and healthcare largely underdeveloped.

Bridging these silos requires Catholic social thought to illuminate emerging healthcare challenges and to provide robust analytical tools for bioethical reflection. By beginning from the lived realities of health seekers—particularly those facing poverty, violence, human trafficking, food insecurity, and unsafe environments—bioethics is expanded beyond the treatment of individual clinical cases toward the healing of communities. Such an approach directly addresses the structural injustices, or "structures of sin," that perpetuate inequality and poor health outcomes. Critics have long argued that Catholic Social Teaching is overly theoretical or non-binding; however, its integration with bioethics offers a pathway for concrete application, moving Catholic healthcare ethics beyond a narrow manualist focus on clinical beginnings and ends of life. Instead, it enables engagement with broader concerns such as healthcare disparities, social determinants of health, environmental degradation, and global inequality.

Within this framework, CST provides indispensable principles for analysis and action: the dignity of the human person, the universal destination of goods, the common good, the preferential option for the poor, solidarity, participation, justice, and subsidiarity. Human dignity remains the foundational principle, shaping all ethical reflection and practical engagement. Applied to social determinants of health such as homelessness, illiteracy, and gender inequity, these principles call for interventions that prioritize the most vulnerable, foster participation, ensure listening and inclusion, and dismantle unjust social structures.

Building on this theoretical and practical framework, the following chapter turns to a concrete case study: the engagement of the Zambian Catholic bishops with bioethics through the lens of Catholic Social Teaching. By examining their pastoral letters, public statements, and collaborative initiatives, it will demonstrate how CST has been translated into local praxis, informing ethical decision-making, shaping healthcare discourse, and contributing to efforts toward more just and equitable health systems in Zambia.

CHAPTER FOUR

THE PRACTICE OF CATHOLIC BIOETHICS IN ZAMBIA

4.0 Introduction

This chapter examines the role of the Catholic bishops in Zambia in promoting equal access to healthcare through their engagement with the principles of bioethics and Catholic Social Teaching. Guided by the question, "which resources within Catholic Social Teaching can be leveraged to help Zambia achieve universal healthcare?", it further considers the specific tools and resources utilised by the bishops in their efforts to advance universal healthcare in Zambia. The chapter is organised into two main sections: the first focuses on the bishops' defence of the sanctity and dignity of human life, while the second explores their engagement with and advocacy for universal healthcare in Zambia.

Drawing on selected documents from the bishops' conference, the discussion considers their sustained engagement with persistent social challenges such as injustice, poverty, food insecurity, and inadequate infrastructure, all of which continue to hinder equitable access to healthcare. The bishops' influence derives in part from their consistent and outspoken involvement in addressing a broad spectrum of moral and social concerns, which resonates strongly with local communities, particularly the most vulnerable. Issues including abortion, contraception, the death penalty, and broader questions of social justice are addressed through the lens of the Church's teaching on the sanctity and dignity of human life and its protection.

4.1 Promotion and Protection of the Sanctity of Life

As previously noted, the sanctity and dignity of human life constitute a foundational principle for both bioethics and Catholic social teaching (CST). Each framework exists to safeguard life and to affirm the inherent dignity of every person as a being created in the image of God. This section examines the contributions of the Zambia Conference of Catholic Bishops (ZCCB) to the protection and promotion of human dignity through their social teachings. To this end, a selection of pastoral documents issued by the ZCCB will be analysed and discussed.

4.1.1 The ZCCB's Opposition to the Legalisation of Abortion

Within both bioethical discourse and Catholic social teaching, abortion represents one of the most contested moral issues, situated at the intersection of law, medicine, and theology. For the Catholic

Church, the protection of human life from conception to natural death is a non-negotiable moral principle. In Zambia, the Zambia Conference of Catholic Bishops (ZCCB) has played a pivotal role in articulating and defending this principle, particularly in response to legislative developments that challenge it. Their position on abortion reflects not only doctrinal fidelity but also a broader commitment to shaping public policy in ways that uphold the dignity of every human person.

One of the ZCCB's most significant contributions to the protection of the sacredness of human life is its teaching on abortion. When the Government of Zambia legalised abortion through an Act of Parliament, the Catholic bishops responded with the *Declaration on Abortion* (1972), firmly opposing the legislation on the grounds that it encouraged the termination of life. Drawing upon the encyclical *Humanae Vitae*, the bishops declared: "Therefore, we base our words on the first principle of the human being and Christian doctrine of marriage when we are obliged once more to declare that the direct interruption of the generative process already begun and, above all, all direct abortion, even for therapeutic reasons, are to be absolutely excluded as lawful means of regulating the number of children."[1] Through this statement, *Humanae Vitae* reaffirmed the Catholic Church's longstanding belief in the sanctity of human life from conception to natural death, calling for its respect, protection, and care at all stages. In the same spirit, the *Declaration on Abortion* asserted unequivocally: "Regardless of the reasons that lead to abortion, or the circumstances attending it, whether it is performed in a hospital, in a clinic, or secretly, abortion is evil, and nothing can make it good."[2] By underscoring that abortion constitutes the deliberate killing of an unborn child, the bishops positioned themselves as defenders of innocent life. Their opposition to the legalisation of abortion in Zambia was also rooted in the concern that such legal provisions could be subject to foreseeable abuse.

According to the *Zambian Termination of Pregnancy Act* (1972), abortion may be recommended when it is established that:

> (a) the continuance of the pregnancy would involve—
> (i) risk to the life of the pregnant woman; or (ii) risk of injury to the physical or mental health of the pregnant woman; or (iii) risk of injury to the physical or mental health of any existing children of the pregnant woman, greater than if the pregnancy were terminated; or (b) there is a substantial risk that, if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.[3]

The justifications outlined in the Act centre on potential risks to the pregnant woman, her existing children, and the unborn child. From a medical or logical standpoint, these considerations may appear valid and rooted in scientific reasoning. However, such provisions invite deeper theological and

[1] Paul VI, *Humanae Vitae* (July 25, 1968), no. 14.
[2] Zambia Episcopal Conference (ZEC), *Declaration on Abortion* (November 12, 1972), no. 2.
[3] National Assembly of Zambia, *Termination of Pregnancy Act,1972*, Article 3 (1).

philosophical reflection. Where, within these arguments, is the Creator acknowledged? How is the divine purpose of each human life considered? And crucially, what ethical implications arise if the anticipated risks prove to be unfounded?

In the context of the abortion debate, arguments that support abortion often prioritize individual autonomy, subjective rights, and secular reasoning over divine law and the sanctity of life as understood by religious traditions. The Church emphasizes that the recognition of someone as a human being is based on the certitude of their infinite value from conception, which comes from their relationship with God, not on human awareness or experience.

Legal arguments frequently locate the threshold of moral personhood at stages significantly later than conception, such as the point of foetal viability, the moment of birth, or, in some philosophical frameworks, even later developmental milestones.[4] By maintaining that the unborn child does not qualify as a "person" within legal definitions, such perspectives effectively withhold the inherent dignity and right to life that Catholic teaching accords to every human being from the moment of conception. This position stands in marked contrast to the Catholic view, which grounds human dignity in the belief that every person is created in *imago Dei* (Gen 1: 27) and is therefore entitled to full moral respect and legal protection from the very first moment of existence. The postponement of legal recognition of personhood to an indeterminate stage, whether defined by physiological markers such as viability or by subjective social or philosophical criteria, undermines the principle of the sanctity of life.[5] From the Catholic perspective, such an approach risks instrumentalising human life, allowing its value to be measured against variable or utilitarian considerations, rather than recognising it as inviolable and sacred in itself. This divergence between legal and theological understandings has profound implications for bioethical debates, particularly on abortion, since it shapes the moral and legal status of the unborn in ways that either uphold or erode their right to live from the moment of conception.

A central claim in many legal arguments is the emphasis on a woman's right to privacy and bodily autonomy, affirming that she alone has the authority to decide what happens to her body. While Catholic teaching recognises the value of privacy, it maintains that this right is neither absolute nor paramount when weighed against the fundamental right to life.[6] The Church contends that individual freedom, when conceived in absolute and individualistic terms, risks becoming a destructive force,

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[4] USCCB, *Pastoral Message of the Administrative Committee* (Washington DC: USCCB, 2014).
[5] *Catechism of the Catholic Church*, no. 2270.
[6] USCCB, *Pastoral Message of the Administrative Committee* (Washington DC: USCCB, 2014).

particularly towards those who are weak, dependent, and unable to defend themselves.[7] From this perspective, authentic freedom is inherently relational. It is oriented toward the good of others and finds its fullest expression in self-giving and openness to relationship, rather than in isolation or self-determination detached from moral responsibility. This understanding reframes freedom not as an autonomous claim over one's body alone, but as a vocation to live in solidarity with others, safeguarding their dignity and life, especially when they are most vulnerable.[8] The dignity of every human being is intrinsic and valid from the moment of conception.

The ethical implications of abortion, from a Catholic perspective, are not dependent on the presence or absence of anticipated risks during pregnancy. The fundamental principle remains the sanctity of human life from the moment of conception, a principle that must always be respected and protected.[9] Even when a pregnancy is initially perceived to involve serious risks, and such risks are later found to be unfounded, the moral obligation to safeguard the life of the unborn child persists. The Church teaches that no court, legislative body, or government authority possesses the legitimate power to assign lesser value to any human life.[10] Saint John Paul II further underscores that laws legitimising abortion are to be regarded as profoundly unjust and immoral.[11] The priority must be the safeguarding of human life with the utmost care from the moment of conception, rather than the selective determination of whether a particular life is deemed worthy of being allowed to develop and grow.

The Catholic bishops in Zambia regarded the list of reasons permitted under the *Termination of Pregnancy Act* as inadequate and unsatisfactory. Certain grounds cited in the Act such as "risk to the life of the pregnant woman" or "risk of injury to the physical health of the pregnant woman" were, in their view, increasingly mitigated by advances in modern medical science.[12] Furthermore, the bishops argued that the mere existence of potential risk does not in itself constitute sufficient moral justification for taking the life of an unborn child. They also raised critical questions about the socio-demographic patterns surrounding these concerns. Why, for instance, does the perceived risk of pregnancy appear higher among middle- and upper-class citizens, who typically enjoy greater access to advanced healthcare, than among poorer populations, who often have limited healthcare access yet tend to have larger families? Why is the fear of pregnancy-related risk more prevalent in urban settings compared to

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[7] John Paul II, *Evangelium Vitae*, no. 60.
[8] John Paul II, *Evangelium Vitae*, no. 60.
[9] Dicastery for the Doctrine of the Faith, *Declaration 'Dignitas Infinita' on Human Dignity*, no. 47.
[10] USCCB, *Pastoral Message of the Administrative Committee* (Washington DC: USCCB, 2014).
[11] John Paul II, *Evangelium Vitae*, no. 60.
[12] ZEC, *Declaration on Abortion*, no. 7.

rural areas? Such questions suggest that the fears outlined in the Act may at times be influenced by factors beyond purely medical considerations.

Nevertheless, the bishops acknowledged that exceptional circumstances do exist in which therapeutic abortion may be unavoidable. In such cases, the termination of pregnancy might occur indirectly, as an unintended consequence of medical intervention aimed at addressing a serious health condition, rather than as the deliberate ending of an unborn life.

Certain medical interventions may foreseeably result in the loss of a pregnancy. The *Ethical and Religious Directives for Catholic Health Care Services* (ERDs) affirm that: "Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child."[13] For example, in the case of an ectopic pregnancy, the death of the embryo is an unintended and indirect consequence of a morally permissible procedure undertaken to protect the mother's life. Similarly, a pregnant woman diagnosed with uterine cancer may undergo a hysterectomy to preserve her life, even though the procedure results in the loss of the pregnancy.[14] In such instances, the act is not directly intended to terminate the life of the foetus but is justified by the presence of a proportionately grave threat to the mother's life.

Nevertheless, pregnancy complications can present morally complex situations in which the justification for terminating a pregnancy is not straightforward. Directive 45 of the ERDs explicitly prohibits physicians from intentionally killing one person to save another.[15] In circumstances where values appear to be in conflict, the Church advocates for the application of the *principle of double effect*. This moral principle, rooted in the thought of Thomas Aquinas provides a framework for evaluating actions that have both good and bad effects. According to Aquinas, such an act is morally permissible if four conditions are met: (1) the act itself is morally good or at least morally neutral; (2) the good effect, not the bad effect, is intended; (3) the good effect is not achieved by means of the bad effect; and (4) there is a proportionately grave reason for permitting the bad effect.[16]

Applied to pregnancy-related medical dilemmas, the principle of double effect requires that legitimate reasons for permitting an intervention that may result in the death of the unborn must also

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[13] USCCB, *Ethical and Religious Directives*, no. 47.

[14] Kevin O'Rourke, "Complications: a Catholic Hospital, a Pregnant Mother and a Questionable Excommunication." *America*, (August 2, 2010). *Gale Academic OneFile*. https://link-gale-com.may.idm.oclc.org/apps/doc/A234250867/AONE?u=nuim&sid=summon&xid=5c4352ae.

[15] USCCB, *Ethical and Religious Directives*, no. 45.

[16] *Summa Theologica*, II–II, q.64, a.7.

demonstrate respect for the dignity of both lives. In practice, this may include medically indicated premature delivery in the hope of saving both mother and child. If the infant dies due to complications of prematurity, such an outcome is not considered a direct abortion, because the primary intention was to deliver and preserve both lives.[17] Thus, the principle of double effect affirms that, in morally permissible interventions, both the mother and the unborn child are accorded equal value, and the loss of either life is never the intended objective.

A close examination of the *Zambian Termination of Pregnancy Act* suggests that its framers may have presupposed that the legislation would primarily apply to women who were already married. Contrary to this assumption, however, a growing proportion of requests for termination of pregnancy originate from women outside this demographic. Research indicates that the majority of such requests come from unmarried young women, particularly those pursuing tertiary education or in the early stages of their careers. According to Lubeya and others, the reasons for seeking termination of pregnancy are especially prevalent among unmarried women and residents of high-density urban areas.[18] For this demographic, the decision to terminate a pregnancy is often driven more by socio-economic considerations, such as the financial burden of child-rearing, disruption to education, or career aspirations, than by medical concerns related to maternal morbidity or mortality. Despite Zambia being recognised as one of the African countries with comparatively liberal abortion legislation, many women, especially young and unmarried ones, continue to experience severe morbidity and maternal mortality as a result of unsafe abortion practices. This indicates that, more than fifty years after the *Termination of Pregnancy Act* was promulgated, the Zambian community continues to regard the practice with moral disapproval, thereby perpetuating the secrecy surrounding it.

One of the principal reasons why many women in Zambia do not easily utilise the existing legal provisions for abortion is that the *Termination of Pregnancy Act* introduced a framework that not only conflicted with Christian teaching but also ran counter to prevailing cultural norms. As a result, the law has remained difficult to implement in practice, as many Zambians prioritise the preservation of deeply held socio-cultural values. Women who undergo abortion, whether legally or illegally, often face significant social stigma if their actions become known within the community. As Lubeya and colleagues observe, "In most sub-Saharan African countries, women continue to seek secret abortions despite it being legal [in some parts of the continent]. This is attributable to cultural and religious

[17] O'Rourke, "Complications: a Catholic hospital, a pregnant mother."

[18] Mwansa Ketty Lubeya et. al. "Magnitude and Determinants of Unsafe Abortion Among Zambian Women Presenting for Abortion Care Services: A Multilevel Analysis." *International Journal of Gynecology & Obstetrics* 159, no. 3 (December 2022), 981. doi: 10.1002/ijgo.14351.

beliefs that are deep-rooted with negative connotations towards abortion."[19] Such stigma is compounded by structural barriers, including limited access to healthcare facilities that provide comprehensive abortion care, fear of medical complications, and the social repercussions associated with the procedure. Together, these factors contribute to the continued prevalence of unsafe abortion, even in legal contexts.

In the *Declaration on Abortion*, the Catholic bishops of Zambia reminded the faithful that, although abortion had become legal under certain conditions, it remained morally unjustifiable.[20] The hierarchy of the Catholic Church in Zambia opposed the *Termination of Pregnancy Act* (1972) for three principal reasons. First, the Act contravened Catholic teaching that abortion constitutes the taking of innocent human life and that life is sacred from conception to natural death.[21] Second, the bishops held that the mere existence of risk could never serve as sufficient moral justification for ending an innocent life. Third, they expressed concern that the Act would be vulnerable to abuse, particularly among young people.[22] The *Declaration on Abortion* concluded with an appeal to invoke the conscience clause of the *Termination of Pregnancy Act*, thereby protecting those who did not wish to cooperate, formally or materially, in any treatment authorised by the law. While the document was primarily addressed to the Catholic faithful, it found broader resonance across Zambian society, as most cultural groupings similarly regarded abortion as the deliberate killing of an innocent child. In this way, the bishops' stance united Catholics, other Christian denominations, and traditionalists in affirming the enduring moral principle that what is legal is not necessarily morally right.[23] This convergence of religious conviction and cultural ethos sets the stage for a deeper exploration of how Catholic bioethical teaching engages with Zambia's socio-cultural landscape in shaping attitudes toward the sanctity of life.

4.1.2 Religious and Cultural Foundations for the Rejection of Abortion in Zambia.

In their *Letter to All Catholics*, issued four years after the publication of the *Declaration on Abortion*, the Catholic bishops of Zambia reaffirmed their opposition to abortion, condemning it as both a violent crime and a grave injustice. They described it as a violent crime because it constitutes a direct attack on

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[19] Lubeya et. al. "Magnitude and Determinants of Unsafe Abortion," 979.

[20] Joe Komakoma, ed. *The Social Teaching of the Catholic Bishops and Other Christian Leaders in Zambia* (Ndola: Mission Press, 2003), 17.

[21] ZEC, *Declaration on Abortion*, no. 2.

[22] ZEC, *Declaration on Abortion*, no. 16.

[23] ZEC, *Declaration on Abortion*, no. 4.

an innocent life by its own parent, with prevailing attitudes treating the developing child as an unwelcome intruder whose presence cannot be tolerated. Accordingly, the bishops asserted, “It is the greatest injustice in our society since it takes away the first of all human rights: the right to live.”[24] This renewed objection was grounded not only in Catholic moral teaching, which affirms the sanctity of life from conception to natural death, but also in African traditional values, where the unborn are considered integral members of the community. Anthropological studies of Bantu-speaking societies in Zambia indicate that pregnancy is traditionally regarded as a communal blessing, with rituals and taboos designed to protect both mother and child until birth.[25] Within this worldview, terminating a pregnancy is equated with disrupting the natural and spiritual order, thereby incurring both social condemnation and perceived spiritual consequences. The comparatively low rate of legal abortions in Zambia may therefore be attributed not only to legal restrictions or Church influence but also to the enduring power of these cultural and religious frameworks, which together continue to shape public attitudes toward the protection of unborn life.

Initially, the Zambian *Termination of Pregnancy Act* permitted abortion under specific criteria: if the pregnancy significantly jeopardised the mother's life, her physical or mental health, the well-being of existing children, or posed a high risk of severe foetal abnormality. Today, however, “mental health” has become the most frequently invoked ground, particularly among women seeking to pursue education or early career ambitions. This reflects a shift toward individual autonomy, where a child may be seen as an obstacle to personal fulfilment.

Recent public-health analyses suggest that “family planning” motives could soon eclipse traditional medical or health-based reasons for termination of pregnancy. Among Zambia’s urban elites, there is growing acceptance of smaller family norms, influenced by exposure to more individual-centred lifestyles abroad. Ferdinand Nwaigbo aptly observes: “Most Africans who study, studied, or live abroad have unconsciously conformed to the culture of more comfort and less children, more leisure and small families, more pleasure and less responsibilities from larger households.”[26] Within this framework, an unplanned pregnancy often becomes equated with an unwanted burden, leading to its termination. Consequently, lifestyle considerations, rather than the medical risks enumerated in the Act, are increasingly guiding abortion decisions in Zambia.

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[24] Zambia Episcopal Conference, *Letter to All Catholics* (August 25, 1976), no. 11.

[25] Magdalena Ohaja and Chinemerem Anyim, "Rituals and Embodied Cultural Practices at the Beginning of Life: African Perspectives" *Religions* 12, no. 11(2021), 1024. https://doi.org/10.3390/rel12111024

[26] Ferdinand Nwaigbo, “A Theological Perspective of Abortion in Africa” in *Africa Ecclesial Review* 47, no. 1 & 2 (May-June 2005), 93.

Empirical studies lend weight to this trend. In Lusaka and Copperbelt, unmarried status and residence in high-density areas significantly increase the likelihood of unsafe abortion, indicating that sociocultural and economic factors, rather than medical need alone, drive such decisions.[27] Nationally, the prevalence of unintended pregnancies, especially among youth and the unmarried, further reinforces this pattern.[28] Alarmingly, unsafe abortions continue to account for approximately 30% of maternal deaths in Zambia, despite legal provisions allowing abortion under broad criteria.[29] Thus, while the Act's criteria initially centred on health-related risks, today's narratives reveal a profound shift: lifestyle and socio-economic motivations have become the predominant determinants in abortion decisions, raising new questions about moral, cultural, and legal tensions in Zambia's evolving reproductive landscape.

The debate over abortion in Zambia remains far from resolved. Contributing to the national discourse prompted by Article 282 of the draft amendment to the Republican Constitution, which stipulates that "life begins at conception," Jones Chitalu argues that the understanding of when human life begins is a decisive factor shaping public attitudes and practical interventions during the earliest stages of human development.[30] In a related discussion, in his work *The Fallacy of Safe Abortion*, Chitalu challenges the notion of "safe abortion" and underscores the inherent value of human life.[31] This position aligns closely with the teaching of the Catholic bishops of Zambia, who affirm that "the truth that all life is a precious gift from God has profound implications for the questions of stewardship over human life."[32] In their view, the sacredness of human life and the dignity of the human person form the foundational framework guiding the Church's health-related interventions and moral reasoning.

4.1.3 Balancing Reproductive Health Rights and the Sanctity of Life in Zambia

In their pastoral letter *Choose Life*, the Catholic bishops of Zambia reaffirmed their commitment to promoting and safeguarding the sanctity and dignity of human life, with particular emphasis on

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[27] Lubeya et. al. "Magnitude and Determinants of Unsafe Abortion," 979-980.

[28] Joseph Mumba Zulu et al. ""The Ones at the Bottom of the Food Chain": Structural Drivers of Unintended Pregnancy and Unsafe Abortion Amongst Adolescent Girls in Zambia." *Archives of public health = Archives belges de sante publique* vol. 82,1 137. 26 Aug. 2024, doi:10.1186/s13690-024-01377-3

[29] Peter Sims, Abortion as a public health problem in Zambia, *Journal of Public Health Medicine*, Volume 18, Issue 2, June 1996, Pages 232–233, https://doi.org/10.1093/oxfordjournals.pubmed.a024484

[30] Jones Chitalu, "The Beginning of New Life" in *Daily Nation* (May 16, 2014), 6. (Rev. Dr. Jones Chitalu is the current Rector of St. Dominic's Major Seminary – Lusaka. He is also Lecturer of Moral Theology).

[31] Jones Chitalu, "The Fallacy of Safe Abortion" in *Daily Nation*, 11.

[32] Zambia Episcopal Conference (ZEC), *Health Policy for the Catholic Church in Zambia* (2009), #4.

ensuring the safety of women in relation to their reproductive capacity. In the wake of the 1994 Cairo International Conference on Population and Development and the 1995 Beijing Conference on Women, various international organizations engaged with Zambia to support governmental reforms aimed at advancing women's rights and implementing reproductive health initiatives. Both conferences underscored the importance of addressing population control and gender equality, recognizing these as critical areas requiring sustained attention. These global platforms injected new momentum into the pursuit of equal justice for women in Zambia, coinciding with heightened concern over persistently high maternal and infant mortality rates. While proposals for comprehensive reproductive health strategies offered hope in addressing these challenges, progress has been impeded by structural and systemic barriers. Limited access to quality healthcare, inadequate obstetric services, shortages of qualified personnel, and delays in seeking medical attention, often linked to low levels of education and entrenched social attitudes, continue to undermine efforts to reduce mortality rates. As a result, the struggle to reconcile the promotion of reproductive health rights with the defence of life remains a complex and ongoing public health and ethical challenge.

Written twenty-five years after the *Declaration on Abortion*, the pastoral letter *Choose Life* (1997) sought to clarify the distinction between abortion and contraception in response to the growing dissemination of information on pregnancy termination and the indiscriminate use of contraceptives. The Zambian bishops expressed concern that contraception could be misused as a means of concealing abortion. The letter explicitly stated that any intervention preventing the development of life after conception, such as inhibiting implantation or destroying the viability of the conceptus, must be regarded as abortifacient.[33] Accordingly, any agent, whether pharmaceutical or mechanical, that destroys a fertilised ovum or prevents its implantation and continued growth falls within the category of abortifacients. In contrast, contraceptives were defined as methods intended to prevent conception from occurring in the first place. While acknowledging that contraception carries a lesser moral gravity than abortion, the bishops nevertheless underscored an intrinsic link between the two. They cautioned that "the negative values inherent in the 'contraceptive mentality' are such that they strengthen the temptation to abortion when an 'unwanted' life is conceived."[34] This position reflects the bishops' broader moral framework, which views both abortion and certain forms of contraception as part of a continuum that undermines the sanctity of human life and the moral responsibility to protect it from the moment of conception.

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[33] Zambia Episcopal Conference (ZEC), *Choose Life* (November 30, 1997), no 13.

[34] Komakoma, *The Social Teaching of the Catholic Bishops*, 18.

Choose Life was written in response to a government family planning programme that pursued two principal objectives: reducing high maternal and child mortality rates and controlling Zambia's population growth.[35] Both aims remain relevant, as the country continues to face elevated maternal mortality while its population growth outpaces economic development. The maternal mortality ratio, defined as the number of women who die from pregnancy-related causes while pregnant or within 42 days of pregnancy termination per 100,000 live births, currently stands at 135 per 100,000 live births.[36] Against this backdrop, improving women's reproductive health is a legitimate and urgent priority. However, the programme generated significant concern because it placed considerable emphasis on promoting and disseminating information about abortion and contraception, with a stronger focus on preventing pregnancy as a population control measure than on enhancing women's health. The bishops rejected the notion, consistent with the teaching of *Humanae Vitae*, that abortion and contraception constitute legitimate means of population control or family planning.[37] Of particular alarm was the lowering of the target beneficiary group to include school-aged children. This shift effectively reoriented the programme's primary purpose from improving women's reproductive health to promoting "safer sex" for the general population.[38] In cases of conception, the programme safeguarded the mother's right to choose but failed to accord equal protection to the unborn child's right to life. As a national policy, equal attention should be given to both the mother's right to health and the unborn child's right to life. Moreover, there is a pressing need for deeper societal understanding of the purpose of human sexuality and the responsibilities it entails, an area in which the government has fallen short, prompting the Church in Zambia, through its magisterium, to intervene.

The most commendable aspect of *Choose Life* lies in its emphasis on compassion and its practical proposals to address the widespread practice of abortion. The bishops recognised that certain perplexing and tragic circumstances, such as profound suffering, loneliness, economic deprivation, depression, and anxiety about the future, can lead some mothers to consider abortion.[39] Importantly, *Choose Life* made the crucial distinction that an unplanned or unintended pregnancy is not necessarily an unwanted pregnancy.[40] With adequate support, understanding, and encouragement, many women might choose to welcome the child, who, as affirmed in Psalm 127:3, is always a blessing from God.

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[35] Zambia Episcopal Conference (ZEC), *Choose Life* (November 30, 1997), no. 26.

[36] Zambia Maternal Mortality Rate 2020-2024. https://www.macrotrends.net/global-metrics/countries/ZMB/zambia/maternal-mortality-rate#:~:text=Zambia%20maternal%20mortality%20rate%20for,a%200.65%25%20increase%20from%202016.

[37] ZEC, *Choose Life*, no. 31.

[38] ZEC, *Choose Life*, no. 31.

[39] ZEC, *Choose Life*, no, 9.

[40] ZEC, *Choose Life*, no. 15.

The pastoral letter underscores that genuine compassion must be accompanied by truth and justice. The truth regarding the value of human life, drawn both from the Church's teaching and from African traditional values that uphold respect for life, must remain uncompromised, while justice demands that the unborn child's right to life be fully protected. Additional factors identified as contributing to abortion include poverty, inadequate sexual education and counselling, increasing permissiveness among youth, failure of contraceptive methods, the breakdown of traditional family structures, the erosion of religious and moral values, and the lack of respect for women.[41] Notably, these drivers are largely rooted in social and economic circumstances rather than in the physical or mental health of the mother.

These additional push factors driving women to seek abortion call for greater pastoral guidance and compassion. In the past, the Zambian Church sometimes sanctioned parents by denying them access to the sacraments if their daughters became pregnant outside of marriage. While intended as a moral deterrent, this measure had unintended consequences: some parents, seeking to avoid both ecclesial penalties and the social stigma attached to such pregnancies, resorted to procuring abortions for their daughters. Recognising these harmful outcomes, the Church eventually abrogated the practice, as it was found to strain relationships within the faith community, particularly in Small Christian Communities (SCCs). Within SCCs, members often engaged in close scrutiny of one another's conduct, sometimes imposing informal sanctions when a family was deemed to have transgressed community norms. Such pressures, rather than encouraging the acceptance of a pregnancy, at times reinforced the decision to terminate it. Furthermore, some scholars note that in certain African traditions, abortion could be considered permissible if a mother's reputation was at stake, on the grounds that the loss of one's social honour outweighed the loss of life.[42] Such cultural considerations have historically been invoked especially in cases of rape or incest.

Foremost among the Zambian bishops' proposals for addressing the root causes of abortion was the eradication of poverty, which they identified as a major factor influencing decisions not to welcome new life. The bishops expressed concern that many "international friends" of the Ministry of Health were directing substantial resources toward population control measures, particularly the provision of abortion services and contraceptives, rather than toward alleviating poverty and expanding educational opportunities for girls.[43] Similarly, Nwaigbo observed that "the debate on abortion is blamed on the population explosion on the continent [of Africa]. The economists, sociologists, humanitarians, and

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[41] ZEC, *Choose Life*, no. 16.
[42] Nwaigbo, "A Theological Perspective of Abortion," 96.
[43] ZEC, *Choose Life*, no. 18.

commentators have exaggerated the population of Africa in disregard of epidemics such as HIV/AIDS, malaria, etc., which claim thousands of lives on a daily basis." Nwaigbo, "A Theological Perspective of Abortion,"[44] This neglect of demographic realities also extends to overlooking other critical sectors such as skills training, education, health, and nutrition. Bernard Häring offers a pointed illustration of these challenges:

> Take the situation of Zambia, where last year I gave fourteen workshops, speaking on each occasion to a number of lay groups, nursing and training schools, … and what everyone there says is that they still have forty to forty-five percent infant mortality. Zambia is as big as France and West Germany together, with only 4,100,000 inhabitants. What they need is a more nourishing diet and better care for children, because they must have more people to do the necessary labour and to organise themselves. … They find it an imposition and a seduction when the so-called development helpers come in and acquaint the girls with the pill and advocate for abortion.[45]

Häring's analysis underscores the importance of prioritising Zambians' overall well-being over externally driven population control agendas. In many cases, international development agencies attempt to address the symptoms rather than the underlying causes of social and economic vulnerability. Lasting solutions require investment in building local capacity through skills development and the cultivation of attitudes that promote long-term resilience. Given that much of Zambia's rural population lacks access to quality education, stakeholders should place greater emphasis on non-formal education in literacy, vocational training, agriculture, and health, as a means of improving both the social and economic standing of the poor.

The second major proposal in the bishops' campaign to address the root causes of abortion was the promotion of women's rights. In Zambia, women continue to face systemic injustices and inequalities that leave them vulnerable to various forms of exploitation by men. Advancing justice and equality for women requires the creation of equal opportunities at all levels of decision-making. Women should be recognised as equal partners, created in the image of God, and entitled to the full rights and privileges inherent to every human being, while retaining their unique dignity and identity.[46] In contexts where women are relegated to a second-class status, such abuses are not only possible but inevitable. Addressing these structural inequities is therefore a concrete and urgent area in which the Church must engage when providing moral and pastoral guidance on healthcare in Zambia.

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[44] Nwaigbo, "A Theological Perspective of Abortion," 102.

[45] Bernard Haring, Quoted by Gary MacEoin, "Conversation with Bernard Haring." *Worldview* 15, no. 8 (1972), 26. Doi:10.1017/50084255900014509. (Gary MacEoin was an internationally known journalist, author of *Latin America: The Eleventh Hour*, *What Happened at Rome*, and *Revolution Next Door: Latin America in the 1970's*. "Conversation with Bernard Haring." *Worldview* 15, no. 8 (1972), 22. Doi:10.1017/50084255900014509).

[46] ZEC, *Choose Life*, no. 22.

The most notable feature of *Choose Life* is its strong pastoral care orientation. By this stage, the bishops had recognised that Zambia's social and cultural landscape was undergoing significant change in both attitudes and lifestyles. Traditional African values, such as the primacy of the extended family, were diminishing as more people adopted a nuclear family model, exercising greater autonomy in family decision-making. This transformation could be attributed to several factors, including the expansion of formal education, the influence of modernity, and the growth of Christianity. As increasing numbers of Zambians obtained formal education, it would have been unrealistic to expect society to remain unchanged. Likewise, the conversion of many to Christianity has had a profound impact on moral and social behaviour, often diminishing the influence of certain cultural and traditional practices.

Furthermore, Zambia has witnessed a rise in inter-cultural marriages, partly as a result of the post-independence government policy of assigning civil servants to districts outside their places of origin. This mobility fostered greater ethnic integration and marital unions across cultural boundaries, contributing to a new cultural dynamism that continues to shape behaviour and values. Suzanna Mulligan's perspective underscores the need to understand culture in its evolving context rather than as a static heritage. She observes:

> Cultural values are often spoken of as though they are somehow beyond revision. These values, it is argued, ought to be preserved because they are part of a long tradition. But even the most cursory glance at history reveals that this is not an accurate reading. It is necessary to remember that culture is not a static, unchanging reality. Rather, culture and cultures are dynamic and ever-changing. Change, progress, development—however one would like to describe it—is a very real part of what we mean by culture.[47]

Mulligan's insight serves as a valuable reminder to the bishops that their teaching must adopt a universal approach, transcending specific cultural groupings while remaining sensitive to the influences of education, religion, and inter-cultural exchange. The faithful and indeed all "people of good will" to whom the bishops often address their pastoral messages, are ultimately concerned with what is true and beneficial for themselves and for future generations. Rather than focusing primarily on the perceived threats posed by cultural interaction, such encounters should be viewed as opportunities for mutual enrichment through intellectual engagement and creative imagination.[48] In this way, the Church's pastoral approach can remain both faithful to its core moral principles and responsive to the evolving cultural realities shaping contemporary Zambian society.

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[47] Suzanne Mulligan. "Capabilities and the Common Good." *Irish Theological Quarterly*, 75, no. 4 (2010), 401. https://doi-org.may.idm.oclc.org/10.1177/0021140010377739.

[48] Mulligan. "Capabilities and the Common Good," 393.

The tone and approach of *Choose Life* reflect the bishops' unwavering commitment to affirming the dignity and inviolability of human life. The document demonstrates a resolute decision to stand firmly on the path of truth and to speak on behalf of the voiceless. This stance embodies the Church's prophetic mission in every age: to guide people toward informed moral choices, particularly concerning the wellbeing of women and children in society. Justice demands that the bishops consistently proclaim the truth about the moral evils of direct abortion and the ethical concerns surrounding contraception. Genuine compassion is inseparable from justice, and justice is complete only when it is grounded in love and truth. By their teaching, the bishops reaffirm that the sanctity of life and the protection of human dignity are non-negotiable principles, transcending all cultural, religious, and social boundaries.

4.1.4 Capital Punishment and the Sanctity of Life in Zambia.

Capital punishment is another area in which the sanctity of human life is violated, and it has been a focal point of the Zambian bishops' campaign for the abolition of the death penalty. The bishops argued that retaining capital punishment in Zambian law stands in direct contradiction to the nation's proclaimed identity as a Christian nation, as well as to the moral imperative of protecting life. They also challenged the commonly cited justification for the death penalty, the prevention of possible escape by individuals deemed dangerous criminals, arguing that such reasoning is insufficient in light of the nation's moral commitments.

On 29 December 1991, the second Republican President, Dr. Frederick Chiluba, declared Zambia a Christian nation, leading to an amendment of the Preamble of the Zambian Constitution to reflect this declaration. In January 1992, Christian church leaders responded by reminding the president that "*A nation is not Christian by declaration, but by deeds*."[49] Beyond ensuring freedom of conscience and worship, the Christian identity of the state was expected to inspire constitutional reforms that would embody the values it professed. Among these anticipated reforms was the abolition of the death penalty. As a Christian nation, Zambia's constitution ought to safeguard life at every stage and in every circumstance. This requires finding alternatives to the death penalty that uphold human dignity while addressing public safety concerns. Hardened offenders, rather than being executed, could be rehabilitated, reintegrated into society, and constructively engaged in ways that serve both justice and the common good.

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[49] Komakoma, *The Social Teaching of the Catholic Bishops*, 264.

In *Let My People Go*, the bishops urged those involved in preparing constitutional amendments to include, on the agenda, the removal of the death penalty from the Bill of Rights.[50] In their formal submission to the Mung'omba Constitution Review Commission, the Zambia Catholic bishops reaffirmed that capital punishment is incompatible with the Church's teaching on the sanctity of human life from conception to natural death. Consequently, the Church opposes all actions that violate this sanctity, including abortion, suicide, euthanasia, murder, and the death penalty.[51] Pope Francis offered a clear and authoritative articulation of this position in his encyclical *Fratelli Tutti*, underscoring the Church's global commitment to the abolition of capital punishment. He asserted: "The death penalty is inadequate from a moral standpoint and no longer necessary from that of penal justice. There can be no stepping back from this position. Today we state clearly that the death penalty is inadmissible, and the Church is firmly committed to calling for its abolition worldwide."[52] It is therefore imperative that episcopal conferences across the world join their voices with that of the Roman Pontiff in advocating for the protection of life in all circumstances and for the definitive eradication of the death penalty.

As a result of sustained advocacy by the bishops of Zambia, together with other Christian leaders, the President of Zambia signed into law Amendment Bill No. 25, which abolished the death penalty, on 23 December 2022. This legislative change was widely hailed as a progressive step, given that capital punishment was seen as incompatible both with the constitutional guarantee of the right to life and with Zambia's identity as a Christian nation. However, the presidential assent to the ban effectively meant that the Head of State had renounced the exercise of capital punishment; the constitutional provision for the death penalty remains in force until it is formally removed through the requisite referendum process.

At the time of publishing the pastoral letter *Let My People Go*, the Church's teaching on the death penalty had not yet been revised and still acknowledged the State's authority to execute criminals under exceptional circumstances. As the Catechism then stated: "Assuming that the guilty party's identity and responsibility have been fully determined, the traditional teaching of the Church does not exclude recourse to the death penalty, if this is the only possible way of effectively defending human lives against the unjust aggressor."[53] The ZCCB's campaign for the abolition of the death penalty gained renewed momentum following Pope Francis' revision of this teaching in the Catechism,

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[50] Zambia Episcopal Conference, *Let My People Go* (November 2003), no. 14.

[51] Zambia Episcopal Conference, "Submission to the Mung'omba Constitutional Review Commission." (Lusaka: Kapingila House, 2004), no. 21.

[52] Pope Francis, *Fratelli Tuttti*, no 263.

[53] *Catechism of the Catholic Church*, no. 2267.

declaring the practice inadmissible under all circumstances and affirming the Church's commitment to its worldwide abolition.[54]

Notably, the Zambian bishops' campaign against the death penalty has been consistent over the decades, but it intensified significantly in recent years following explicit papal pronouncements on the matter. While the Catholic Church's rejection of capital punishment has developed gradually, a definitive and categorical stance was only established in recent decades. In *Evangelium Vitae*, Pope John Paul II reaffirmed the State's right, in principle, to impose the death penalty for the protection of society; however, he underscored that in contemporary circumstances such cases are "very rare, if not practically non-existent."[55] This position reflects the recognition that modern penal systems possess highly effective means of securely detaining offenders, rendering execution unnecessary for public safety. Furthermore, a growing body of argument against capital punishment highlights the grave moral and legal implications of wrongful convictions, with documented cases where innocent individuals have been executed due to flawed investigations, prosecutorial errors, or judicial bias.

The most decisive development in the Church's stance on capital punishment occurred in 2018, when Pope Francis formally revised the teaching on the death penalty in the *Catechism of the Catholic Church* (CCC). The updated paragraph 2267 now unequivocally states that the death penalty is inadmissible in all circumstances because it constitutes "an attack on the inviolability and dignity of the person."[56] The revised text affirms:

> Recourse to the death penalty on the part of legitimate authority, following a fair trial, was long considered an appropriate response to the gravity of certain crimes and an acceptable, albeit extreme, means of safeguarding the common good. Today, however, there is an increasing awareness that the dignity of the person is not lost even after the commission of very serious crimes. In addition, a new understanding has emerged of the significance of penal sanctions imposed by the State. Lastly, more effective systems of detention have been developed, which ensure the due protection of citizens but, at the same time, do not definitively deprive the guilty of the possibility of redemption. Consequently, the Church teaches, in the light of the Gospel, that "the death penalty is inadmissible because it is an attack on the inviolability and dignity of the person," and she works with determination for its abolition worldwide.[57]

Both Pope John Paul II and Pope Francis agree that the traditional justification for capital punishment, protecting the common good by eliminating dangerous offenders, is no longer tenable in light of modern penal systems capable of securely detaining criminals. More significantly, the contemporary

[54] *Vatican News*, "Pope Francis: Death Penalty Inadmissible." August 2, 2018. https://www.vaticannews.va/en/pope/news/2018-08/pope-francis-cdf-ccc-death-penalty-revision-ladaria.html.
[55] John Paul II, *Evangelium Vitae*, no. 56.
[56] *Vatican News*, "Pope Francis: Death Penalty Inadmissible."
[57] *Vatican News*, "Pope Francis: Death Penalty Inadmissible."

emphasis on the sanctity of life, the intrinsic dignity of every human person, and the enduring possibility of moral conversion and redemption renders state-sanctioned execution morally unacceptable. Pope Francis further contends that the death penalty not only violates human dignity but also perpetuates a cycle of violence and retribution, failing to provide a truly just or restorative response to crime.[58] Instead, society is called to pursue more humane and rehabilitative approaches to justice that respect the life and dignity of every person.

The Zambian Catholic bishops' campaign for the abolition of the death penalty reflects the Church's unwavering commitment to the inviolability and dignity of the human person from conception to natural death. Their sustained opposition to capital punishment was grounded in the conviction that the deliberate taking of life, regardless of circumstance, is fundamentally incompatible with the moral duty to defend and protect life. To advocate for the sanctity of life at its beginning while leaving it unprotected at its end would represent a contradiction in principle. In celebrating the President's decision to abolish the death penalty in Zambia, the Zambia Conference of Catholic Bishops (ZCCB) reaffirmed the Church's teaching that human dignity is inalienable, even for those who have committed the most grievous crimes.[59] While other Christian bodies, such as the Evangelical Fellowship of Zambia and some Pentecostal churches, maintained divergent positions, the ZCCB found common cause with the Christian Council of Zambia, whose support proved instrumental in achieving this moral and legislative milestone.

4.1.5 The Principle of Equality and Human Dignity in the Bishops' Pastoral Teaching.

The equality of all people, created in the image and likeness of God, remains a central theme in socio-economic, political, cultural, and religious discourse. This theme also figures prominently in the pastoral letters of the Catholic bishops of Zambia, whose advocacy for equality draws on the Catholic Social Teaching (CST) principle of human dignity. In 1953, the Catholic Ordinaries of Northern Rhodesia (now Zambia) issued *The Pastoral Letter Addressed to All Catholic Missionaries and Members of the African Clergy in Northern Rhodesia* in response to widespread discrimination and injustice. The document sought to provide moral guidance on the inherent dignity and equality of every person in Zambia and beyond.[60] At the time, the Colonial Government was deliberating on the creation

[58] Pope Francis, *Fratelli Tutti*, nos. 263-270.

[59] AMECEA Social Communications, January 20, 2023.

[60] Catholic Ordinaries of Northern Rhodesia, *Pastoral Letter Addressed to all Catholic Missionaries and Members of the African Clergy in Northern Rhodesia* (Lusaka, 1953), no. 4. An important note to make here is that the

of a federation comprising present-day Malawi, Zambia, and Zimbabwe. The process, however, excluded indigenous Africans from participation in decision-making, heightening racial tensions among African, European, and Asian communities. Political authority rested in the hands of a minority European settler population, who made decisions on behalf of the African majority. The bishops denounced such exclusion as a form of discrimination, interpreting the proposed federation primarily as a political manoeuvre serving colonial interests. Accordingly, they called on all Catholic faithful, both African and European, to recognise and respect the dignity of every person, regardless of race.[61] During this period, the so-called "colour bar," a system akin to apartheid, institutionalised racial segregation between European settlers and the indigenous population of Northern Rhodesia. The underlying message of the pastoral letter was unequivocal: any form of racial exclusion or discrimination constitutes a violation of human dignity.

As a starting point for dismantling barriers of exclusion, the bishops invoked the principle of the dignity of the human person. At the same time, they identified the Church as the proper context for embodying the Gospel imperative to love others as oneself. For them, human dignity affirms that all humanity shares a common origin in God, which in turn confers equal rights upon all people. Even after the Fall, humanity has been redeemed by Christ, and all are destined for the same eternal life in heaven.[62] The bishops grounded this conviction in the biblical teaching that every human being is created *imago Dei*, drawing extensively on the writings of the Apostle Paul.

In emphasising the dignity of every person, Paul declared: "For in Christ Jesus you are all children of God through faith. As many of you as were baptised into Christ have clothed yourselves with Christ" (Galatians 3:26–27). His further assertion that there is "no longer Jew or Greek, slave or free, male and female; for all of you are one in Christ Jesus" (Galatians 3:28) provided a compelling theological basis for opposing discrimination. Other Pauline texts underscore the unity of all the baptised within the mystical body of Christ, where no distinctions divide its members. This theological vision connects the principle of human dignity to the intrinsic worth of each person as the image of God: "For we are what he has made us, created in Christ Jesus for good works, which God prepared beforehand to be our way of life" (Ephesians 2:10). While Paul does not explicitly employ the term *imago Dei* as found in Genesis, his understanding of human dignity is firmly rooted in this foundational truth.

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entire episcopal conference of Northern Rhodesia was comprised of bishops who came from a missionary background. Although technically could have considered themselves foreigners spoke on behalf of the majority indigenous people.

[61] Catholic Ordinaries of Northern Rhodesia, *Pastoral Letter Addressed to all Catholic Missionaries*, no. 20

[62] Catholic Ordinaries of Northern Rhodesia, *Pastoral Letter Addressed to all Catholic Missionaries*, no. 21.

Five years later, the bishops issued another pastoral letter, evidently intended to clarify and reinforce the principles articulated in 1953. In the 1958 statement, they unequivocally condemned the unjustified racial disparities that persisted in Zambia and reminded all citizens of their moral responsibility to foster racial harmony and social peace.[63] The practice of maintaining separate churches, one designated for European Catholics and another for African Catholics within the same locality, had become a visible counter-witness to the Gospel message. As shepherds of the faithful, the bishops reminded Catholics of every race that "one of the fundamental doctrines of the Church is that the human race is one. The fact of its oneness is not affected by any secondary differences, such as differences in colour."[64] Racial distinctions, being merely accidental, cannot undermine the essential foundations of human identity: common descent, shared human nature, and universal fraternity in Christ. By virtue of this unity in Christ, all human beings possess the same inalienable rights, including the right to life and to bodily dignity.[65] Consequently, all are obliged to protect these rights and to work actively toward the promotion of equality for every person. This, the bishops stressed, is precisely what Catholic Social Teaching seeks to advance in every society.

By the time of these pastoral interventions, Pope Leo XIII's *Rerum Novarum* had already been published, a landmark encyclical that underscored the dignity of labour, the necessity of just wages, and the imperative to respect the dignity of the human person.[66] *Rerum Novarum* articulates several guiding principles: all people are created and redeemed by God; while natural inequalities in talents exist, God has endowed all with equal dignity.[67] The encyclical affirms that the common good is the ultimate end of civil society and that all individuals have the right to participate fully in it. Pope Pius XI, in *Quadragesimo Anno* gave prominence to the principle of subsidiarity, defining it as respect for human dignity through the protection of individual and local community autonomy in decisions affecting their lives.[68] Subsidiarity, in this sense, promotes personal responsibility, participation, and self-determination. In applying these principles to the Zambian context, the Episcopal Conference identified the exclusion of indigenous people from decision-making processes as a direct violation of subsidiarity—one that significantly disempowered the population and undermined their human dignity.

It was for this reason that the bishops emphasised the equality of all people, an issue that remains highly relevant in Zambia today. During the pre-independence era, the primary source of social

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[63] Catholic Ordinaries of Northern Rhodesia, *Joint Pastoral Letter of the Catholic Bishops of Northern Rhodesia Addresses to the Catholics of All Races* (January 6, 1958), no. 2.

[64] Catholic Ordinaries of Northern Rhodesia, *Joint Pastoral Letter of the Catholic Bishops*, no. 5.

[65] Catholic Ordinaries of Northern Rhodesia, *Joint Pastoral Letter of the Catholic Bishops*, no. 8.

[66] Leo XIII, *Rerum Novarum* (May 15, 1891), no. 5.

[67] Leo XIII, *Rerum Novarum*, no. 26.

[68] Pius XI, *Quadragesimo Anno*, no. 79.

tension lay in the relationship between European settlers and the indigenous population. In contemporary Zambia, however, even greater tensions arise from entrenched tribal affiliations, which continue to distort political and economic processes in the country. Political and civic leaders often prioritise the welfare of their own kin over the well-being of the entire population, regardless of tribal identity.

Joleen Steyn Kotze offers a valuable analysis of the political culture inherited from the colonial administration in Zambia. He observes that colonial authorities deliberately favoured certain groups over others for political and commercial convenience, thereby sowing the seeds of ethnic inequality.[69] This pattern of preferential treatment fostered divisions that remained unresolved at independence and continue to influence the distribution of national resources today. However, some scholars caution against attributing ethnic tensions exclusively to colonial policies. Kotze, for example, notes that "ethnic mobilization has dictated much of Africa's political life, and this becomes centred upon a competition for resources, benefits, and access."[70] While colonial policies undoubtedly entrenched certain patterns of ethnic favouritism, it would be reductive to overlook the agency of Zambians in perpetuating ethnic politics. The persistence of such practices after independence, despite the creation of single, unified states, demonstrates that ethnic affiliation remains a central feature of Zambia's political landscape. This continuing reality presents a significant obstacle to the development of inclusive citizenship and the equitable distribution of opportunities.

The urgency of securing equality in human rights for all Zambian citizens cannot be overstated. Central to this endeavour is the promotion of the doctrine of the dignity of every human person, which serves as the foundation for the basic rights of equal citizenship. Kotze argues that achieving inclusive citizenship in African politics requires an intentional effort to depoliticise and demystify ethnicity, drawing on the philosophy of *ubuntu*.[71] This African communal ethic emphasises social solidarity, the restoration of humanness across all communities, and the recognition that all people are bound together within the web of humanity.[72] As both a theological and ethical framework, *ubuntu* offers a constructive pathway for addressing the ethnic divisions that hinder equitable access to opportunities, goods, and services in Zambia. It affirms the shared humanity of all, urging collaboration and mutual

[69] Joleen Steyn Kotze, "In Search of Justice: African and Western Approaches for Transitional Justice." *AFER* 56, no. 1 (March 2014), 59. https://search-ebscohost-com.may.idm.oclc.org/login.aspx?direct=true&db=lsdar&AN=ATLA0001983989&site=ehost-live

[70] Kotze, "In Search of Justice," 60.

[71] Kotze, "In Search of Justice," 69.

[72] Kotze, "In Search of Justice," 70.

care for the common good of society. By embracing *ubuntu*, Zambia can move closer to realising a political culture rooted in human dignity, social justice, and the genuine equality of all its citizens.

In conclusion, it can be affirmed that the Catholic bishops of Zambia have played a pivotal role in promoting and safeguarding the sanctity of life and the dignity of the human person in the country. Their consistent advocacy, from matters concerning the beginning of life to the realm of interpersonal and social relationships, reflects a deep commitment to the fundamental ethical principle that all human life is sacred and inviolable. This principle, rooted in both divine revelation and natural law, serves as the moral foundation for Catholic Social Teaching and guides the Church's engagement with the wider society. The bishops' interventions have underscored that the defence of life is not limited to resisting threats such as abortion, capital punishment, or euthanasia, but also encompasses the pursuit of social justice, the elimination of discrimination, and the fostering of conditions in which every person can flourish. Consequently, every programme, policy, and human endeavour, whether political, economic, or cultural, must be oriented toward the protection, enhancement, and celebration of human life in all its stages. By insisting on this integrated vision, the Zambian episcopate has provided a prophetic witness that challenges both the Church and society to measure progress not merely by material advancement, but by the degree to which the dignity of every person is recognised, respected, and upheld.

4.2 Catholic Bishops' Promotion of Access to Healthcare.

This second part examines the advocacy of the Catholic bishops of Zambia in promoting equitable access to adequate healthcare across the nation. Through numerous pastoral letters, the bishops have drawn attention to the persistent shortcomings in healthcare delivery, particularly for the rural poor. As part of their prophetic and pastoral mission, they have lamented the widening rural–urban divide, noting that "for many years the rural–urban gap has been widening in terms of income, wages, and terms of trade, as well as in the distribution of social amenities such as healthcare, transport, and recreational facilities."[73] This disparity, which has endured for decades with minimal improvement, has been linked to increased urbanisation coupled with stagnation or decline in rural development, particularly in agricultural productivity, educational provision, and healthcare services. In response, the Zambian government-initiated health sector reforms in 1992 aimed at addressing systemic weaknesses

[73] CCZ, EFZ, ZEC., *Christian Liberation, Justice, and Development*: *The Church's Concern for Human Development* (February 1987), no. 32.

in service delivery. However, many of the challenges that hinder equitable healthcare provision remain unresolved, especially in rural areas where access to medical services is often severely limited.

Against this backdrop, this section explores how the Catholic bishops, informed by the Church's social teaching and pastoral concern for the most vulnerable, have sought to address these inequalities and contribute to the enhancement of healthcare access in Zambia.

4.2.1 The Catholic Church's Role in Healthcare Delivery in Zambia

The Catholic Church in Zambia has been actively involved in healthcare delivery since the arrival of the first missionaries in the late nineteenth century. According to the Churches Health Association of Zambia (CHAZ), there are currently 162 affiliated Church Health Institutions (CHIs), collectively providing approximately 50% of healthcare services in rural and hard-to-reach areas.[74] The majority of these CHIs are administered by the Catholic Church. Most of these Catholic healthcare institutions began as small infirmaries or parish dispensaries, established by missionaries as part of their broader pastoral and social mission to respond to the needs of local communities. Over time, these modest mission-based healthcare initiatives have expanded and developed into fully fledged referral hospitals. The establishment of such healthcare facilities has always been intrinsically linked to the Church's mission of evangelisation, which encompasses both the proclamation of the Gospel and the ministry of healing (cf. Luke 9:1–2). It is worth noting that, for early missionaries, healthcare and education served not only as essential social services but also as effective avenues for evangelisation.

From the outset, Catholic healthcare services have been inclusive, catering to all individuals regardless of religious affiliation. This commitment reflects the Church's enduring vision of contributing to the creation of a healthy Zambian nation in which every citizen can enjoy physical, mental, and social well-being. Through sustained investment in infrastructure development and ongoing healthcare advocacy, the Catholic Church has played, and continues to play, a vital role in improving the accessibility and quality of healthcare in Zambia.

Rather than establishing an independent association dedicated solely to Catholic health institutions, the Catholic Church in Zambia has consistently chosen to collaborate with other faith-based organisations in the health sector. While this ecumenical approach has fostered unity, resource-sharing, and a common front in addressing national health challenges, it has also had certain drawbacks. One notable consequence is the delay in formulating distinct ethical guidelines tailored

[74] Churches Health Association of Zambia (CHAZ), https://www.chaz.org.zm/index.php/about-chaz/#:~:text=The%20Churches%20Health%20Association%20of,government%20health%20provider%20in%20Zambia.

specifically for Catholic hospitals. As a result, Catholic health facilities often operate under broader interfaith frameworks, which may not always fully capture or safeguard the unique moral and doctrinal principles that guide Catholic medical practice.

4.2.2 Health Policy for the Catholic Church in Zambia.

Health Policy for the Catholic Church in Zambia represents the first systematic effort by the Zambia Conference of Catholic Bishops (ZCCB) to establish national guidelines for Catholic healthcare institutions. Issued in 2007, the policy provides a general ethical framework for Catholic healthcare facilities and identifies priority areas aimed at improving the health status of the population. Importantly, this policy also contributed to the recognition of the fundamental right to healthcare within Zambian law. The document opens with a declaration on the sanctity and dignity of the human person, affirming marriage as the proper context for the transmission of new life. It underscores the Church's position that, "The Church has the deepest respect for the family, for the marriage covenant, and for the love that binds a married couple together. This includes respect for the marriage act by which husband and wife express their love and cooperate with God in the creation of a new human being."[75] The policy establishes the principle that the transmission of life is grounded primarily in the marital act.

Consequently, Catholic healthcare institutions are called to support couples in exercising responsible parenthood through natural means. At the same time, the policy recognises the challenges faced by couples who experience infertility and acknowledges the growing availability of reproductive technologies. However, it cautions that technical feasibility does not automatically equate to moral acceptability. In line with Catholic teaching, the policy maintains that reproductive technologies which substitute for the marital act are inconsistent with human dignity.[76] Accordingly, Catholic healthcare institutions are encouraged to guide couples towards morally acceptable approaches, including natural methods of addressing infertility. In cases where infertility cannot be resolved, the policy recommends alternative solutions such as adoption.

On the ethical front, the policy directs all Catholic health institutions to uphold the principle that "the Church's healthcare ministry witnesses to the sacredness of life from the moment of conception until death."[77] This doctrine serves as the foundation for all processes and procedures within Catholic health facilities. Building on the Church's long-standing opposition to the legalization of abortion in

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[75] Zambia Conference of Catholic Bishops (ZCCB), *Health Policy for the Catholic Church in Zambia* (Lusaka: Catholic Secretariat, 2007), no. 8.

[76] ZCCB, *Health Policy for the Catholic Church in Zambia*, no. 2.

[77] ZCCB, *Health Policy for the Catholic Church in Zambia*, no. 1.

1972, the Zambia Conference of Catholic Bishops (ZCCB) reaffirmed that the Church cannot endorse any form of contraceptive intervention, whether pursued as an end in itself or as a means to prevent procreation.[78] They restated their uncompromising stance against abortion, clarifying that the intentional ending of a pregnancy, whether prior to viability or through the deliberate destruction of a viable foetus, can never be permitted.[79] Accordingly, Catholic healthcare institutions are strictly prohibited from providing abortion services. In addition, the policy instructs healthcare workers within these institutions to refrain from any form of cooperation, whether material or formal, in the act of direct abortion.

The principle of the sacredness of life imposes a fundamental obligation of stewardship upon all who are engaged in healthcare processes and procedures. Stewardship, in this context, signifies that human beings are neither owners nor masters of life, but rather custodians entrusted with its preservation and care. Accordingly, every individual bears the responsibility not only to safeguard their own life but also to direct it toward the glory of God and the service of the common good. In cases of illness, the policy stipulates that each person has a moral duty to employ proportionate means to preserve life. Nevertheless, it acknowledges that human existence will inevitably be marked by illness, suffering, and death, even when the best available methods of preserving life are applied.[80] Notably, the policy does not address in detail the issue of long-term, critical end-of-life care. This omission is particularly significant given the limited availability of such services in many rural health centres where the Church operates. It therefore underscores the need for a proactive response within the Church's healthcare advocacy initiatives.

Pastoral care for the sick, particularly for those receiving end-of-life care, constitutes a fundamental dimension of healthcare. The Church's commitment to pastoral and spiritual support for the sick is grounded in the conviction that healthcare extends beyond the treatment of disease; it encompasses the restoration of the person's integral well-being—body and soul.[81] When the prospects of healing and recovery are no longer attainable, pastoral care seeks to prepare both the patient and the family for death. This preparation includes the opportunity for the sick to receive the sacraments of reconciliation, the anointing of the sick, and the Eucharist in the form of *viaticum*.[82] Within Catholic teaching, human dignity is understood as having been redeemed by Jesus Christ, such that even in the

[78] ZCCB, *Health Policy for the Catholic Church in Zambia*, no. 2.
[79] ZCCB, Health Policy for the Catholic Church in Zambia, no. 10.
[80] Irish Catholic Bishops' Conference, ……
[81] Pontifical Council for Health Pastoral Care, 1995.
[82] *Catechism of the Catholic Church*, nos. 1499–1532.

face of death, the faithful are called to embrace the hope of eternal life.[83] Accordingly, the integration of pastoral care into healthcare requires close collaboration between health workers, clergy, parishes, and other religious leaders and communities, to provide services such as counselling and the sacraments. Moreover, the Church emphasizes that all patients, regardless of religious belief, ethnicity, nationality, or political affiliation, should be afforded both physical and spiritual support when confronted with illness or the end of life.[84]

Furthermore, the policy directs Catholic healthcare facilities to align their programmes with the National Health Reforms initiated in 1992, which pledged to "provide Zambians with equity of access to cost-effective, quality healthcare as close to the family as possible."[85] Despite this vision, the goal of ensuring equal access to healthcare in Zambia remains largely unrealized. Successive national health plans have reiterated this commitment, yet progress towards universal health coverage has been limited, with many pledges lapsing without substantial implementation. One significant factor contributing to persistent inequities in healthcare access is the absence of an explicit constitutional or legislative guarantee of the right to healthcare in Zambian law.[86] Notably, the Zambia Conference of Catholic Bishops' (ZCCB) health policy does not sufficiently address this legal lacuna. Within the current socio-economic and political context, effective legislative oversight is necessary to ensure that health outcomes prioritize the needs of the poor and marginalized. This highlights the broader imperative for Zambian society to consider making socio-economic and cultural rights justiciable, thereby strengthening accountability mechanisms for their realization. In addition to legal and policy gaps, structural barriers continue to hinder universal healthcare coverage. These include inadequate health infrastructure, poor transport networks, long distances to health facilities, and recurrent shortages of essential drugs and medical supplies.[87] Addressing these challenges requires not only improved resource allocation but also sustained collaboration between state actors, faith-based providers, and civil society.

Additionally, the policy highlights the prevailing burden of disease in Zambia and calls for stronger collaboration between government and non-state actors to alleviate human suffering. The key health and healthcare-related issues identified include food insecurity and malnutrition, HIV/AIDS,

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[83] John Paul II, *Evangelium Vitae*, ...

[84] Second Vatican Council, *Gaudium et Spes*,

[85] ZCCB, *Health Policy for the Catholic Church in Zambia*, no. 19.

[86] Zambia Law Development Commission, "The Right to Food in Zambia." https://www.zldc.org/the-right-to-food-in-zambia/?utm_source=chatgpt.com.

[87] Zambia Ministry of Health, *National Health Strategic Plan 2017–2021* (2016), 3. https://extranet.who.int/countryplanningcycles/sites/default/files/public_file_rep/ZMB_Zambia_National-Health-Strategic-Plan_2017-2021.pdf.

malaria, tuberculosis, sexually transmitted infections, the orphan crisis, and gender disparities. Food security and nutrition are given particular priority, as they represent the most significant contributors to ill health, especially in rural communities. The policy notes that nutritional levels remain generally low for many Zambians.[88] Contributing factors to food insecurity include poor farming techniques, inadequate access to agricultural inputs, limited market access, and poor road infrastructure. Gender inequality is also emphasized as a special area of concern. Women, who disproportionately shoulder the responsibility of family care, often lack an equal voice in decision-making processes. The policy therefore encourages Catholic healthcare ministries to engage with communities in initiatives aimed at reducing gender imbalances, many of which are reinforced by cultural and traditional practices.[89] Beyond malnutrition, HIV/AIDS has been one of the most devastating public health challenges since the late 1980s. The epidemic has resulted in the loss of some of the most active and productive members of society, while also driving an unprecedented increase in the number of orphans, further straining families and communities.

One significant observation regarding the *Health Policy for the Catholic Church in Zambia* is that the document does not function as a code of ethical directives. Rather than presenting a formal framework of ethical standards, it describes the nature and mission of the Catholic healthcare ministry. The policy is best understood as a program of action that directs Catholic healthcare facilities toward addressing the most pressing health challenges within their catchment areas. With a particular emphasis on rural communities, Catholic healthcare centres also engage in broader social transformation, including efforts to shift power dynamics between men and women, especially in relation to household economics and food security. Although women often have limited influence in decision-making, experience has shown that they are central to efforts aimed at eradicating poverty and improving food security for smallholder households. For instance, the *Mawa Project*, piloted by Catholic Relief Services (CRS) in Eastern Province, demonstrated that household food security and nutrition improved significantly when women were empowered to make decisions on non-cash crops cultivated primarily for home consumption.[90] The success of such initiatives was closely linked to the work of community healthcare agents, who combined clinical responsibilities with the promotion of hygiene and nutrition education.

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[88] ZCCB, *Health Policy for the Catholic Church in Zambia*, no. 47.

[89] ZCCB, *Health Policy for the Catholic Church in Zambia*, no. 46.

[90] Catholic Relief Services, *Mawa Project*: *Zambia Economic Resilience Program for Improved Food Security* (Lusaka, 2012), 9.

Among the guiding principles of the policy is the recognition of the right to healthcare, framed through the promotion of equality, non-discrimination, fairness, and justice, alongside advocacy for increased investment in the health sector.[91] It is both desirable and necessary that the promotion of the right to healthcare be explicitly articulated in such a policy document. Once the Church begins to advocate more clearly for this right, the likelihood of its incorporation into national laws increases. This is a right that the Zambia Conference of Catholic Bishops (ZCCB) can confidently promote, as it is firmly rooted in Catholic social teaching, affirmed by the United Nations Charter on Human Rights, and integral to the dignity and equality of every human person. Moreover, the ZCCB has a demonstrable history of influencing public policy and legislation in Zambia, providing a strong basis for its continued advocacy in the area of healthcare rights and environmental justice.

In addressing the dignity of human life at its beginning, the policy states that reproductive technologies that replace the marital act are viewed as incompatible with the dignity of the human person.[92] It affirms that any form of medically assisted reproduction must respect the Catholic Church's teaching on the sanctity of marriage, the dignity of human life, and the unitive and procreative dimensions of the marital act.[93] However, the policy does not provide specific guidance on which reproductive methods are morally acceptable and which are not. According to Corkery, procedures that substitute for the conjugal act, such as in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), and intra-cytoplasmic sperm injection (ICSI), are deemed inconsistent with Catholic teaching.[94] By contrast, interventions that assist the conjugal act and support its natural fertility, such as surgery, pharmaceutical treatment, or NaProTechnology, are morally permissible. Ethical approaches like NaProTechnology offer hope for couples experiencing infertility, enabling them to pursue conception in a way that upholds both the dignity of the child and the integrity of marriage.

The absence of a detailed list of permitted and prohibited reproductive methods in the Zambian Catholic health policy raises questions. One plausible explanation is that, at the time of drafting, assisted reproductive technologies were not widely available in Zambia, and the bishops were therefore more focused on articulating doctrinal principles than on confronting concrete practices. Nevertheless, the growing number of fertility clinics in the country indicates a rapid increase in the adoption of artificial reproductive technologies. In this context, the bishops' responsibility to provide authoritative teaching on these issues has become increasingly urgent.

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[91] ZCCB, *Health Policy for the Catholic Church in Zambia*, no. 58.
[92] ZCCB, *Health Policy for the Catholic Church in Zambia*, no. 2.
[93] ZCCB, *Health Policy for the Catholic Church in Zambia*, no. 2.
[94] Corkery, *Bioethics and the Catholic Moral Tradition*, 55.

The issues surrounding care for the dying have long been central to healthcare discourse. While the debate on euthanasia is only remotely addressed in Zambia, serious ethical concerns remain regarding the withdrawal of treatment or feeding, decisions that are often left to the discretion of a single doctor due to the existing shortage of personnel. It is therefore surprising that the national health policy merely provides a general directive that individuals have a moral obligation to use proportionate means of preserving life, without further clarification of what constitutes proportionate or disproportionate means. Moreover, the formation of conscience, crucial in making decisions in morally complex situations, should have been emphasized by the bishops, whose pastoral duty includes guiding and shaping consciences. Since the beginning of campaigns promoting women's reproductive health, there has been an intensified dissemination of information on contraception and abortion. To prevent the faithful from being left vulnerable to pressure to accept such practices, the ZCCB must be unequivocal in articulating the Church's position. Emerging innovations in reproductive health can easily confuse many, and clear guidance from the Church can help the faithful make informed and morally grounded decisions. Finally, while it is evident that the ZCCB healthcare policy is rooted in Gospel values and the principles of Catholic Social Teaching (CST), the document does not elaborate sufficiently on some of these principles or their broader scriptural foundations. CST provides a rich framework for addressing healthcare ethics and practices. This study, in particular, is grounded in the principles of the universal destination of goods, the preferential option for the poor, and the common good, each of which is essential to ensuring equal access to adequate healthcare.

4.2.3 HIV/AIDS and the Response of the Catholic Bishops in Zambia

HIV/AIDS has been one of the most pressing health concerns shaping the healthcare interventions of the Catholic Bishops of Zambia for the past four decades. The devastating impact of the disease drew significant attention not only from civil authorities but also from the Church. Key areas of concern included prevention, access to medication, care, and support for those infected and affected. The HIV/AIDS pandemic began manifesting its destructive effects in Zambia in the early 1980s, at a time when it was surrounded by myths, misconceptions, and conspiracy theories. In response to the growing crisis, the Zambia Interfaith Networking Group (ZINGO) was established in 1997 to coordinate efforts, foster networking, build competencies, and mobilize both technical and material resources for religious communities willing to engage more actively in HIV/AIDS prevention, care, and support interventions.

ZINGO brings together seven faith mother bodies, including the four major Christian church mother bodies in Zambia: the Council of Churches in Zambia (CCZ), the Evangelical Fellowship of Zambia

(EFZ), the Independent Churches of Zambia (ICOZ), and the Zambia Conference of Catholic Bishops (ZCCB), formerly known as the Zambia Episcopal Conference (ZEC). Alongside these are three non-Christian faith mother bodies: the Islamic Supreme Council of Zambia (ISCZ), the National Spiritual Assembly of the Baha'i (NSAB) in Zambia, and the Hindu Association of Zambia (HAZ). Together, these faith mother bodies share a common vision of fostering an interfaith community that contributes to national development.

The response of religious leaders to the HIV/AIDS crisis was significantly shaped by powerful personal testimonies from those affected and infected. A turning point came on December 21, 1986, when Masuzgo Gwebe Kaunda, the son of Zambia's founding President, Dr. Kenneth David Kaunda, passed away. One year later, Dr. Kaunda publicly announced that his son had died of AIDS.[95] This bold declaration underscored the severity of the epidemic and highlighted the urgent need to confront stigma, one of the greatest barriers preventing people from disclosing their HIV status or seeking care. In the same year, Winstone Zulu became the first Zambian to publicly acknowledge his HIV-positive status.[96] His courageous testimony, alongside Dr. Kaunda's revelation, exposed the grim reality of the epidemic and laid the foundation for an urgent, coordinated response. Among the most notable faith-based interventions was the pastoral statement issued by Christian church leaders titled *Choose to Live*, which provided an ecumenical response to the crisis. Additionally, the Zambia Catholic Bishops published a dedicated pastoral document on HIV/AIDS entitled *Have Life to the Full*. The following sections, examine these documents more closely, highlighting their contributions to addressing the challenges of HIV/AIDS in Zambia.

4.2.4 *Choose to Live*: An Ecumenical Call to Halt the Spread of HIV/AIDS

The central thrust of *Choose to Live* was to curb the spread of HIV/AIDS through the dissemination of accurate and reliable information. It is often said that "information is power" and that "to be forewarned is to be forearmed." In this spirit, the document emphasized that people needed adequate knowledge about HIV/AIDS in order to safeguard themselves against contracting the deadly virus.

One of the critical issues the pandemic exposed was the lack of formal sexual health education in Zambia. *Choose to Live* (1988) responded to this gap as an ecumenical document jointly prepared by the three main Church bodies in Zambia: the Zambia Conference of Catholic Bishops (ZCCB), the

[95] The Correspondent, "Zambian, in Appeal, Says Son Died of AIDS," *The New York Times* (October 5, 1987). https://www.nytimes.com/1987/10/05/world/zambian-in-appeal-says-son-died-of-aids.html.

[96] Mercedes Sayagues, "Zambia's First HIV Activist Loses Battle for Life but Wins Fight for Change." *ICFJ* (October 18, 2011). https://www.icfj.org/news/zambias-first-hiv-activist-loses-battle-life-wins-fight-change.

Christian Council of Zambia (CCZ), and the Evangelical Fellowship of Zambia (EFZ). Drawing on data from the extensive network of Church medical centres, the Church leaders were able to grasp the devastating impact of the epidemic. Faced with widespread misinformation, fragmented messaging, and rising infection rates, they recognized the urgent need for all stakeholders to provide an accurate and coordinated account of the pandemic.

Although *Choose to Live* was primarily intended to educate people about HIV/AIDS, it also functioned as an important form of formal sexual health education in Zambia. At a time when there was no cure, treatment, or vaccine for HIV/AIDS, health education became far more than the simple dissemination of information—it was a critical tool for prevention and survival. The document helped people understand the progression of the disease through the imagery of a pyramid: "At the base are normal looking but infected individuals. At the top are those who have developed AIDS and are very sick. It is believed that all those at the base of the pyramid will eventually move to the top."[97] This analogy was vital in conveying the hidden nature of the virus and the urgency of early prevention. HIV/AIDS was widely recognized as a sexually transmitted disease, with approximately 95% of infections in Zambia being sexually related.[98] This reality made comprehensive sexual health education, rooted in moral and social responsibility, an indispensable part of the Church's response.

The statistical information presented in *Choose to Live* did little to reduce fear among the population; rather, it heightened anxiety instead of providing practical guidance on how to avoid infection. By attributing the spread of HIV/AIDS largely to casual and indiscriminate sexual relationships, framed as the result of imported philosophies that separated sex from the institution of marriage, the document, to some extent, diverted attention from society's broader responsibility to provide formal sexual health education. Without a well-formed and informed population, the mere distribution of contraceptives and condoms was unlikely to have a significant impact on sexual practices.[99] Over time, however, *Choose to Live* turned to be an important tool for peer education and facilitated open discussions on HIV/AIDS across different age groups. Central to its message was the emphasis on personal responsibility for behavioural change as the most effective way to stop the spread of the disease. The bishops reminded the faithful that safeguarding one's own health and that of others is an enduring moral duty. This responsibility included avoiding multiple sexual partners and exercising restraint in personal relationships.

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[97] Zambia Episcopal Conference (ZEC), Christian Council of Zambia (CCZ), and Evangelical Fellowship of Zambia (EFZ), *Choose to Live*: *Reflection on the AIDS Crisis from Christian Churches in Zambia* (Lusaka, January 1988), #11.

[98] ZEC, CCZ, and EFZ, *Choose to Live*, no. 21.

[99] ZEC, CCZ, and EFZ, *Choose to Live*, no. 23.

For those already infected, the responsibility was twofold: a moral duty and a duty of charity. They were urged to abstain from sexual activity or, at the very least, to disclose their HIV status to their partners. For the unmarried and uninfected, the choice of chastity was presented as an act of solidarity with those who were suffering from the disease. Solidarity was also to be expressed through concrete acts of care for the sick and support for affected families.[100] With hospitals overwhelmed by the rising number of long-term patients, families were encouraged to take in loved ones with AIDS for palliative care, while at the same time developing community-based frameworks to support the growing population of orphans left in the wake of the pandemic.

One of the most significant achievements of *Choose to Live* was its role in halting the Ministry of Health's proposal to terminate the pregnancies of all HIV-infected mothers.[101] This proposal represented a direct attack on innocent life and would have opened the door to the systematic abortion of foetuses of HIV-positive women. The Christian leaders strongly demanded respect for human life, which they affirmed as sacred from the moment of conception. As subsequent events demonstrated, many children were born to infected mothers free of HIV/AIDS. The Church leaders also opposed the ABC (Abstinence, Be Faithful, and Condom) approach because of its inclusion of condoms. Upholding their apostolic mandate to promote Christian values on matters of sexuality, the leaders emphasized that sexual activity is sacred and should be reserved for couples faithful to one another.[102] While the Zambian Ministry of Health and civil society organizations mounted vigorous campaigns promoting the ABC strategy, the Christian leaders maintained the Church's teachings on abstinence for the unmarried and faithfulness for the married.

Choose to Live became an important formal instrument for sexual health education, reinforcing moral responsibility while providing practical guidance on preventing infection. The document also contributed significantly to reducing the stigma associated with HIV/AIDS; infected individuals were no longer forced into isolation or subjected to separate utensils. Furthermore, the pastoral guidance in *Choose to Live* laid the foundation for the development of community-based home care programs, marking the beginning of structured support for both patients and affected families.

In essence, the document placed strong emphasis on the formation of conscience, recognizing it as the foundation for making responsible moral choices in the face of the HIV/AIDS crisis. This point was underscored by Justin Matepa when he asserted that "Education in the right moral principles is thus another key to formation of conscience. We cannot make good moral choices unless our moral

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[100] Komakoma, *The Social Teaching of the Catholic Bishops*, 21.
[101] ZEC, CCZ, and EFZ, *Choose to Live*, no. 58.
[102] Komakoma, *The Social Teaching of the Catholic Bishops*, 25.

compass is correctly pointed."[103] By appealing to conscience, *Choose to Live* sought to help individuals and communities internalize values of honesty, responsibility, and self-discipline, rather than merely relying on external rules or fear-based approaches. The Church leaders understood that long-term transformation required people to develop the moral capacity to freely choose life-giving behaviours, such as abstinence before marriage, fidelity within marriage, and compassionate care for those infected, over destructive practices. The focus on conscience also reflected the broader Christian conviction that authentic human freedom is not simply the ability to choose, but the ability to choose what is right and life-giving. Thus, the document went beyond offering medical facts about HIV/AIDS; it aimed to shape the moral outlook of the faithful, equipping them to respond to the epidemic with both wisdom and compassion.

4.2.5 *Have Life to the Full*: A Pastoral Response to HIV/AIDS

The pastoral letter *Have Life to the Full*, issued by the Catholic Bishops of Zambia, is a document rooted in hope, liberation, and restoration, drawing inspiration from Luke 4:18–19. It serves as both a theological and educational tool, particularly on matters of sexual health. The bishops structured the letter around a threefold mandate: *prophetic*—announcing the good news while denouncing immorality; *advocacy*—speaking on behalf of the voiceless; and *mediation*—taking practical action in caring for the sick.[104] In doing so, the bishops presented themselves not only as teachers but also as shepherds accompanying their flock through a time of crisis. The pastoral letter was released at a stage when many continued to die in silence, secrecy, denial, and fear of stigmatization.[105] The bishops candidly observed: "In many parts of the world sickness and death from AIDS had become a thing of great shame. In Africa too, families tried to hide their tragic misfortune. They camouflaged its presence as tuberculosis (T.B.) or some other wasting disease. Under the veil of secrecy, the AIDS pandemic flourished and even spread further."[106] This secrecy was largely fuelled by the growing stigma and discrimination against people living with HIV/AIDS, which led many to avoid testing or treatment altogether. As Michael Kelly lamented, "stigma and discrimination kill because they stop people from

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[103] Justin Matepa, *Moral Truth*: *Insights of John Paul II and the Formative Role of Conscience* (Saarbrucken: LAP LAMBERT Academic Publishing, 2013), 80. Fr. Matepa is a Zambian Diocesan priest from the Diocese of Mpika. He studied at St. Mary's Seminary and University in Maryland, USA. He holds a Licentiate degree in Moral Theology. He worked as the National Pastoral Secretary for the Zambia Conference of Catholic Bishops before being appointed Diocesan Administrator for Mpika Diocese in April 2020, where he worked for one and half years. He is now Lecturer at St. Dominic's National Major Seminary in Lusaka, Zambia.

[104] Zambia Episcopal Conference (ZEC), *Have Life to the Full*: *A Pastoral Letter from the Catholic Bishops of Zambia on the HIV/AIDS Pandemic* (Lusaka: Kapingila House, 2002), no. 2.

[105] ZEC, *Have Life to the Full*, no. 10b.

[106] ZEC, *Have Life to the Full*, no. 3

coming forward for testing and life-preserving therapy."[107] The communal way of life in Zambia further complicated the matter. Within the tight-knit family and community structures, medical confidentiality was difficult to maintain, as the HIV status of an individual often became known to family and neighbours, sometimes leading to even greater marginalization.

In their prophetic role, the Catholic bishops acknowledged that *Have Life to the Full* was written with deeper insight, having drawn on new information and lived experiences.[108] The document thus reflected a careful reading of the *signs of the times*. Among Zambia's most iconic and prophetic voices in the fight against HIV/AIDS was Fr. Michael Kelly, whose pioneering work shaped both public understanding and pastoral responses to the epidemic. In 1989, Fr. Kelly established the Kara Counselling Centre—an institution dedicated to counselling, testing, and reducing the stigma surrounding HIV. It was the first organized and institutionalized educational programme on HIV/AIDS in Zambia.[109] Through this initiative, it became increasingly evident that some people could live far longer than the previously assumed five-year survival span after contracting the virus.

This marked a significant shift in teaching and response: the focus expanded beyond prevention to include nutrition, holistic care, and the promotion of "positive living." Positive living emphasized avoiding re-infection, treating opportunistic illnesses, maintaining good nutrition, and ensuring adequate rest. The outcome of this new approach was to help people "walk back to life," offering hope and renewed strength even in the absence of widespread access to antiretroviral therapy at the time. Personal responsibility remained central to this approach. Recognizing that behaviour change was possible, the bishops promoted peer education as a vital tool. They also reaffirmed the Christian understanding of sexual ethics, emphasizing that "safe sex" or "protected sex" meant abstinence before marriage and fidelity within marriage.[110]

Access to therapeutic programmes for people living with AIDS—such as hospice care and nutritional support—was becoming increasingly limited. In response, the Catholic bishops, through their advocacy, called for equal access to every available therapeutic intervention. The establishment of the National AIDS Council (NAC) was intended to streamline treatment and nutritional support; however, its initial composition excluded Church leaders. The Catholic bishops, together with other

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[107] Irish Aid and Irish Global Health Network, *From Zambia to Ireland*: *15 Years of Insights on HIV and AIDS*, 10. https://globalhealth.ie/wp-content/uploads/2021/11/From-Zambia-to-Ireland-15-Years-of-Insights-on-HIV-and-AIDS.pdf. Professor Fr. Michael Kelly was a Zambian-Irish priest well-known for his advocacy on HIV-AIDS, gender and other health matters. From 2006 to 2020, Prof. Kelly gave an annual lecture at the Royal College of Surgeons in Ireland (RCSI) based on his work in Zambia and his publications.

[108] ZEC, *Have Life to the Full*, no. 1

[109] USAID, *HIV/AIDS Care and Support Capacity and Needs in Zambia*: *An Assessment in Four Districts* (December 2002), 30. https://pdf.usaid.gov/pdf_docs/Pnacu851.pdf.

[110] ZEC, *Have Life to the Full*, no. 8.

religious leaders, strongly argued that their inclusion in the NAC would amplify the voice of the poor and ensure more just policies.[111] The bishops consistently advocated for greater allocation of both human and material resources to the fight against HIV/AIDS. They also insisted that mechanisms be put in place to guarantee food and job security for the poor, recognizing that poverty and hunger created conditions in which AIDS thrived. A central aspect of their advocacy was the demand for universal and equal access to free antiretroviral drugs. Grounding their stance in the principle of the preferential option for the poor, the bishops emphasized that special attention must be given to the most vulnerable. Adequate access to life-saving drugs, along with nourishment rich in proteins, vitamins, and essential minerals, was seen as not only a medical necessity but also a moral imperative.

While continuing to prioritize education, the bishops also collaborated with various agencies to achieve more positive outcomes in the fight against HIV/AIDS. One of the most impactful initiatives was the introduction of *Youth Alive Zambia*, inspired by Uganda's successful response that reduced infection rates from 30% to 8% over two decades through behaviour change in attitudes, lifestyles, and practices. This programme specifically targeted young people, the group most at risk of contracting HIV. *Youth Alive Zambia* promoted awareness campaigns that emphasized human and moral values, while fostering chastity and faithfulness as key strategies for prevention. The programme relied heavily on the power of peer influence as its primary mechanism for change. Remarkably, its impact was felt almost immediately, as young people began adopting healthier attitudes and choices.

Peer influence has remained a powerful tool for social transformation in Zambia, particularly among the youth. As a social dynamic, it shapes attitudes, behaviours, and decision-making processes, often more effectively than formal instruction. In the context of HIV/AIDS prevention and education, peer influence has been harnessed to promote positive values such as responsibility, chastity, and fidelity, while discouraging risky behaviours.[112] Beyond health, peer influence has also contributed to broader social change by fostering solidarity, building confidence, and encouraging active participation in community development. Among young people, who are often more receptive to advice and example from their peers than from authority figures, this approach has proven especially impactful. When effectively structured through programmes such as *Youth Alive Zambia*, peer influence becomes not only a channel of information but also a sustainable force for shaping attitudes and practices that contribute to long-term transformation in society.

Have Life to the Full emphasized the restoration of health for those infected, the support of affected families, and the rebuilding of communities devastated by the HIV/AIDS pandemic. Yet new

[111] ZEC, *Have Life to the Full*, no. 11.
[112] ZEC, *Have Life to the Full*, no. 9.

challenges quickly emerged, particularly the growing number of patients requiring long-term hospitalization and the increasing population of orphaned children. In response, Catholic parish-led home-based and community-based care initiatives made an immediate impact, as they were widely embraced by families across Zambia.[113] The response to HIV/AIDS evolved alongside a deeper understanding of the disease. While the initial reaction was often marked by fear, accusations, stigma, and ultimatums, this document not only provided reliable information about HIV/AIDS but also offered guidance, encouragement, and hope—helping those infected to resist viewing the virus as a "death sentence." Most importantly, the community became deeply involved in caring for those who were infected and affected, providing support, comfort, and essential assistance to help them through their difficult circumstances.

4.2.6 Poverty, Food Security, and Adequate Nutrition

As this study has shown, healthcare can no longer be considered in isolation from its social determinants. In Zambia, poverty and inadequate nutrition are among the most significant social factors affecting health outcomes. Poverty, in particular, is a major underlying barrier to accessing adequate healthcare, and the poor face persistent and recurrent healthcare challenges. The HIV/AIDS pandemic further exacerbated these vulnerabilities. Scholars have also identified food insecurity, malnutrition, and diseases such as malaria and tuberculosis as contributing factors to Zambia's struggle to achieve universal healthcare. For example, Peter Henriot provides a historical overview of the country's broader challenges, highlighting the profound impact of poverty on healthcare access and delivery:

> Because of its copper wealth, Zambia was one of the richest of the newly independent African states. But today it is one of the poorest. Its economic difficulties, accompanied by decline in social services and deterioration of infrastructure, were caused by (1) a development model inherited from the colonial period (e.g., over-reliance on copper as an export-earner, under-appreciation of agriculture), (2) a series of policy decisions (e.g., adoption of an inefficient controlled economy model, closing of the border to Rhodesia), and (3) negative external structural forces (e.g., declining price of copper, rising price of petrol and other imported goods, increasing foreign debt burden).[114]

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[113] ZEC, *Have Life to the Full*, no. 10.

[114] Peter Henriot, "Zambia: A Case Study of Economic Reform and the Impact on the Poor." *The Jesuit Centre for Theological Reflection* (Lusaka, 1996), 1. https://core.ac.uk/download/pdf/335024755.pdf. "**Peter Henriot, S.J.** is an internationally respected Jesuit researcher, speaker and writer on social justice, globalization and Africa. He has worked in Zambia since 1990, he has been the director of the Jesuit Center for Theological Reflection (JCTR) in Lusaka. JCTR assists the local church and other groups in matters of political, economic and social justice concerns, through research, education, advocacy and consultation. Their work includes studies on constitutional reform, good governance, poverty eradication, debt cancellation, education for justice, theological reflection. He was also the director of the Center of Concern in Washington, DC, from 1978 to 1988. The Center of Concern is a project founded by the United States Catholic Conference and the Society of Jesus to promote study and advocacy on social issues. He is the author of numerous articles,

All these factors paint a troubling picture of increasing suffering as poverty in Zambia became more widespread and entrenched. Most pastoral letters issued by the Catholic bishops of Zambia have emphasized social justice, particularly focusing on poverty eradication and sustainable development. This emphasis is understandable, given that more than 60% of Zambians live below the poverty line.[115] The main drivers of poverty in the country include: "an inherited structural economic weakness; a harsh Structural Adjustment Programme that removed subsidies, imposed service fees, and caused retrenchments; a series of droughts (three out of the past four years) that drastically reduced agricultural output and necessitated costly food imports; and the rapid spread of HIV/AIDS, which has disproportionately affected the younger, productive age group."[116]

The majority of the poor in Zambia face low household incomes, inadequate nutrition and healthcare, and limited wealth-generating opportunities. In response, the Catholic bishops have prioritized agricultural and rural development under the broader framework of economic justice.[117] This focus is guided by the principle of the preferential option for the poor, a cornerstone of Catholic social teaching, which emphasizes the moral obligation to prioritize the needs and rights of the most marginalized and disadvantaged members of society. Zambia's rural areas frequently experience higher levels of poverty than urban centres due to limited access to essential services such as education, healthcare, and employment opportunities.

Practically, the preferential option for the poor in rural Zambia translates into formulating inclusive economic policies, empowering communities through education and vocational training, promoting increased community participation, and improving access to resources and technology. For example, Pope Benedict XVI, in *Caritas in Veritate*, underscores the importance of equitable agrarian reform and the right to food, principles crucial for sustainable rural development.[118] Three consecutive pastoral letters exemplify the bishops' commitment to these issues: *Economics, Politics, and Justice* (1990), *The Future is Ours* (1992) and *Hear the Cry of the Poor* (1993).

Collectively, these pastoral letters underscore the Church's sustained commitment to alleviating poverty and promoting social and economic justice in Zambia, recognizing that economic well-being is intrinsically linked to the health of the population. By addressing structural inequalities, improving

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scholarly and popular, on socio-economic development and on church's social teaching. He is the co-editor of *The Pastoral Circle Revisited: A Critical Quest for Truth and Transformation*; co-author of Catholic *Social Teaching: Our Best Kept Secret;* co-author of *Social Analysis: Linking Faith and Justice*, and author of *Opting for the Poor: The Challenge for the Twenty-First Century*" (Social Justice Resource Center. https://socialjusticeresourcecenter.org/biographies/henriot-sj-peter/.

[115] ZCCB, *Strategic Plan 2017-2026*, 17.

[116] Henriot, "Zambia: A Case Study of Economic Reform," 3.

[117] Komakoma, *The Social Teaching of the Catholic Bishops*, 12.

[118] Benedict XVI, *Caritas in Veritate* (June 29, 2009), 27.

access to food, education, and healthcare, and advocating for policies that empower the marginalized, the Church sought to create conditions in which individuals and communities could thrive physically, socially, and spiritually. In this way, poverty reduction and social justice were not treated as isolated moral concerns but as essential components of a comprehensive strategy to enhance public health, reduce vulnerability to disease, and foster resilient, sustainable communities.

4.2.6.1 The Pastoral Letter *Economics, Politics, and Justice*

The pastoral letter *Economics, Politics, and Justice* is regarded as one of the most significant documents issued by the Catholic bishops of Zambia. The editor's note sets the context of the letter: "June 1990 was a tumultuous time in Zambia, marked by a week of deadly riots triggered by increases in the price of mealie meal, followed by an attempted military coup. The Catholic bishops responded with a pointed letter, identifying the suffering of the poor as the immediate cause of the turmoil and the lack of government accountability as the root of the nation's problems."[119] The hardships faced by the population were driven by food shortages, rising food prices, and limited employment opportunities, all of which exacerbated poverty. In urban areas, poverty was primarily fuelled by high unemployment rates and rapid population growth due to internal migration. In rural communities, poverty was compounded by declining agricultural production. In a non-industrialized country like Zambia, agriculture remains the primary source of income, food security, and wealth creation.

While the government has provided some support to help rural households produce sufficient food and generate surplus for sale, the agricultural sector continues to struggle. Persistent challenges include diminishing productivity, limited access to financial services, poor market engagement, and unsustainable farming practices. Additional constraints such as limited land availability and high input costs further undermine rural livelihoods. Rural development is also hindered by poor road infrastructure, which restricts access to markets, education, and healthcare services, leaving many communities trapped in cycles of poverty and malnutrition. Through this letter, the bishops emphasized the urgent need for structural reforms, social justice, and equitable economic policies to address both urban and rural poverty, highlighting the intrinsic link between economic well-being and human dignity.

Among the key factors contributing to low agricultural production in Zambia are poor farming methods, limited land availability, and the adverse effects of climate variability. However, the bishops identified corruption as one of the most significant causes of recurring low productivity in the sector.

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[119] Komakoma, *The Social Teaching of the Catholic Bishops*, 224.

They questioned why the government agency responsible for food security consistently delayed the delivery of agricultural inputs, the payment of farmers, and the collection of produce from hardworking rural households.[120] While the government has offered some support for maize production, ranging from cultivation to marketing, through subsidized inputs such as certified seeds and fertilizers targeted at poor and vulnerable farmers, this initiative has often been undermined by mismanagement and corruption. Officials entrusted with selecting beneficiaries, ensuring timely delivery of inputs, and securing a transparent marketing system frequently failed in their duties. As a result, crop yields have suffered, exposing rural communities to food insecurity, malnutrition, and declining health outcomes.[121] For households already struggling with food deficits, the sudden and drastic rise in the price of mealie meal, the staple food for most Zambians, was a devastating blow, deepening both poverty and vulnerability.

The persistently high poverty levels in Zambia can be attributed largely to the government's failure to ensure the equitable distribution of goods and services. Corruption remained pervasive, fuelled by the ruling party's practice of running state affairs without clear separation between party and government finances. As a result, party loyalists enjoyed privileged access to resources for their programs, while critical social sectors, such as health, education, road infrastructure, and employment creation, were left underfunded and neglected. This mismanagement deepened inequality, widening the gap between the powerful, wealthy elite and the deprived, powerless poor. The majority of Zambians longed for a political system that would guarantee broader participation, not only in democratic governance but also in economic enterprise. Such a system, they believed, would help achieve a more just and equitable distribution of the nation's resources.

This situation brings to the fore the persistent failure of successive governments to grasp the true meaning of stewardship of national resources. Stewardship, in its authentic sense, calls for the responsible management of resources for the common good, with special regard for the needs of the poor and marginalized. Instead, many government officials have repeatedly reduced governance to an avenue for self-enrichment. Rather than serving as custodians of the nation's wealth, they have often assumed the posture of masters rather than servants, prioritizing personal gain and partisan interests over the welfare of the people. This abuse of authority distorts the very purpose of leadership, which is to ensure justice, equity, and the flourishing of all citizens.

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[120] [120] Zambia Episcopal Conference (ZEC), *Economics*, *Politics*, *and Justice* (Lusaka: Catholic Secretariat, 1990), no. 10.

[121] ZEC, *Economics*, *Politics*, *and Justice*, no. 9.

The bishops, echoing the long-standing tradition of Catholic social teaching, have consistently reminded leaders that public office is not a privilege for self-benefit but a sacred trust of service. Genuine stewardship demands transparency, accountability, and a deliberate commitment to policies that foster equitable access to healthcare, education, food security, and sustainable livelihoods. Where governance is treated as self-service, corruption festers, poverty deepens, and the dignity of the people is undermined. Improved access to healthcare, nutritious food, clean water and sanitation, quality education, employment opportunities, and functional markets all contribute positively to the well-being and health of the population. The absence of these essentials, however, perpetuates cycles of poverty, poor health, and social exclusion.

4.2.6.2 *The Future is Ours*: A Call to Economic Justice and Shared Responsibility

The Future is Ours was issued at the dawn of a new milestone in Zambia's history. In October 1991, the country witnessed its first change of government after twenty-seven years of one-party rule, following the historic multi-party elections. The new government quickly embarked on an ambitious programme to rebuild the economy, restore social services, rehabilitate roads and other infrastructure, and to rekindle a spirit of nationalism and patriotism. Yet, despite these promises, poverty remained the most significant barrier to equal access to social benefits such as healthcare, education, and employment. The pastoral letter therefore urged the new government to prioritize poverty reduction by promoting the common good and giving particular attention to the preferential option for the poor**.** The bishops reminded Zambians that the pursuit of the common good requires responsibility, accountability, and hard work from everyone—not just political leaders.[122] They emphasized that reducing poverty levels could only be achieved through meaningful participation in economic activities, especially by the most vulnerable groups. The letter thus expressed the aspiration for broader participation in building self-reliance and reducing dependency, calling for increased productivity at national, community, and household levels.[123] To avoid leaving anyone behind, the bishops strongly reiterated that the top national priority must be agricultural and rural development**.** More than half of Zambia's workforce could meaningfully participate in the economy through agriculture, which in turn delivers two essential outcomes: increased household income and improved family nutrition. At the

[122] Zambia Episcopal Conference (ZEC), *The Future is Ours* (Lusaka: Catholic Secretariat, 1992), no. 8 and no. 11.

[123] ZEC, *The Future is Ours*, no. 13.

time of publication, however, nearly two-thirds of Zambian households were unable to meet the standard requirements for adequate nutrition.[124]

Measured against the working definition of the common good, "the sum total of conditions necessary for human flourishing," the prevailing conditions were found to be deeply inadequate for most poor Zambians. Both the rural population and residents of densely populated urban settlements faced significant challenges, including limited access to education, healthcare, markets, roads, communication, and electricity.

Unfortunately, instead of alleviating the suffering of the majority poor, greater misery was imposed on them following the Zambian Government's adoption of the Structural Adjustment Programme (SAP)—an economic recovery package agreed with international lenders, namely the International Monetary Fund (IMF) and the World Bank**.** According to Peter Henriot, "SAP is an approach to managing the economy based on an economic theory or model guided by certain classical economic principles. These principles of neo-liberal capitalism include: the uncontrolled free market, the primacy of private control of capital, and the minimal role of the state."[125] As a recipient nation of SAP, Zambia was compelled to implement the full scale of conditionalities. These included: drastic reductions in public spending**,** trade liberalisation**,** privatisation of state-owned enterprises, and currency devaluation.[126] The conditionalities also demanded the reduction and eventual removal of subsidies on essential goods and services such as agricultural inputs, electricity, and fuel. Furthermore, education and health budgets were severely cut, with user fees introduced in schools and health facilities.

The consequences were devastating. Poor families, who already struggled with poverty, now faced even greater challenges in accessing healthcare and education. The removal of subsidies and introduction of fees not only reduced household purchasing power but also widened inequalities between the rich and the poor. Instead of creating economic recovery, SAP deepened social vulnerability, leaving the majority trapped in cycles of poverty, malnutrition, and ill health.

The bishops strongly emphasized the social protection of the most vulnerable, insisting that the fundamental criterion for evaluating any economic restructuring must be how well it serves the poor.[127] They warned against repeating the mistakes of the past, where austerity measures disproportionately hurt the poor, cutting off their access to essential services and economic opportunities, while

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[124] ZEC, *The Future is Ours*, no. 9.
[125] Henriot, "Zambia: A Case Study of Economic Reform," 4.
[126] Henriot, "Zambia: A Case Study of Economic Reform," 4-5.
[127] ZEC, *The Future is Ours*, no. 25.

government officials continued to live in luxury and extravagance. For the bishops, economic recovery was not merely about balancing budgets or meeting external debt obligations, but about creating an enabler of people's development. They argued that any meaningful reform must be guided by principles of equity, inclusion, and sustainability, ensuring that growth translated into tangible improvements in people's lives. They drew attention to reports from other countries that had adopted the Structural Adjustment Programme (SAP), which revealed worsening poverty, inequality, and social exclusion. Fearing that Zambia might face the same fate, the bishops cautioned that without deliberate protection of the poor, the newfound culture of hard work and national renewal would soon be undermined and lost.

The Future is Ours was therefore both an exhortation and a warning: an exhortation for every citizen to assume personal and collective responsibility in the fight against poverty, and a warning to the government against creating more barriers that would restrict people's access to the nation's resources. For the sake of the common good, the bishops called on government officials to demonstrate genuine commitment and accountability, focusing on economic growth while ensuring that social welfare was not neglected. True development, they argued, could not be measured by macroeconomic indicators alone, but by the extent to which the poor and vulnerable experienced dignity, justice, and improved living conditions.

4.2.6.3 *Hear the Cry of the Poor:* A Prophetic Voice Against SAP

The pastoral letter *Hear the Cry of the Poor* became a prophetic fulfilment for the Catholic bishops of Zambia, who had earlier cautioned the government against adopting the untested Structural Adjustment Programme (SAP). Their fears regarding the negative effects of SAP on people's lives quickly became a painful reality.[128] By the time the pastoral letter was released, the process of privatizing state-owned enterprises was already underway. The consequences were immediate and severe: many workers were retrenched as companies downsized under new ownership, while in some cases operations were

[128] Zambia Episcopal Conference (ZEC), *Hear the Cry of the Poor*: *A Pastoral Letter on the Current Suffering of the People of Zambia* (Lusaka: Catholic Secretariat, 1993), no. 9. Some statistics showed that: i) 20% of all children born die before the age of five; ii) 40% of all children under five are short for their age, a condition reflecting chronic malnutrition; iii) between 20 and 25% of under-five hospital admissions are related to malnutrition; iv) the maternal mortality rate has almost doubled over the past decade, from 110 to 200 per 100,000 deliveries; v) the proportion of school children enrolled in primary grades has been declining in recent years; for example, on 56% of the 7 year old in Lusaka can find places in Grade One; vi) 80% of our rural population and almost 50% of our urban population live below the poverty line; vii) an annual inflation rate of close to 200% is placing unbearable burdens of parents struggling to feed their families; and viii) only 350,000 people are currently employed in formal sector and future retrenchments may cut back this figure further by more than 75,000.

suspended or shut down entirely. This wave of economic restructuring pushed countless Zambians into deeper poverty and destitution.

In response, the bishops issued a pastoral appeal, insisting that**:** "privatization should be carried forward in ways that safeguard the delivery of public services to all, respect the rights of workers in the period of transition, and give priority to widespread ownership among Zambians. Land reform should especially protect small family farms and the right of Zambians to own land."[129] Ownership opportunities must be extended widely among Zambians, rather than benefiting only a privileged few or foreign investors. Land reform should prioritize the protection of small family farms and secure the right of Zambians to own land, ensuring that rural communities were not displaced or marginalized**.** The bishops' concerns reflected a holistic vision of economic justice, where development was not defined solely by market liberalization and foreign investment, but by how economic policies protected dignity, promoted equity, and advanced the common good.

Other reforms under the Structural Adjustment Programme (SAP) included the abrupt removal of subsidies, the introduction of new taxes such as the Value Added Tax (VAT), as well as the imposition of medical and education fees. These measures had direct and immediate consequences: soaring food prices, limited access to healthcare, higher transportation costs, lack of disposable income, and frustration from public workers who often displayed little sympathy toward the poor.[130] In this new market-led economy, the government withdrew from controlling prices without putting in place any effective intermediary mechanisms to cushion the poor. As a result, the majority of Zambians, already grappling with mass job losses and declining productivity, lost their purchasing power and their ability to access basic goods and services.[131] For the government, this suffering was justified as "short-term pain for long-term gain."[132] Yet, the promised macroeconomic benefits of SAP proved elusive. The reforms failed to produce tangible improvements in people's daily lives. Instead, immediate economic and social hardships were overlooked in favour of a distant and uncertain future. Moreover, the anticipated long-term benefits of SAP came under serious doubt. The programme showed little evidence of delivering on its promises, there was no clear improvement in public health or education, no significant creation of jobs, and no effective promotion of small-scale entrepreneurship.[133] Rather than empowering citizens, SAP deepened social inequalities and widened the gap between the rich and the poor.

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[129] ZEC, *Hear the Cry of the Poor*, no. 25.
[130] ZEC, *Hear the Cry of the Poor*, no. 8.
[131] ZEC, *Hear the Cry of the Poor*, no. 26.
[132] ZEC, *Hear the Cry of the Poor*, no. 19.
[133] ZEC, *Hear the Cry of the Poor*, no. 20.

While the majority of Zambians were enduring severe suffering, the government continued to insist that SAP was the only viable path forward. International lending agencies, such as the IMF and World Bank, praised Zambia for its strict adherence to the programme's conditionalities. Yet, the celebrated economic indicators—such as improved fiscal balances and reduced inflation—did not translate into improvements in social welfare indicators. This was a case of managing "book theories" effectively while ignoring the harsh realities faced by ordinary citizens. The bishops emphasized that "we must recall the fundamental norm for judging the success of any economic reforms: they must serve all people."[134] They further reminded the government that "SAP is not a fixed law of nature that cannot be modified. It is a human creation, a product of theory and practice. …It needs to be continually subjected to ethical consideration as well as to economic analysis."[135] Two years into the programme, the trickle-down effects of the promised benefits were still nowhere in sight. Instead, poverty deepened, hunger spread, and access to essential services such as healthcare and education was gravely undermined by the debilitating economic hardships. Far from offering relief, SAP left the poor more vulnerable and marginalized, raising doubts about whether the government's priorities were aligned with the common good and concern for the most vulnerable.

4.2.7 Statement on Agriculture and Food Security

In their *Statement on Agriculture and Food Security*, the bishops lamented the government's ill-timed withdrawal from the agricultural sector, a move compelled by SAP conditionalities. Henriot observed that, "SAP has meant the quick withdrawal of the government from its heavy intervention in every aspect of agricultural activities: subsidising of inputs of seeds and fertilisers, supplying of credit, providing facilities for marketing and storage."[136] With this shift, all agricultural activities were effectively left to the private sector. The government, once the sole actor in production, procurement, storage, and distribution, repositioned itself merely as an enabler of the free market economy.

The consequences were immediate. The first crop marketing season after government's withdrawal proved disastrous. The newly registered private agents lacked the capacity to handle production, procurement, storage, and distribution of maize—the nation's staple food. As a result, significant quantities of maize were wasted, aggravating food insecurity. In their statement, the bishops reminded the government that maize is not just another commodity but a basic necessity that sustains

[134] ZEC, *The Future is Ours*, no. 25.
[135] ZEC, *Hear the Cry of the Poor*, no. 20.
[136] Henriot, "Zambia: A Case Study of Economic Reform," 7.

the lives of Zambians. As such, it must be treated as a national priority within economic policy.[137] Each year, government is duty-bound to assess the required annual food tonnage and to ensure effective mechanisms are in place so that all players in the sector contribute toward achieving food security.
The bishops were emphatic in their declaration: "Food is the most important element in any economy. Consequently, the arrangements to make food readily available to all people take on the very highest priority in a well-ordered society. Our political leaders must recognise and respond to this priority, independent of any political or economic ideology."[138] This powerful reminder underscored that the well-being of citizens must never be sacrificed at the altar of economic experiments, because a nation that fails to feed its people undermines both its stability and its future.

In conclusion, poverty and food insecurity have remained perennial challenges to the welfare of the Zambian people, particularly the most vulnerable groups. The country's struggles in these areas have been closely tied to the economic policies pursued over the years. Several economic programmes, though intended to stimulate recovery and growth, have instead left behind a trail of devastation in the lives of ordinary citizens. Most notable among these was the Structural Adjustment Programme (SAP), a recent attempt at economic recovery. Far from improving livelihoods, SAP worsened poverty levels due to its harsh conditionalities and lack of sensitivity to the lived realities of the people. It stood as a clear example of an externally imposed, one-size-fits-all model that ignored Zambia's specific social and economic context, as Mulligan observed:

> Structural adjustment programmes implemented by the IMF in the 1990s severely restricted many Developing World countries' economic decisions. Many sovereign nations had to adopt economic policies that had a regressive impact on their social and economic situation. One of the most obvious features of structural adjustment programmes was the IMF's unwillingness to consult with poorer nations. It was a clear case of 'we know best,' and local expertise was rarely taken into account by the organization.[139]

Mulligan demonstrated that the imposition of SAP on developing countries reflected a profound imbalance of power and a lack of respect for genuine mutual dialogue. This top-down approach, marked by disregard for local contexts and voices, has been characteristic of powerful international financial institutions such as the IMF, the World Bank, and the World Trade Organization (WTO).

Adverse weather conditions have also significantly undermined agricultural productivity, particularly in rural areas. The 1991/92 farming season marked the onset of a devastating drought that affected more than half of the country, resulting in severe crop failure. During the same period, many

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[137] Zambia Episcopal Conference (ZEC), *Statement on Agriculture and Food Security* (Lusaka: Catholic Secretariat, 1994), no. 1.

[138] ZEC, *Statement on Agriculture and Food Security*, no. 18.

[139] Mulligan, *Capabilities and the Common Good*, 395.

regions faced acute shortages of water for both people and livestock, compounding the crisis.[140] Within communities, "for those who have, it is a call to solidarity, compassion, and charity. For those who have not, it is a call to work for a society marked by greater social justice."[141] The bishops' appeal captured the urgency of an immediate, short-term response to poverty and food insecurity. However, they also highlighted that long-term strategies for disaster preparedness, management, and mitigation remained largely absent and must be urgently developed if Zambia is to build resilience against recurring crises.

Although adverse weather patterns have been recurrent in Zambia, there have been no consistent or well-coordinated steps to build resilience or promote climate adaptation for the people. Moments of disaster should serve as opportunities for research, innovation, and the design of more effective responses, as well as moments to strengthen social justice in support of those most affected by job losses and declining agricultural productivity. Water scarcity further limits communities' ability to grow multi-annual crops, as bulk agricultural production in Zambia remains heavily dependent on rainfall. In such circumstances, government officials are called upon to demonstrate genuine care and responsibility for the suffering majority by reducing non-essential expenditures and redirecting resources toward sustainable food security measures. Practical interventions such as creating water reservoirs, expanding irrigation systems, and promoting climate-smart agriculture would not only safeguard livelihoods but also build long-term resilience. Ultimately, addressing poverty and food insecurity in the face of adverse weather requires leadership rooted in solidarity, accountability, and a preferential option for the poor.

The ZCCB's advocacy for improved healthcare has consistently been anchored in the call to eliminate barriers to access and to address the broader social determinants that hinder the attainment of sound health. Weak infrastructure, persistent shortages of skilled personnel, and poor resource allocation and management remain major contributors to Zambia's poor health outcomes. Recognizing that health is shaped by more than hospitals and medicines, the bishops have repeatedly highlighted the importance of tackling underlying challenges such as poverty, food insecurity, and the lack of clean drinking water. Through their pastoral letters, the ZCCB has reminded both government and society that true healthcare reform requires a holistic approach, one that integrates social justice, equitable resource distribution, and a preferential option for the most vulnerable.

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[140] Zambia Episcopal Conference (ZEC), *Pastoral Statement on Drought and Famine* (Lusaka: Catholic Secretariat, 1992), no. 3.

[141] ZEC, *Pastoral Statement on Drought and Famine*, no. 5.

4.3 Marriage and Family Life as a Cross-Cutting Healthcare Issue

Marriage and family life are included here as cross-cutting issues in healthcare. Beyond being the foundation of social cohesion, the family is also the primary centre of healthcare, where nurturing, care, and prevention begin. As such, the family is a fundamental stakeholder in healthcare processes, both in terms of delivery and policymaking. This section explores how the Catholic Church in Zambia has sought to promote and protect the integrity of marriage and family as essential components of healthcare delivery. The Catholic bishops in Zambia have consistently defended the family against disproportionate pressures placed on couples to adopt population control measures, particularly through artificial reproductive technologies and abortion. During the centenary celebrations of Catholicism in Zambia, the bishops affirmed: "The family is the heart of our nation and our Church. It plays a particularly privileged role in our own culture, in nurturing, educating, protecting, and sustaining several generations."[142] Four years later, the bishops emphasized that marriage is "the proper setting for conception, birth, and upbringing of children and is the cell or the basic unit of society."[143] By these declarations, the bishops underscored both the integrity of marriage and the dignity of human procreation, affirming the family as the cornerstone of human development, social well-being, and national health.

In defence of the integrity of the family, the Zambian bishops were compelled to respond to the new definition of family promoted by the United Nations (UN), which included "family in all its various forms."[144] Their pastoral letter exhorted the President to ensure that Zambia's delegation to the UN-sponsored Cairo International Conference on Population and Development was equipped with concrete proposals that safeguarded the integrity of the family. What alarmed the bishops most was the way in which the family appeared to be directly targeted as a means of implementing population control policies.

The Catholic bishops of Zambia recognized the legitimate need to align population growth with the rate of resource development.[145] However, they emphasized that this balance must be achieved through the practice of responsible parenthood. Responsibility for determining the size of a family rests primarily with the family itself, which should be guided to make informed and conscientious decisions.

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[142] Zambia Episcopal Conference (ZEC), *You Shall Be My Witnesses* (Lusaka: Catholic Secretariat, 1991), no. 37.

[143] ZEC, *Open Letter to the President of the Republic of Zambia Mr. F.J.T Chiluba on the 1994 International Conference on Population and Development* (Lusaka: Catholic Secretariat, 1994), no. 10.

[144] ZEC, *Open Letter to the President*, no. 10.

[145] ZEC, *You Shall Be My Witnesses*, no. 38.

Responsible parenthood includes the prudent spacing of children, but the notion that it necessarily means having only a small family is misguided. Rather, the number of children a couple chooses to have should be considered in light of both their own available resources and the needs of the wider society, always with respect for the common good. In this regard, the bishops stressed the importance of educating couples about Natural Family Planning (NFP). As a scientific, effective, and reliable method of regulating birth, NFP promotes the holistic well-being of its users and upholds the dignity of the human person.[146] Crucially, it is consistent with the natural moral law. Couples, therefore, should be helped to understand that authentic family planning takes place before conception, not after.

The bishops' rejection of population control through abortion and artificial methods was clear, firm, and unequivocal. They firmly opposed the UN's concept of population control, particularly where it included the termination of unplanned pregnancies. Without hesitation, they declared: "Abortion is the destruction of existing human life and cannot be offered as a respectable tool of population policy or as a permissible means of family planning."[147] Equally, they rejected the idea that responsible parenthood could only be achieved through artificial contraceptives while disregarding abstinence. To assume that people are incapable of self-control or sexual discipline, they argued, is offensive to human dignity. Even when birth regulation is necessary, couples should never be subjected to methods that undermine their dignity, such as contraceptives, sterilization, or abortion.[148] Instead, approaches to population management must respect the sanctity of human life and uphold the integrity of marriage. The bishops also cautioned against alarmist rhetoric about "population explosion," warning that it often leads to panic-driven and indiscriminate applications of reproductive technologies.[149] In Zambia's context, they noted, the challenge was less about physical space, since vast areas of land remained available, and more about the fair distribution and effective management of public resources such as schools, hospitals, and infrastructure. Yet even these challenges, they stressed, could not justify resorting to harsh or dehumanizing population policies.

The ZCCB acknowledge the essential role of the family in the face of HIV/AIDS. The family proved to be exceedingly essential at the height of the HIV/AIDS pandemic in Zambia. When hospitals and hospices were overwhelmed and unable to cope with the growing number of patients, families became the primary caregivers. This shift gave rise to a dynamic model of care that has since become a permanent feature of the healthcare system—Home-Based Care.[150] Recognizing this reality, the

[146] ZEC, *Open Letter to the President Chiluba*, no. 9.
[147] ZEC, *Open Letter to the President Chiluba*, no. 5.
[148] ZEC, *Open Letter to the President Chiluba*, no. 5.
[149] ZEC, *Open Letter to the President Chiluba*, no. 13.
[150] CCZ, EFZ, and ZEC, *Have Life to the Full* (November 24, 2002), no. 10.

Catholic bishops of Zambia placed special emphasis on the gender dimension within families, particularly on equality and decision-making. Women, who bore the greatest burden as primary caregivers, were often denied the fundamental recognition of their equal dignity as human beings. The bishops stressed that this imbalance was unjust and needed to be addressed both socially and ecclesiastically. They declared: "On our part, we pledge to continue supporting efforts that seek to empower women to take their rightful place in society and in the Church. In line with Proposition No. 47 of the Second African Synod on Women in Africa, we acknowledge that women in our country and in Africa make a great contribution to the family, society, and the Church with their many talents and resources."[151] This affirmation underscored the bishops' conviction that empowering women is not only a matter of justice but also a crucial step toward strengthening families, improving healthcare delivery, and building a more equitable society.

4.4 Conclusion

This chapter has explored the practice of bioethics by the Catholic Bishops of Zambia. The intervention of the ZCCB in matters of bioethics is reflected in their pastoral teaching, as articulated in several of the documents examined in this chapter. Their contribution has been two-fold: fulfilling their mandate to teach and engaging in policy advocacy**.** The bishops recognized the authority entrusted to them to proclaim the truth and to denounce practices that contradict it.

In relation to bioethics and healthcare, their central teaching underscores the sacredness of human life and the inherent dignity of every human being. They emphasized that all bioethical decisions and interventions must be guided by the principle that human life is inviolable and must be safeguarded at every stage. This conviction is grounded in two foundational principles of bioethics: nonmaleficence (the obligation to do no harm) and beneficence (the obligation to do good). These principles apply comprehensively to human life and extend across all aspects of healthcare—from conception to natural death**.** In doing so, the bishops not only reaffirmed the moral framework of Catholic teaching but also provided a critical ethical lens for evaluating contemporary health practices and policies in Zambia.

The central thrust of the bishops' advocacy has been ensuring access to adequate healthcare for all and eliminating the social determinants that exacerbate health challenges among the people. Zambia's healthcare system has consistently failed to realize the vision of universal and equitable

[151] ZEC, *That They May Have Abundant Life* (September 11), no. 54.

access, largely due to structural weaknesses and flawed policy decisions. Nearly 60% of Zambians live in poverty, with the majority residing in rural areas where road networks are poor and healthcare facilities are scarce or inadequately equipped. For many, the aspiration of living within a five-kilometre radius of a functioning health centre remains an unattainable ideal. At the heart of this failure lies the government's persistent lack of commitment to allocate sufficient resources, both human and material, to the health sector. This perennial policy deficit has left the most vulnerable without reliable access to essential healthcare, undermining both national development and the dignity of human life.

Another major area of advocacy by the bishops has been their persistent appeal for the eradication of poverty and the improvement of food security. As a largely non-industrialized country, the majority of Zambians depend on agriculture for both household nutrition and income—factors that are central to overall health outcomes. The bishops have repeatedly emphasized that "good, workable agricultural policies will … go a long way in creating employment for the youth in our country."[152] However, it is important to note a significant gap in their advocacy. While the Catholic bishops of Zambia have consistently spoken strongly on issues such as poverty, food security, and other social determinants of health, they have not articulated with equal clarity the right to healthcare itself. This absence has left their position on healthcare rights somewhat underdeveloped.

It is evident that, up to this point, the Zambia Conference of Catholic Bishops' engagement with bioethical discourse has been more implicit than explicit. While the Conference has offered clear and authoritative positions on morally and socially contentious issues such as abortion, capital punishment, and the pastoral response to HIV and AIDS, its broader contributions to questions of health and healthcare ethics have remained less systematically articulated, often embedded within pastoral letters, social teachings, or general moral exhortations rather than developed as a sustained bioethical framework.

The next chapter will explore valuable lessons that the Zambian bishops can draw from other episcopal conferences, particularly the United States Conference of Catholic Bishops (USCCB), which has developed a more explicit and rights-based framework for healthcare advocacy. The USCCB's approach not only stresses healthcare as a fundamental human right but also links it to broader principles of social justice, equity, and the common good. By examining these perspectives, the Zambian bishops can find insights that may enrich their own pastoral engagement and strengthen their advocacy for policies that ensure universal, affordable, and dignified access to healthcare.

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[152] ZEC, *That They May Have Abundant Life*, no. 41.

CHAPTER FIVE

INTEGRATION OF CATHOLIC SOCIAL TEACHING AND BIOETHICS BY THE UNITED STATES CONFERENCE OF CATHOLIC BISHOPS

5.0 Introduction

Keeping in mind the question of which resources within Catholic social teaching can be leveraged to help achieve universal healthcare, the United States Conference of Catholic Bishops offer concrete guidance for addressing healthcare inequities by utilising the principles of Catholic social teaching emphasizing the dignity of the human person, the common good, solidarity, and the preferential option for the poor. These principles together form a compelling ethical basis for advocating universal access to healthcare. When integrated with bioethics, these teachings move beyond abstract ideals and provide a practical moral vision that calls for equitable distribution of medical resources, protection of vulnerable populations, and policies that ensure no one is excluded from essential care.

The Catholic hierarchy in the United States (US) have demonstrated consistent and exponential engagement with matters of bioethics and healthcare by underlining the dignity of the human person which is fundamental to Christian anthropology. Debate regarding bioethics and healthcare needs to be given the ethical and theological attention it deserves to safeguard the world from drifting into reducing the human person to a mere specimen for research purposes. The Catholic Church's social teaching on the dignity of the human person calls for medical and social responsibility in healthcare. This magisterial teaching is rooted in the sanctity of human life, and the Church's evangelising mandate. The social responsibility in healthcare contained in the *Ethical and Religious Directives* reflects the US bishop's commitment to promote respect for human dignity across the spectrum of the society. The bishops further reflect the Church's concern for the poor and vulnerable and calls for responsible stewardship and social justice. This section will be guided by the question: How does the regional Catholic Church's hierarchy contribute to the integration of bioethics and Catholic social teaching (CST) in healthcare delivery? To achieve this purpose, the study will rely on selected documents by the USCCB on matters of social justice, bioethics, and healthcare.

5.1 Healthcare as a Right

It is generally accepted that healthcare is a fundamental human right of the human person. This is enshrined both in church's teachings and the constitutions of many nations. The common maxim:

"health is wealth" attest to this assertion. For the U. S. bishops, "The dignity of human life flows from creation in the image of God (Gen 1:26), from redemption by Jesus Christ (Eph. 1:10; 1 Tim 2:4-6), and from our common destiny to share a life with God beyond all corruption."[1] This understanding is rooted in the Scriptures and Christian theological anthropology that stresses the sanctity of human life and the need to preserve it. This is the background of church's teaching on healthcare and bioethics, without which the human person may be reduced to a mere specimen for scientific exploration while inequality in access to healthcare may also remain unresolved. Several documents of the USCCB point to the fact that healthcare is a human right. In the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs), the U. S. bishops pointed out that the right to life is "the first right of the human person, [and it] entails a right to the means for the proper development of life, such as adequate health care."[2] The ERDs is the primary document on healthcare provision which opens with a significant pronouncement on the right to health care. ERDs have served as a very robust guide to answer common ethical conflicts within Catholic health institutions as modern healthcare becomes ever more advanced and expansive. One observation is that by stating a right as a means for the proper development of life including access to adequate healthcare weakens the pronouncement of healthcare as a fundamental right. For instance, Zalot observed in his proposal for the revision that "The text [ERDs] does not specifically use the phrase *right to healthcare*, but it could be implied."[3] Although the above interpretation may be true for the ERDs, the U.S. bishops have been unambiguous on their teaching that healthcare is a right across other documents.[4]

To begin with, the U. S. bishops have categorically stated that, "On the societal level this (human dignity) calls for responsibility by society to provide adequate care which is a basic human right. Healthcare is so important for human dignity and so necessary for proper development of life that it is a fundamental right of every human being."[5] By this declaration the bishops emphasised the moral principle that healthcare is a basic human right and is integral to human dignity. The argument here is that since every human life is sacred, healthcare should be accessible to all, regardless of their social and economic status. In this regard, it is the duty of the government to provide the requirements for the fulfilment of this entitlement. Simultaneously, there is the duty apportioned to individuals to take care

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[1] United States Conference of Catholic Bishops (hereafter, USCCB), *Ethical and Religious Directives for Catholic Health Care Services* (Washington D. C, 2018), Part Two, Introduction, Par. 1.

[2] USCCB, *Ethical and Religious Directives*, Part One, Introduction, Par 2.

[3] Joseph D. Zalot, "Commentary on Revising Part One of the ERDs)," *The National Catholic Bioethics Quarterly* 23, no. 2 (Summer 2023), 248.

[4] Other documents include *Health and Health Care* (1981), *Resolutions on Health Care Reform* (1993), and *Forming Consciences for Faithful Citizenship* (2020 Edition).

[5] USCCB, *Health and Health Care*: *A Pastoral Letter of the American Bishops* (Washington, D. C.: United States Catholic Conference, 1981), 5.

of their personal health.[6] This is another way of talking about the social responsibility attached to healthcare as an imperative for living well to fulfil the purpose for which we were created by God in this world. Healthcare is everybody's business, in as much as there is the demand for the government to provide resources for its achievement. Everyone needs to look after their health by avoiding habits that are detrimental to their health and adopting best practices of keeping healthy. The advocacy for reforms of the healthcare systems that guarantee basic health services for all, demands to a greater extent on the cooperation of the people in the healthcare processes.[7]

The vulnerable population which includes the poor, the elderly, and disabled often suffer significant barriers to healthcare. The U. S. bishops further understand that the categories of those who are vulnerable and in need of healthcare have since evolved to include inhabitants of the underserved inner-city and rural areas, especially the Hispanics, Blacks, Native Americans, and other minorities.[8] The list of vulnerable groups may vary from one country to another, but such groups overlap across nations. The growing concerns for trafficked persons and illegal immigrants who largely remain undocumented are an added tragically vulnerable group. This shows that there is an urgent need to address the problem of inequality that has bedevilled our world.

In addition, through *Resolution on Health Care Reform*, the U. S. bishops reaffirm that access to healthcare is a fundamental human right. Along with this declaration the bishops explain that "This right flows from the sanctity of human life and the dignity that belongs to all human persons."[9] The paramount duty to address the healthcare needs of the people by the government and society is specially highlighted. Significant reforms are demanded to reverse the trend of huge expenditure but serving too few people. In support of reforms, the bishops declared, "We believe reform of the healthcare system which is truly fundamental, and enduring must be rooted in values which reflect the essential dignity of each person, ensure that basic human rights are protected, and recognise the unique needs and claims of the poor."[10] Here the poor mean the vulnerable populations who lack adequate access to healthcare. To that effect, the bishops make a bold imperative saying, "When there is a question of allocating scarce resources, the vulnerable and the poor have a compelling claim to first consideration."[11] The imperative signifies the bishops' preferential option for the poor by emphasising that the right to healthcare must not be treated as a privilege for the few but a requirement for the well-

[6] USCCB, *Health and Health Care*, 5.
[7] USCCB, *Health and Health Care*, 17.
[8] USCCB, *Health and Health Care*, 14.
[9] U. S. Bishops, "Resolution on Health Care Reform." *Origins* 23, no. 7 (July 1, 1993), 97.
[10] U. S. Bishops, "Resolution on Health Care Reform," 99.
[11] U. S. Bishops, "Resolution on Health Care Reform," 100.

being of every person. The plight of the vulnerable who include the uninsured and the illegal immigrants is specially highlighted. Relying on experience and principles of the Church, the U. S. bishops believe reforms are possible that can mandate different layers of stakeholders to provide healthcare needs to everyone.[12] Among stakeholders are private healthcare providers, who although some portion of their aim is to make profit, often they are found to offer better healthcare services than the public hospitals. The hope is that reforms of public healthcare delivery must aim at reaching some levels seen in private healthcare and better.

Furthermore, the U. S. bishops' landmark document, specifically intended to educate the lay faithful, spells out clearly that "affordable and accessible health care is an essential safeguard of human life and a fundamental human right."[13] *Forming Consciences for Faithful Citizenship* provides guidance for Catholics in political life and engagements with public policy. In this document, apart from stating the right to healthcare, the U. S. bishops advocate for public policies that guarantee universal access to healthcare which Catholics must take into consideration in their political decisions and choices.[14] Access to adequate healthcare constitutes a voting issue on account of the many challenges that arise from a poorly managed national health programme. The aspirants for election must prioritise justice, sanctity of life, the common good through achievable reforms that guarantee increased accessibility and affordability in healthcare delivery systems. Making healthcare an election issue further underscores the continuous effort to form the conscience of the people and a mechanism of compelling State actors to implement policies that lead to universal healthcare coverage. Justice and inclusiveness should be enduring characteristics of the healthcare system.

As a principle of CST, how is the *right to healthcare* applied to bioethics? Zalot asks pertinent and fundamental questions evoking further reflection: "Is there a right to healthcare? If so, is this a negative right whereby another cannot interfere with my pursuit of or access to health care? Or is this a positive right in that another (employer, government, etc.) has a duty to provide healthcare to me? If health care is not a right, what are the bishops calling for?"[15] When enumerating some entitlements, the *Catechism of the Catholic Church* insists that families can claim from the civil authority "the right to medical care, assistance for the aged, and family benefits."[16] This answers Zalot's first question, there is the existence of the right to healthcare. This teaching is part of the broader magisterial teaching.

[12] U. S. Bishops, "Resolution on Health Care Reform," 100.

[13] USCCB, *Forming Consciences for the Faithful Citizenship* (Washington DC.: United States Conference of Catholic Bishops, 2020), no. 80.

[14] USCCB, *Forming Consciences for the Faithful Citizenship*, no. 25.

[15] Zalot, "Commentary on Revising Part One of the ERDs," 248.

[16] *Catechism of the Catholic Church*, no. 2211.

While listing healthcare as a basic human right, John XXIII stated that "Man has the right to live. He has the right to bodily integrity and to the means necessary for the proper development of life, particularly food, clothing, shelter, medical care, rest, and, finally, the necessary social services. In consequence, he has the right to be looked after in the event of ill-health…."[17] Noticeably John XXIII isolated the right to healthcare from other basic rights. That stand alone gave the right to healthcare a deserved prominence. It is on this basis of that the Catholic vision of universal healthcare is grounded.[18] Like every human right, the right to healthcare must be universal. This reminder is very important when considering that everyone is entitled to healthcare, especially the poor and the vulnerable. It is also an important reminder to all healthcare providers (public and private) and society that a nation's healthcare system must be rooted in values that respect human dignity, protect human life, and defend individuals and their communities regardless of their social status.

Zalot's second question is whether the right to healthcare is a negative or a positive right?[19] Before proceeding to deal with this question, it is essential to understand the distinction between a negative right and a positive right. Andrew Bradley explains that negative rights are about freedom from non-interference and impose no obligation on anyone to provide goods to others.[20] In this understanding, it means other people must respect the right of every individual to keep and enjoy the fruits of his/her labour without external interference. Negative rights include the right to life: no one should harm and kill another; the right to liberty: no restriction of freedom of movement and expression; and the right to property: no one should steal or damage another's property.[21] Supporters of strict adherence to negative rights consider statutory taxation as a burden on some people to provide unearned goods to another group of people and taking away one's freedom to share and trade the products of his/her active enterprise as they wish. This view is in line with the strict interpretation of autonomy. In the restrictive understanding of autonomy, making healthcare a right is considered an interfering with personal freedom through taxation understood as providing goods for others through creating burdens for those who are taxed.[22] The objection is that it is unfair to impose an obligation on individuals to fulfil a human right. The practice is also considered as taking away the responsibility from individuals to provide for themselves, at the same time providing services and goods to people

[17] John XXIII, *Pacem in Terris*, (April 11, 1963), no. 11.

[18] The Irish Catholic Bishops' Conference. *Code of Ethical Standards for Healthcare* (Dublin: Veritas Publications, 2018), 25.

[19] Zalot, "Commentary on Revising Part One of the ERDs," 248.

[20] Andrew Bradley, "Positive Rights, Negative Rights and Health Care" in *Journal of Medical Ethics* 36, no. 12 (October 2010), 838. doi:10.1136/jme.2010.036210.

[21] Bradley, "Positive Rights, Negative Rights and Health Care," 838.

[22] Bradley, "Positive Rights, Negative Rights and Health Care," 838.

who may not deserve them. Such thinking and approach do not take into account the various challenges faced by people to earn a living and is a total disregard of the common good.

The primary desire to keep one's independence and freedom must be moderated by sacrifice. To act in solidarity with the vulnerable in accessing adequate healthcare is participating in the common good as well contributing to resolving the crisis. The U. S. bishops make an enduring reminder for everyone keen on reforms in healthcare policy that one needs to be prepared "to make the changes, address the neglect, accept the sacrifices, and practice the discipline that can lead to better health care for all."[23] Solidarity asks everyone to see a neighbour as one "to be made a sharer on par with ourselves, in the banquet of life to which all are equally invited by God."[24] More radically, John Paul II appeals that in promoting social equality, "you must take of your substance, and not just of your abundance."[25] With these considerations, the proposal of individual philanthropic contributions to the poor instead of statutory pool is both unsustainable and unattainable because there is a high risk that many would be left out in the process.

Positive rights are entitlements that require others to provide you with certain goods or services and technically impose a duty of action on others and the civil authority.[26] Positive rights permit the government to use the accumulated resource pool for redistributive processes. At the same time, positive rights obligate government to track, prosecute, and punish those who interfere with and violate the rights of others. Positive rights further oblige individuals to take positive actions such as paying taxes or submitting oneself to a cause in order to secure negative rights.[27] The claim of taxation as an interference on the right to use of one's fruit of labour is one of the narrow interpretations of the nature of positive rights. Among the well-known positive rights which also draw significant attention include healthcare, education, food, and the provision of shelter. Inadequacies in the areas of health, education, food, and housing are easily noticeable within a country and globally as failures in the promotion of human dignity.

The identification of healthcare as a positive right has several ramifications. Bradley argues that "Healthcare falls into the category of positive rights since its provision by the government requires taxation and therefore redistribution."[28] The first implication is the government's duty to provide for the right to healthcare for all. Right to healthcare means that when the individual and families are

[23] U. S. Bishops, "Resolution on Health Care Reform," 101.
[24] John Paul II, *Sollicitudo Rei Socialis*, no.39.
[25] John Paull II, *Holy Mass at Yankee Stadium*: *Homily of His Holiness John Paul II*, 2.
[26] Bradley, "Positive Rights, Negative Rights and Health Care," 838.
[27] Bradley, "Positive Rights, Negative Rights and Health Care," 840.
[28] Bradley, "Positive Rights, Negative Rights and Health Care," 838.

confronted with health threatening conditions that require immediate and primary interventions, the services must be easily accessible, available, affordable, and of good quality. Naturally, there would be more demand on the resources to fulfil the right to healthcare when individuals are faced with extraordinary health conditions and are impeded from functioning properly. People who are beset with disease or disability and who have their functionalities severely affected tend to have a bigger demand on resources. In essence, government assumes the mandate to promote, protect, and restore the functionalities of people under its sovereign jurisdiction through health care ensuring equal access. To attain minimum standards of healthcare, government policies must compel all stakeholders namely the State, the Church, and other diverse providers to prioritise the common good and promote equal access to healthcare.

The second implication is the individual duty to contribute to the resource pool by taxation and otherwise. Contributive justice regulates citizens' obligation towards the larger society and government through paying taxes. This justice stresses the duty of all, who are capable, to help to create the goods, services, nonmaterial, and spiritual contributions for the welfare of the whole community.[29] It is on contributive justice and the common good on which the State anchors its demand on citizens to contribute to the welfare of all and from which the State gets its authority to impose penalties for failure to honour one's obligations. In essence, the contributive justice is a mechanism to spreading the burdens. It must be noted that some contributions to the common welfare are not always in financial terms. Society's recognition of other forms of contribution comes with exemptions of some people from taxation.

Although the ERDs do not state categorically the right to healthcare, all major documents of the U. S. bishops have acquitted themselves unequivocally on the existence of the right to healthcare. However, Zalot's recommendation that the ERDs should enshrine the right to health care is valid, since it is the primary document on healthcare by the USCCB. At the same time, to leave the right to healthcare as an implied matter in the ERDs may undermine the consistency in the stance on the existence of the right to healthcare and the overall teaching on universal access. The very fact that healthcare is a basic human right, it must be universal, meaning accessible to all and it desirable that the declaration runs categorically through all documents.

[29] National Conference of Catholic Bishops (NCCB), *Economic Justice for All*: *Pastoral Letter on Catholic Social Teaching and the U. S. Economy* (Washington D. C.: NCCB, 1986), no. 71.

5.2 Healthcare as a Common Good

The principle of the common good is what best describes what must be done to achieve human flourishing, because its implications embrace individuals, families, nations, and the entire human community. The common good reveals the demand for equality and an obligation for duty towards humanity's common purpose and goals. Within a sovereign State, national policies and local policies must enable individuals to achieve fulfilment and together with others work for the good of all. The U. S. bishops state that "The common good is realised when economic, political, and social conditions ensure protection for the fundamental rights of all individuals and groups and enable all to fulfil their common purpose, reach their common goals, and secure the transcendent values that are the purpose of life."[30] This is the vision healthcare intends to serve. A healthy population whose health challenges are resolved with ease contributes greatly to the common good through enterprise. It is for this reason that Todd Salzman makes an important claim that the common good forms the central principle which other principles must serve as imperatives to realise universal healthcare.[31] It is generally agreed that the common good is the most important principle of CST after human dignity.

Based on the sanctity of every human life, healthcare is a common good that must be accessible to all regardless of their social and economic status. The common good points to the need to create public policies aimed at eradicating factors that create barriers to adequate healthcare access or worsen the health problems of the people. Elements that worsen health problems include food insecurity, inadequate housing, joblessness, poor education, poverty, and inadequate allocation of resources. It is, therefore, imperative that the common good strengthens distributive justice which prioritises those who have the greatest claim on the goods of society - the poor.[32]

The USCCB's vision of the common good in healthcare mandates different layers of stakeholders to contribute to the healthcare needs for everyone, especially the poor, the uninsured, and the underinsured. This means that health care becomes a shared responsibility of individuals, families, institutions, and the state. The common good puts special demand on individual responsibility "to protect, sustain, and nurture one's health to the greatest extent possible."[33] One's ability to function depends on good health. One does not expect to contribute directly to the common good under the stress and burden of ill-health. More importantly, individuals must pay attention to lifestyle diseases.

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[30] Zalot, "Commentary on Revising Part One of the ERDs," 249

[31] Todd Salzman, "Catholic Social Teaching, the Common Good, and Healthcare in the US: Seeking a Universal Model of Health Care Coverage." *The Linacre Quarterly* 67, no.3 (2000), 68. doi:10.1080/20508549.2000.11877584.

[32] Salzman, "Catholic Social Teaching, the Common Good, and Healthcare in the US," 69.

[33] Salzman, "Catholic Social Teaching, the Common Good, and Healthcare in the US," 69.

The burden of disease can be lessened when individuals agree to take personal reforms of their habits as the first step. Similarly, individuals contribute to public health when they take care of their environment and when they accept to have their freedoms restricted - as in the pandemic. Furthermore, individuals promote the common good when they take part in universal immunisation when it becomes necessary to protect public health.

Society through government assumes the duty to promote and support multifaceted healthcare interventions for individuals and families under their care. Programmes of health education can build the common good and community resilience since they help individuals and their families in their quest for sound health. To promote preventive programmes the bishops, suggest the promotion of "health fairs, immunization projects, and blood pressure and hypertension clinics."[34] The Church has been a key stakeholder augmenting State efforts in expanding healthcare coverage. This continued collaboration and networking between the Church, and the State has exponentially improved health indicators in many regions. The Church, as part of its mission of evangelisation, joins with other actors to alleviate the pain and suffering arising from opportunistic health challenges. Recalling that Jesus sent his disciples to preach the gospel and to heal the sick is the driving force of the Church's mission (Lk. 9).

In the contemporary situation there is a strong movement to consider the common good in a manner that transcends national borders to one that embraces the "global village." Pope Francis reminded the world that "some parts of our human family … can be readily sacrificed for the sake of others considered worthy of a carefree existence. Ultimately, persons are no longer seen as a paramount value to be cared for and respected when they are poor and disabled, not yet useful – like the unborn, or no longer needed – like the elderly."[35] The fears of a throwaway culture are real, they extend across borders and cultures, and manifest in different forms. International relationships need to be built on mutual benefit. The universal demand of the common good wants to see greater sharing of goods – material, financial, skills, and technology - between the global north and the global south, as an approach of integral human development. Sustaining integral development is an important component of the universal common good which can be achieved through effective transfer of modern goods. The purpose of the exchange is to create a world good for everyone, everywhere. Part of the immigration crisis currently being experienced is as a result of dissatisfaction with the deplorable economic and social conditions of their homelands largely created by poor political leadership, rampant corruption, poor work culture, and limited expertise, skills, knowledge and the impact of climate change. Most of

[34] USCCB, *Health and Health Care*, 6.
[35] Pope Francis, *Fratelli Tutti*, (October 3, 2020), no. 18.

citizens of the countries in the global south are yearning for the improvement of healthcare systems and other social conditions. One contribution to better healthcare globally can be achieved through sharing knowledge, skills, expertise, and patents to support and facilitate what can be accomplished locally such as the manufacturing of generic medicines. Other important areas requiring sharing of goods include agriculture, education, and energy. Agriculture is particularly critical as some regions on the globe need constant adaptation to secure sufficient food production. Countries in the global south, have also to learn to share goods and services among themselves for mutual growth and economic resilience. In the spirit of both solidarity and subsidiarity, such cooperation is essential to address common challenges, enhance self-reliance, and create a more equitable universe.

The need to realise healthcare as a global common good is urgent on the understanding that the well-being of each person must be secured "regardless of the physical proximity, regardless of where he or she was born or lives."[36] The global Covid-19 pandemic showed the world how failure to share skills, resources, knowledge, and patent licences could be detrimental to the global common good. While fighting for the marginalised on the national level is their urgent call, the U. S. bishops may also consider the poor of the world who could be reached through just policies and programmes by developed nations and multi-national organisations. Pro-poor policies especially for countries over-burdened by external debts must be encouraged to release resources for the development of social sectors such as health and education. The campaign for a more just and safer world, should be balanced between the investment in world security systems and sustainable development. Many developing countries require support to build capacity and resilience to deal with natural disasters. Such an appeal underlines the truth that "development [is] the new name for peace."[37] Societies whose basic human needs have been met, are less likely to experience tensions and conflicts. When Paul VI introduced the concept of integral human development, he meant that development is a holistic processes that goes beyond economic growth to encompass the overall well-being of the human person in his/her social, cultural, and spiritual dimensions.[38] Integral human development views every person as deserving opportunities for flourishing that respect their dignity and foster their potential within society. Commitment to justice and equitable distribution of resources is one of the core values of integral human development in view of the required campaign to reduce inequality between wealthy and impoverished nations.[39] Holistic development calls for a solidarity that recognises that all people are

[36] Pope Francis, *Fratelli Tutti*, no. 1.
[37] Paul VI, *Populorum Pregressio* (March 26, 1967), no. 76.
[38] Paul VI, *Populorum Progressio*, no. 14.
[39] Paul VI, *Populorum Progressio*, no. 16.

interconnected and contribute to the common good where nations should work and cooperate to alleviate suffering worldwide.

5.3 Adequate Healthcare for the Poor and Vulnerable

The Church's mission and mandate in view of the preferential option for the poor is to reduce poverty, to raise human dignity, achieve justice, and promote the common good. It is evident that poverty is frequently seen through the lens of material and financial deprivation which is the major focus of this section. However, the U. S. bishops draw attention to the fact that poverty transcends the lack of adequate financial resources to include "a denial of full participation in the economic, social, and political life of society and an inability to influence decisions that affect one's life."[40] In material terms, the worst level of poverty is absolute poverty given that it creates the inability to take control of one's own life and destiny. When poverty is absolute, it means primary basic needs such as food, clothing, home, health, are unmet. Although poverty is mainly viewed through the lens of material deprivation, other forms including economic (lack of sufficient resources to live a decent life), political (excluded due to social structures), and cultural (marginalized because of their social status, race, sex, age, or religion) are considered relative poverty. Generally, relative poverty results from the problem of distribution of national resources among the different levels of society.

The proposed revision of the ERDs with regard to preferential option for the poor reads: "…the biblical mandate to care for the poor requires us to express this in concrete action at all levels of Catholic health care. This mandate prompts us to work to ensure that our country's health care delivery system provides an adequate *social safety net to meet the health care needs of the poor and vulnerable members of society.* In Catholic institutions, particular attention should be given to the healthcare needs of the poor, the uninsured, and the underinsured."[41] Commenting on the proposed revision, Zalot urges that the phrase "vulnerable members of society" represents a more accurate spirit of Catholic social teaching as it encompasses several marginalised members of society including the poor, the weak, and the powerless.[42] Vulnerability includes the employed whose income is borderline and may not be able to provide for their basic needs in the event of an unfortunate medical emergency. Such vulnerable members of society are "those whose income is above the poverty line but also above the eligibility

[40] USCCB*, Economic Justice for All*, no. 188.
[41] Zalot, "Commentary on Revising Part One of the ERDs," 249.
[42] Zalot, "Commentary on Revising Part One of the ERDs," 249.

threshold for public healthcare assistance. These are people for whom an illness or injury (even on medical bill) can be financially ruinous."[43] They are the employed poor.

Preferential option for the poor means to create conditions which do not discriminate against the marginalized, the defenceless, and the poor. The concrete actions include assessing lifestyles, policies, and social structures in terms of their impact on the poor in view of possible reforms. One of the aspects prioritised by the U. S. bishops is the reform in healthcare delivery systems with the focus on the vulnerable members of society. The insurance system continues to create inequality in accessing adequate healthcare. In their methodological approach the bishops explained, "We look at healthcare reform from bottom-up, how it touches the unserved and underserved. …those unable to pay, unable to gain access, inadequate education, or discrimination."[44] This approach demonstrates that to start healthcare reforms from the point of vulnerability is in conformity with the demand of the principle of preferential option for the poor and minimises the risk of leaving out those most affected. Every intervention in healthcare must be evaluated based on how it impacts on the most vulnerable of society namely: the poor, elderly, children, the sick, and the undocumented immigrants. Starting from the point of vulnerability may also help to ensure that no one is forced out. The vulnerable members of society have an urgent demand on any nation. In a quote often attributed to Mahatma Gandhi it is explained, "The basic test (moral conscience) of a moral society lies in how it treats its most vulnerable members. The poor are the most urgent moral claim on the conscience of the nation." The face of the most vulnerable often manifests itself in the homeless who roam the streets every day, persons with disabilities, the drug addicts, and the elderly. In line with this study, vulnerability shows itself in the sick, the malnourished, and those who cannot access adequate healthcare.

The fundamental essence of the principle of preferential option for the poor draws attention to how the allocation of resources is applied to alleviate the suffering of the vulnerable population. In healthcare delivery, the allocation of scarce resources is an integral part of ensuring quality care. Allocation of resources, both failed and delayed delivery amount to denial of accessibility.[45] Further, the bishops noted that, "When there is a question of allocating scarce resources, the vulnerable and the poor have a compelling claim to first consideration. Special attention must be given to ensuring that those who have suffered from inaccessible and inadequate healthcare are first brought back into an effective system of quality care."[46] This implies not only continued handouts, but to empower them to

[43] Zalot, "Commentary on Revising Part One of the ERDs," 248.
[44] U. S. Bishops, "Resolution on Health Care Reform," 100.
[45] U. S. Bishops, "Resolution on Health Care Reform," 100.
[46] U. S. Bishops, "Resolution on Health Care Reform," 100.

take hold of their own destiny. Building a culture of direct and active participation of the vulnerable in their healthcare outcomes guarantees ownership and responsibility.

The truth is that often the poor do not participate meaningfully in change processes due to limited capacities. Greater efforts and resources are needed to create a balance between offering social welfare to cover their urgent needs and to create an environment where the poor and vulnerable get fully involved to achieve the much-needed sustainable development. To delay seeking medical intervention in favour of cost savings creates additional suffering for the vulnerable. Public policy must deliberately be designed to lift the poor and disadvantaged in very real and concrete ways. Acknowledging mutual dependence and the common good, every individual must be "prepared to make changes, address the neglect, accept the sacrifices and practice the discipline that can lead to better healthcare for all."[47] To fulfil the duty of taking personal responsibility for one's personal health, one must have the capacity. The vulnerable are often impeded from making effective decision due to severe deprivation which may even cause them to delay seeking treatment. Each person has a unique role to fulfil in society by contributing to his/her self-realisation and the well-beings of others which every healthcare system must aim to serve and promote.

5.4 Solidarity in Healthcare

The principle of solidarity stresses that healthcare should be accessible, equitable, and oriented towards the common good with special focus on the poor and the marginalised. Solidarity as a principle of CST is a necessary tool for practical reforms since it holds a compelling objective to help to answer the question "why are people poor?" The principle underscores the fact that the realisation of universal access to healthcare depends on the social structures. The principle of solidarity is a new entry in the proposed revision of ERDs, and the directive reads: "Catholic healthcare upholds the principle of solidarity, the 'firm and persevering determination to commit oneself to the common good.' This principle is embodied through efforts to assure access to affordable, quality health care for all people."[48] Equality in healthcare demands drawing up policies and developing systems that ensure everyone especially the most vulnerable have access to the care they need. Although solidarity is a new inclusion in the ERDs, the doctrinal content is already found in other documents of the USCCB. For instance, the *Economic Justice for All* (EJA) states that "solidarity is another name for social friendship

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[47] U. S. Bishops, "Resolution on Health Care Reform," 101.

[48] The National Catholic Bioethics Center, "Proposes Changes to the Text of Ethical and Religious Directives (ERDs)." *The National Catholic Bioethics Quarterly* 23, no. 2 (Summer 2023), 226.

and civic commitment that makes human moral and economic life possible."[49] Fundamental to the principle of solidarity is the mutual interdependence of nations, communities, and individuals. Although the world is made of people identified through boundaries of nations (some artificial), races, ethnicity, and beliefs, "we are our brothers' and sisters' keepers, wherever they may be."[50] There is only one human family which thrives in working together.

The failure of policies, systems, and structures can lead to an increase in poverty. Considered a social justice poverty can be diminished or increased depending on the success or failure of the socially, economically, and politically designed structures meant to promote equity and justice. The Pontifical Council for Justice and Peace defines solidarity as "the firm and persevering determination to commit oneself to the common good."[51] This means structures cannot only fail to support social justice, but they can also fail to promote the realisation of the common good. The most practical way of realising solidarity in healthcare is through the fair distribution of resources for more inclusiveness. However, as it often occurs, the vulnerable members of society such as the poor, the elderly, the disabled, and the marginalised experience greater health risks while facing more barriers to accessing adequate care. By dismantling these barriers to healthcare ensures the protection of the vulnerable population.

Recognising that healthcare is a right closely tied to the dignity of every person means it should be universally accessible to everyone and anywhere. Each society must strive to achieve universal healthcare. One principle the CST employs to ensure there is greater equitable sharing of resources is solidarity. Central to the principle of solidarity is its emphasis on the interconnectedness of humanity and the moral obligation to care for one another, especially the most vulnerable.[52] Furthermore, solidarity is oriented towards the common good, the sum total of social conditions for achieving human fulfilment.[53] Grounded on the inherent dignity and worth of every person, solidarity demands that society ensures access to healthcare for all its members. Solidarity endeavours to unite people in pursuit of justice. By promoting the inherent dignity of each person, promoting the common good, emphasising mutual responsibility, and prioritising the needs of the most vulnerable, solidarity can help to achieve equal access to basic needs for all, and in line with this study to achieve access to healthcare for all.

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[49] USCCB, *Economic Justice for All*, no. 66.
[50] USCCB, *Forming Consciences for Faithful Citizenship*, no. 52.
[51] The Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, no. 193.
[52] Pope Francis, *Fratelli Tutti*, no. 116.
[53] Vatican Council II, *Gaudium et Spes*, no. 26.

The human person is by nature social, therefore, social structures must aim at serving the dignity and development of all people. At the same time, each person has a duty and responsibility to contribute to the common good. To uphold solidarity, individuals and communities must resist and dismantle collective patterns that promote inequality, exclusion, and exploitation collectively termed structures of sin.[54] Solidarity is one principle of CST that directly addresses the subject of transforming or overcoming structures of sin that violate equality and inclusion. Pope John Paul II defines structures of sin as the accumulation and concentration of personal sins, which then become embedded in social, economic, and political systems, creating obstacles to justice and the common good.[55] Such structures systematically oppress human dignity and violate human rights, stifle human freedom, and impose gross inequality between the rich and poor.[56] Sinful structures manifest in many forms like structures, situations, systems, institutions, and attitudes that facilitate injustice and violate human dignity. In other words, "sinful social structures can be formal (e.g., legal, institutional, political, or economic) or informal (e.g., language, customs, or social roles)."[57] The implication here is that evil is perpetuated through social structures which individual and communities accept as normal due to sometimes prolonged practice. Regardless of whatever form a sinful social structure takes, responsibility ultimately lies with individuals.

Reconciliatio et Paenitentia rejects the notion that sin can be attributed to vague entities or anonymous collectivities like situations, systems, or society without the involvement of human persons, as explained, "sin, in the proper sense, is always a personal act, since it is an act of freedom on the part of an individual person and not properly of a group or community."[58] Although John Paul II maintain personal sin as the root of structures of sin, he admitted that people "may be conditioned, incited, and influenced by numerous and powerful external factors" to behave and act in the manner they do.[59] Some consequences of structures of sin include extremely poverty, hunger, neglect, unemployment, lack of health insurance, lack of access to healthcare, and human trafficking. John Paul II has insisted that every case of social sin

> … is a case of the very personal sins of those who cause or support evil or who exploit it; of those who are in a position to avoid, eliminate or at least limit certain social evils but who fail to do so out of laziness, fear, or the conspiracy of silence, through secret

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[54] John Paul II, *Sollicitudo rei Socialis*, (30 December 1987), no. 36.

[55] John Paul II, *Sollicitudo Rei Socialis*, no. 36.

[56] Vitaliano R. Gorospe, "Sollicitudo Rei Socialis: Structures of Sin: Population, and Ecology." *Philippine Studies*36, no. 4 (1988): 508. http://www.jstor.org/stable/42633118.

[57] Brian Hamilton, "It's in You: Structural Sin and Personal Responsibility Revisited." *Studies in Christian Ethics* 34, no. 3 (2021), 365. DOI: 10.1177/09539468211009764.

[58] John Paul II, *Reconciliatio et Paenitentia* (December 2, 1984), no. 16.

[59] John Paul II, *Reconciliatio et Paenitentia*, no. 16.

> complicity or indifference; of those who take refuge in the supposed impossibility of changing the world and also of those who sidestep the effort and sacrifice required, producing specious reasons of higher order. The real responsibility, lies with individuals.[60]

That means, the effective transformation of structures, systems, attitudes, and practices demands individual positive action more than collective effort. On the personal level this process of transforming structures of sin starts with personal conversion. On the part of society transformation demands meaningful structural changes. Again, honest structural changes would fall short of authenticity if the people involved are not converted. This is why *Reconciliatio et Paenitentia* underscores personal sin as the primary disruptor of harmony when it states that "The mystery of sin is composed of [the] twofold wound which the sinner opens in himself and in his relationship with his neighbour."[61] The individual's internal brokenness is the source of external damaged relationships with one's neighbour. No amount of social guilt and responsibilities can dilute or abolish personal sin. Everyone is exhorted to examine their conscience and assess their attitudes, behaviours, and practices that tend to disrespect the dignity of others. Such self-examination should also lead to acknowledging the interdependence of individuals, communities, and nations in achieving health and well-being for all. This is what John Paul II meant when he appealed to the conscience of everyone to shoulder his/her responsibility seriously and courageously in order to change those disastrous conditions and intolerable situations.[62]

In an effort to eliminate or reduce barriers in healthcare access, the bishops' first step on their mission was to establish healthcare institutions with a special focus to serve the most vulnerable. The U. S. bishops' initiative underscores the spirit of solidarity for mutual responsibility in caring for each other. Furthermore, through advocacy, the bishops continue to challenge the notion that healthcare is solely an individual responsibility while insisting on the need for collective action to ensure access for all. For instance, in a letter to Congress as Chairman of the USCCB Committee on Domestic Justice and Human Development, Bishop Frank Dewane stated, "all people need and should have access to comprehensive, quality healthcare that they can afford, and it should not depend on their stage of life, where or whether they or their parents work, how much they earn, where they live, or where they were born. The Bishop's Conference believes healthcare reform should be truly universal, and it should be genuinely affordable."[63] Access to adequate healthcare involves public funding and other mechanisms of pooling resources and sharing the costs. The desire to guarantee affordable and accessible quality

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[60] John Paul II, *Reconciliatio et Paenitentia*, no. 16.
[61] John Paul II, *Reconciliatio et Paenitentia*, no. 15.
[62] John Paul II, *Reconciliatio et Paenitentia*, no. 16.
[63] Bishop Frank Dewane, *Letter to Congress at the Start of 115th Congress* (Washington D. C.: USCCB Committee on Domestic Justice and Human Development, 2017).

healthcare is a moral obligation which demands persistent advocacy. When healthcare is accessible only to those who can afford it, it becomes a privilege and not a right. Therefore, solidarity cannot simply be as a principle but more so an integral part of promoting self-realisation and potential by ensuring that everyone gets involved in personal growth and community development.[64]

Solidarity stresses sacrifice which means foregoing some of one's personal preferences for the sake of the common good. The duty of solidarity extends beyond national borders by calling for global health equity. Wealthier nations have a responsibility to assist poorer nations in developing their healthcare systems and addressing global healthcare challenges. Paul IV on the development of peoples insisted that "we are all equally responsible for the underdevelopment of poor nations. It is not just a question of eliminating hunger but building a world where all people can live with dignity. … The richer nations must recognise their moral responsibility to help the poorer nations develop."[65] This is one of the strongest statements on global economic solidarity in Catholic teaching which affirms that wealthier nations have a moral obligation to act in solidarity with poorer nations, not only through aid, but through just economic structures, fair trade, and equitable development. Global solidarity may involve among other things providing financial assistance, technical expertise, and access to essential medicines.

5.5 Responsible Stewardship

This section explores the challenges associated with waste generation, environmental degradation, and the consumption of scarce resources within the context of healthcare delivery. Human activities inherently produce substantial amounts of waste, and without proper management or processing, such waste can significantly harm the environment. Among the most environmentally damaging practices are the discharge of industrial waste, the combustion of fossil fuels, uncontrolled deforestation, and the use of specific herbicides, coolants, and propellants.[66] To this list must be added the waste generated by healthcare procedures and services.

While advancements in medical science have led to major improvements, such as faster and more accurate diagnoses, more effective treatments, and increased life expectancy, they have also contributed to a substantial increase in waste production. Medical waste encompasses all materials

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[64] John Paul II, *Loborem Exercens* (1981), no. 9.

[65] Paul IV, *Populorum Progressio* (1967), nos. 44-48.

[66] Christiana Z. Peppard, "Commodifying Creation?" in Schaefer, Jame, and Tobias Winright, eds. *Environmental Justice and Climate Change: Assessing Pope Benedict XVI's Ecological Vision for the Catholic Church in the United States* (Blue Ridge Summit: Lexington Books/Fortress Academic, 2013), 86. Accessed December 11, 2024. ProQuest Ebook Central.

discarded during the processes of diagnosis, treatment, immunisation, and research. These wastes, in the form of plastic, rubber, chemicals, radioactive materials, needles, heavy metals, different sorts of packaging, and human tissues, organs, body parts, and fluids, are often hazardous, infectious, or environmentally detrimental. The volume of such waste tends to rise significantly in long-term or critical care settings. For example, during the COVID-19 outbreak in Hubei Province, China, the volume of infectious medical waste surged by 600%, rising from 40 tons per day to 240 tons per day.[67] Pope Francis, in *Laudato Si'*, draws attention to "the pace of consumption, waste and environmental change,"[68] and warns that "the earth, our home, is beginning to look more and more like an immense pile of filth."[69] This concern is directly applicable to the healthcare sector, where improper handling of medical waste can pose serious threats to both environmental and public health.

Safeguarding the environment is an essential expression of the common good, a foundational principle of Catholic Social Teaching. The common good requires that the social conditions of life enable every individual and community to achieve their full human potential with greater ease and dignity. In this context, the ethical management of medical waste becomes a critical concern.[70] Improper disposal of medical waste not only threatens public health by facilitating the spread of infectious diseases and contaminating ecosystems but also undermines the moral responsibility to uphold justice and charity within healthcare systems. From a theological and ethical standpoint, responsible waste disposal is not merely a technical issue but a moral obligation that protects the health and dignity of all, especially the most vulnerable. The Church's preferential option for the poor compels special attention to marginalized communities, who are often disproportionately affected by environmental degradation and lack the resources to mitigate its effects. As such, environmentally sound healthcare practices should be seen as integral to promoting human dignity, advancing social justice, and ensuring that the right to health is upheld for all members of society.

The United States Conference of Catholic Bishops (USCCB) has thoroughly addressed the importance of stewardship in the responsible allocation and application of healthcare resources. A healthcare delivery system achieves its objectives most effectively when resources are utilised responsibly and waste is minimised. Among the various components of healthcare, resources remain the most tangible and essential in ensuring equitable access to adequate and efficient care. Conversely,

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[67] Secretariat of the Pacific Regional Environment Programme (SPREP). *MEDICAL WASTE ALERT How to Manage COVID-19 Healthcare Waste*. SPREP (2020). *JSTOR*, http://www.jstor.org/stable/resrep46460. Accessed 22 July 2025.

[68] Pope Francis, *Laudato Si'*, no. 161.

[69] Pope Francis, *Laudato Si'*, no. 21.

[70] Catholic Bishops' Conference of England and Wales, *The Common Good and the Catholic Church's Teaching*, no. 108.

the mismanagement, delay, or denial of resources serves as a clear indicator of systemic failure. Central to the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs) is the assertion that "the responsible stewardship of healthcare resources can be accomplished best in dialogue with people from all levels of society, in accordance with the principle of subsidiarity and with respect for the moral principles that guide institutions and persons."[71] This statement reflects a growing recognition that healthcare must now be understood through a multidimensional lens—one that acknowledges stewardship as a fundamental concern not only for clinical care but also for organizational governance and ethical administration.

Stewardship is the process of accountability by which healthcare professionals and administrators apply limited resources in a sustainable and equitable manner. Noticeably, the USCCB discussion of the principle of stewardship is focused was mainly on prudent application of resources and the implication on protecting human life. One major thrust of the U.S. bishops' considerations of stewardship was the call for the central government to respect the initiatives and capacities of local communities to handle their own affairs in the spirit of the principle of subsidiarity. The bishops believe that handling resources at a local level ensures effective utilization and mitigates against waste. The bishops' concerns are in line with the Church's caution on excessive bureaucracy which not only delays processes but also denies effectiveness.[72] The aim of all forms of collaborations and partnerships with other stakeholders is "to realign the local delivery system to provide a continuum of healthcare to the community, to provide a model of a responsible stewardship of limited health care resources, to provide poor and vulnerable persons with more equitable access to basic care, and to provide access to medical technologies and expertise that greatly enhance the quality of care."[73] Such a decentralised approach promotes greater ownership as well as accountability.

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[71] USCCB, *Ethical and Religious Directives*, Part One, Introduction, par. 4.

[72] The Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, no. 412: "As an instrument of the State, public administration at any level — national, regional, community — is oriented towards the service of citizens: "Being at the service of its citizens, the State is the steward of the people's resources, which it must administer with a view to the common good". Excessive bureaucratization is contrary to this vision and arises when "institutions become complex in their organization and pretend to manage every area at hand. In the end they lose their effectiveness as a result of an impersonal functionalism, an overgrown bureaucracy, unjust private interests and an all-too-easy and generalized disengagement from a sense of duty". The role of those working in public administration is not to be conceived as impersonal or bureaucratic, but rather as an act of generous assistance for citizens, undertaken with a spirit of service."

[73] USCCB, *Ethical and Religious Directives*, Part Six: Introduction, par 2. Also Cf.: "Created in God's image and likeness, the human family shares in the dominion that Christ manifested in his healing ministry. This sharing involves a stewardship over all material creation (Gn 1:26) that should neither abuse nor squander nature's resources. Through science the human race comes to understand God's wonderful work; and through technology it must conserve, protect, and perfect nature in harmony with God's purposes. Health care professionals pursue a special vocation to share in carrying forth God's life-giving and healing work." (ERDs, General Introduction, par. 9).

While minimizing waste generation, mitigating environmental degradation, and promoting prudent resource management are essential objectives, their implementation must never come at the expense of human life. This implies that resources must not be withheld based on a judgment that a particular life is unworthy of care due to the individual's deteriorating condition. Individuals receiving end-of-life care or approaching death are sometimes perceived as less deserving of continued medical attention. The first and fundamental care is directed towards treatment of the existing pathological condition. The other important care involves the administration of nutrition and hydration especially for patients in terminal conditions. In their authoritative instruction the USCCB stated that it is a moral obligation to provide food and drink throughout a patient's life, including the provision of medically assisted nutrition and hydration, even for patients in a persistent vegetative state.[74] At this stage, the bishops have not yet differentiated between proportionate and disproportionate interventions. The USCCB's focus is on what is required beyond the failure of treatment. The New York State bishops outlined broadly what is needed when they said, "All those who are sick should rightfully expect, accept, and be provided appropriate food, water, pain control, bed rest, suitable room temperature, personal hygiene measures and comfort care. These are not medical treatments, but basic care-giving, the care that is owed to one human being by another."[75] The interventions listed above are counted as morally obligatory. That said, lived experience has demonstrated that it is not easy to categorise what is always obligatory and what is always optional. Each case may pose unique challenges.

Samaritanus Bonus agrees that medically assisted nutrition and hydration is an essential care for patients in critical and terminal phases of life. Although the *Samaritanus Bonus* teaches that providing nutrition and hydration, even through medically assisted means is generally morally obligatory as it is considered a basic means of preserving life, this obligation is not absolute and admits certain exceptions.[76] The Congregation for the Doctrine of the Faith underlines continuity of care for essential physiological functions which may include administration of nourishment and fluids needed to maintain bodily *homeostatis*, but only if it evidently attains the purpose of providing hydration and nutrition for the patient.[77] Any means of preserving life must be judged based on whether they offer a patient a reasonable hope of benefit and do not pose too great physical, emotional, spiritual, or financial burden on the patient and/or community. Apart from being burdensome, measures for preserving life can become disproportionate if their continued administration is an in futility.[78] Concretely, medically

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[74] USCCB, *Ethical and Religious Directives*, no. 58.
[75] New York State Catholic Conference, *Now and at the Hour of Our Death*, 2.
[76] Congregation for the Doctrine of the Faith (CDF), *Samaritanus Bonus* (July 14, 2020), no. 2.
[77] CDF, *Samaritanus Bonus*, no. 3.
[78] CDF, *Samaritanus Bonus*, no. 8.

assisted nutrition and hydration is disproportionate when the body can longer assimilate nutrients (indicating that the digestive system has shut down); when it merely prolongs the dying process; and when the burdens outweigh the benefits.[79] Some discomfort and burdens associated with disproportionate measures include unbearable discomfort, actual swelling, excessive vomiting, and pain.

The Catholic Church maintains that the use of medical technology or interventions that offer no meaningful benefit, are disproportionate to the expected outcome, or impose an undue burden without significant therapeutic value constitutes a form of waste. This principle extends to cases of overtreatment or the use of advanced and expensive medical procedures when simpler, less costly, and equally effective alternatives are available. Such practices are considered inconsistent with responsible and ethical stewardship of healthcare resources. The reality is that there comes a stage when both treatment and nourishment fail necessitating the inevitable decision to withdraw or refuse. Every person needs to understand that medical interventions that normally sustain them in life may one day become morally optional, therefore, can be withdrawn or refused.

This raises the difficult and often emotionally charged question of when to discontinue medically assisted nutrition and hydration, a decision frequently influenced by complex factors such as ethical uncertainty, clinical judgement, and the fear of failing or abandoning a loved one. However, the Church assures that "the dignity of those who are critically or terminally ill calls for all suitable and necessary efforts to alleviate their suffering through appropriate palliative care and by avoiding aggressive treatments or disproportionate medical procedures."[80] In effect prolonging the process of dying could have more negative implications than to allow someone to die sooner if it is ascertained that the prospect of recovery is unattainable. The paramount duty in palliative care or end-of-life care is to keep the patient as comfortable as possible. When nutrition and hydration become the source of discomfort, the intervention must be avoided.[81] Foregoing aggressive expensive end-of-life care can be respect for the dignity of the patient by protecting him/her from forceful feeding and pain. The exclusion of aggressive therapy is justified on the basis that food prepared in a laboratory and administered through technology does not amount to simple care procedures.[82] Such exclusion of aggressive therapy and nourishment does not amount to hastening death but respecting the natural

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[79] *Samaritanus Bonus*, nos. 3 and 8.

[80] Dicastery for the Doctrine of the Faith, *Dignitas Infinita*, no. 52.

[81] Elise Ann Allan, "Vatican Loosens Stance on Food, Water for Patients in Vegetative State." *The Irish Catholic* (August 15, 2024), 26.

[82] Allan, "Vatican Loosens Stance on Food, Water for Patients in Vegetative State," 26.

course of the illness.[83] Furthermore, the refusal of futile medical interventions is a recognition of the limitation of medical interventions and the concern for others who may benefit from the spared resources. While the primary focus of withdrawing aggressive medical treatment is on respecting human dignity and avoiding disproportionate burdens on the patient and the family, it can also have positive environmental effects.

The New York State bishops encouraged consideration on shared limited resources by observing that "when making a decision to accept or refuse a treatment, we should take into consideration the type of treatment recommended, how risky or complicated it is, its cost, side effects, how painful it will be, its availability, the likelihood of that treatment maintaining or enhancing the life of the patient, and the need to share limited medical resources."[84] A decision to forego aggressive treatment or nutrition can demonstrate a personal commitment to the common good, solidarity with the majority poor, and the protection and restoration of ecology.

The healthcare sector significantly contributes to environmental pollution through resources use, waste generation, and carbon emissions. Healthcare activities especially in ICU setup consume substantial resources and reducing on futile interventions lowers the demand on energy, water, and raw materials used in manufacturing medical supplies and equipment. Additionally, generated waste such as syringes, catheters, and packaging materials all become drastically reduced.

5.6 The Principle of Subsidiarity

Timely and effective decision making is the hallmark of an efficient healthcare system. The principle of subsidiarity empowers local communities, healthcare institutions, families, and individuals to make their own decision regarding their prevailing health needs. The proposed revision for the ERDs asks for the inclusion of the principle of subsidiarity and it reads:

> The principle of subsidiarity is realised when the State and local governments – in concerts with the local Church and family – actively engage in shaping their local healthcare system and advocate for programmes that provide assistance consistent with the actual and particular needs of their communities. To the greatest extent possible, local communities should be empowered to effectively meet these needs.[85]

Subsidiarity stops central government from interfering with the day-to-day operations of the lower organs of State administration. Cardinal Czerny makes a distinction between solidarity and subsidiarity when he stated that, "Solidarity is the golden rule of Catholic social teaching, treating others as you

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[83] *Samaritanus Bonus*, no. 3.

[84] New York State Catholic Conference, *Now and at the Hour of Our Death*, 4.

[85] The National Catholic Bioethics Center, "Proposes Changes to the Text of ERDs," 227

wish to be treated yourself, and subsidiarity is respect for the freedom and responsibility of the local, rather than imposing from above."[86] Subsidiarity recognises the invaluable contributions different groups and associations make to society. The pastoral letter *Health and Health Care* recognised the responsibility of individuals, families, and communities in taking charge of their own health situations, while being aware that several stakeholders may support them with health education and other incentives.[87] The family, the local Church, and local government are most effective in providing health care solutions to their people because they are closest to the needs and resources of their communities.[88] By contrast the centralised one-size-fits-all approach tends to create bottle necks and delay service delivery. It must be pointed out here, the paramount duty of the central government to provide sufficient funds for healthcare is never taken away.

Subsidiarity in many instances promoted participation of the affected community and families in responding to health crisis. There is a powerful advocacy here to allow local communities and families to determine their health care priorities. The authentic manifestation of subsidiarity is that any assistance by a higher body must not diminish greater participation and ownership of the community initiative. Such assistance must allow people to become protagonists of their destiny and accept it as their duty. Subsidiarity supports greater expression, facilitates development of skills and capabilities, and increases initiative of the society. A well-executed principle of subsidiarity has the potential to unlock delays and obstacles to initiatives and development occasioned by excessive decentralization and strict bureaucratization.

5.7 The Role of Political Deficiency in the Inadequacies of the U.S. Healthcare System

Politics is an essential component of society. Ideally, it is the channel of negotiation for political leadership position and decision-making in every political community. Hence, the need for a proficient political system and leadership for the actualisation of an effective universal healthcare in society. The United States Conference of Catholic Bishops (USCCB), building from the Vatican II Fathers reaffirm that politics is oriented toward the pursuit of the common good, which the Vatican II Fathers defined as

[86] Michael Czerny, "In Times of Unprecedented Crises How Can Catholic Social Teaching Help Us?" *The Furrow* (May 2023), 262.

[87] USCCB, *Health and Health Care*, 6.

[88] Catholic Medical Association, *Applying Catholic Principles in Evaluating Health Care Reform Proposals*, no. 4.

the totality of social conditions that enable individuals, families, and communities to flourish.[89] This signifies that *good politics* is required for authentic governmental healthcare service for the common good. In *Fratelli Tutti*, Pope Francis envisions the practice of politics that transcends narrow interests and partisanship, advocating instead for a politics rooted in the common and universal good—a politics that is both for and with the people.[90] *Good politics*, therefore, is geared towards the wellbeing of people.

Given that healthcare services constitute a fundamental common good, its provision is a primary responsibility of those in political authority – the State. Once again, clarity is required regarding the role of government in providing the necessary goods and services for the people. As Suzanne Mulligan articulates, the concept of good politics is "concerned with human flourishing and authentic living, imagining the conditions in which people can live their best lives, realise their potential and discover their gifts. It suggests that social, economic, and political structures exist to facilitate human flourishing and are very much at the service of the common good."[91] In this vision, Pope Francis challenges political models that reduce the notion of 'the people' to a mere rhetorical tool or demographic category. He strongly critiques populist tendencies that exploit cultural symbols for exclusionary purposes, warning against approaches that undermine genuine solidarity and shared aspiration. He maintains that "The word 'people' has a deeper meaning that cannot be set forth in purely logical terms. To be part of a people is to be part of a shared identity arising from social and cultural bonds."[92] Leaders who fail to engage with and respect the complex cultural dynamics of the communities they serve, risk fostering division and exploitation rather than unity and common purpose.

Regrettably, the problem of unequal distribution of national resources has become a common obstacle for the common good in many countries. Among these, disparities in healthcare access stand out as both a symptom and a driver of broader systemic injustices.[93] This entails collective intentionality in fighting this anomaly in our society for human flourishing.[94] The USCCB recommends a comprehensive healthcare reform, emphasizing that the visible unequal distribution of these services are not accidental but are the result of deliberate policy choices and institutional neglect. Their critique is rooted in the conviction that access to healthcare is a fundamental human right and a necessary

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[89] USCCB, "Resolution on Health Care Reform," *Origins* 23, no. 7 (July 1, 1993), 99; Vatican II, *Gaudium et Spes*, no. 26.

[90] Pope Francis, *Fratelli Tutti*, no. 157.

[91] Suzanne Mulligan, "'Builders of a New Social Bond': Fratelli Tutti on Good Politics and the Challenge of Inequality." *American Journal of Economics & Sociology* 80, no. 4 (September 1, 2021), 1175. doi:10.1111/ajes.12421.

[92] Pope Francis, *Fratelli Tutti*, no. 158.

[93] Pope Francis clearly states that "Injustice is not invincible" (See *Laudato Si*, no. 74.)

[94] USCCB, "Resolution on Health Care Reform," *Origins* 23, no. 7 (July 1, 1993), 99

condition for human dignity and social inclusion.[95] The bishops poignantly noted that "in communities across our land we serve the sick and pick up the pieces of a failing system."[96] This reveals the crucial role of *good politics* for political action that prioritizes the common good, corrects structural inequities, and reaffirms the dignity of all human beings.

The current challenges within the healthcare system are the result of policy decisions— that are not immutable and, therefore, can and should be reformed.[97] It is important to note that socio-economic problems are policy driven and they can be replaced when they do not serve the common good. Hence, the need for more equitable socio-economic policies for human flourishing. The USCCB highlights three key strategies for equitable provision of healthcare services in the United States: advocating for universal access to healthcare, actively engaging in public policy discourse, and critically examining structural injustices that perpetuate exclusion. These strategies reveal the deficiencies of the prevailing government healthcare policies which fails to serve a substantial portion of the U.S. population.[98]

In *A Framework for Comprehensive Health Care Reform*, the USCCB presents both the moral criteria and key policy priorities for evaluating healthcare reform firmly rooted in Catholic social teaching. The moral criteria advocate for a healthcare system that upholds human dignity, prioritizes the needs of the poor and vulnerable, ensures universal access, promotes the common good, and advances justice and equity.[99] This criteria emphasises core principles of CST, including respect for human life, a preferential option for the poor, commitment to the common good, protection of institutional and individual conscience rights, and the pursuit of cost-effective solutions that do not compromise ethical standards.[100] This is another way of highlighting political flexibility and effectiveness as contained in the principle of *good politics*, which according to recommendation by Pope Francis, "combines love with hope and confidence" in the service of humanity.[101] The moral criteria draw from the Church's teaching on the sacredness of human life and of the need to safeguard it at all levels.

Consequently, provision of affordable and accessible healthcare is a fundamental human right that should be prioritised by every State. This entails a critical engagement with political candidates vying for leadership position regarding their commitment to advancing healthcare policies that uphold

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[95] USCCB, *Forming Consciences for Faithful Citizenship*, no. 80.
[96] USCCB, "Resolution on Health Care Reform," 99.
[97] Mulligan, "Builders of a New Social Bond," 1184.
[98] USCCB, *A Framework for Comprehensive Health Care Reform*, 1.
[99] USCCB, *A Framework for Comprehensive Health Care Reform*, 2-3.
[100] USCCB, *A Framework for Comprehensive Health Care Reform*, 3-4.
[101] Pope Francis, *Fratelli Tutti*, no. 196.

human life, protect human dignity, and safeguard religious freedom.[102] Additionally, formation of conscience regarding the sacredness of life and safeguarding the dignity of every human person is necessary for all citizens. Recognizing the sacredness of human life in political discourse and policy development regarding healthcare creates awareness and safeguards human dignity. Church's social ethos describes such process as intellectual solidarity, which is a dynamic process of building consensus through a critical and well-informed citizenry capable of evaluating and balancing diverse perspectives.[103]

Furthermore, the U.S. bishops have actively engaged the US citizens regarding the ethical standard for universal healthcare services through the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs). Their Magisterial teaching provides intellectual material and pastoral guidance on Catholic moral and ethical principles for the State and all policy makers. In addition, the USCCB regularly contributes to public policy debates through formal communications such as letters to Congress. For instance, in their letter to the 115th Congress, the bishops advocated for healthcare reform that is truly universal and genuinely affordable, underscoring their belief that healthcare is a basic human right that must be extended to all, especially the poor and marginalized.[104] n June 2025, the United States Conference of Catholic Bishops (USCCB) issued a formal letter to Congress addressing the ethical dimensions of emerging technologies, particularly artificial intelligence (AI). In this correspondence, the bishops articulated a set of guiding principles aimed at shaping proposed legislation, grounded in the dignity of the human person, the preferential option for the poor, and an unwavering commitment to truth and transparency.[105] This timely and proactive intervention reflects a broader ecclesial concern over the ethical neutrality of technological development and its potential to exacerbate existing social inequities. By calling for universally just and human-centred AI policy, the USCCB signals its apprehension about the ideological underpinnings of transhumanism and the uncritical adoption of AI systems, especially in sensitive domains such as healthcare screening.[106] This caution is a reminder that such technological encroachments risk reducing the human person to data points, thereby neglecting the complex web of social determinants that critically shape health outcomes. Without adequate regulation, these advancements could reinforce structural injustice and depersonalize healthcare, ultimately undermining the moral fabric of society.

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[102] USCCB, *Forming Consciences for Faithful Citizenship*, no. 92.

[103] Mulligan, Mulligan, "Builders of a New Social Bond," 1179.

[104] USCCB, *Letter to Congress at the Start of 115th Congress* (Washington DC: USCCB Committee on Domestic Justice and Human Development, 2017).

[105] USCCB, *AI Principles and Priorities Letter* (Washington DC: USCCB, June 9, 2025). https://www.usccb.org/resources/AI%20Principles%20and%20Priorities%20Ltr%206%209%2025.pdf.

[106] USCCB, *AI Principles and Priorities Letter*.

From the perspective of structural injustice, the USCCB has offered a sustained critique of the existing health insurance system, which often excludes economically disadvantaged individuals and marginalized communities. The bishops have been particularly vocal in rejecting proposals for a two-tiered healthcare system, one that would separate the affluent from the poor and vulnerable.[107] Such a model, they argue, institutionalizes inequality by providing higher-quality care to those who can afford it, while relegating low-income individuals to inferior or underfunded services. The bishops unequivocally asserted that separate healthcare for the poor effectively amounts to inferior healthcare.[108] For the USCCB, this stratification not only undermines the principle of the common good but also risks compromising the dignity and well-being of those most in need. They contend that access to quality healthcare must not be determined by socio-economic status and that any system perpetuating such disparities constitutes a moral and policy failure.[109]

In conclusion, the United States Conference of Catholic Bishops asserts that access to healthcare should not be contingent upon an individual's employment status, family income, or geographic location.[110] Given the ongoing reality in which the healthcare system remains inaccessible to many and financially burdensome, the bishops emphasize the urgent need to prioritize the national conversation around universal access, cost containment, and quality improvement. Pope Francis refers to such engagement as *good politics*. According to the Holy Father, "Good politics will seek ways of rebuilding communities at every level of social life."[111] At the heart of this advocacy is the conviction that protecting the most vulnerable from exclusion and inequality is a core obligation of any legitimate political order. This affirms Mark G. Sheppard observation that "good policy is good politics."[112] This study argues that unequal treatment of people threatens human dignity and undermines the common good in every political community. It also reveals lack of political will to safeguard the right and dignity of every human person.

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[107] USCCB, *Comments on the Recommendations of the Citizen's Health Care Working Group* (Washington DC: USCCB, August 23, 2006). https://www.usccb.org/resources/comments-recommendations-citizens-health-care-working-group-august-23-2006.

[108] USCCB, *A Framework for Comprehensive Health Care Reform*, 3.

[109] USCCB, *Letter to Congress at the Start of 115th Congress*.

[110] USCCB, *A Framework for Comprehensive Health Care Reform*, 1.

[111] Pope Francis, *Fratelli Tutti*, no 187.

[112] Mark G. Sheppard, "Good Policy is Good Politics," https://chicagopolicyreview.org/2024/08/15/good-policy-is-good-politics/ Accessed July 30, 2025.

5.8 An Evaluation of the USCCB Integration of Catholic Social Teaching and Bioethics

The American Catholic bishops' teaching on healthcare articulated in several documents over the years has several positive aspects rooted in the Catholic social teaching but also faces challenges. The main teachings on healthcare by the USCCB are contained in the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs), a guide to answering common ethical conflicts within Catholic healthcare institutions. Other documents like the *Health and Healthcare*, *Economic Justice for All* and *A Framework for Comprehensive Health Care Reform* have also been useful instruments on healthcare matters. This section will assess five fundamental contributions promoted by USCCB to achieve universal access to healthcare and will conclude with noticeable criticisms.

5.8.1 Emphasis on Human Dignity and Right to Healthcare

The United States Conference of Catholic Bishops (USCCB) has consistently asserted that affordable and accessible healthcare is a fundamental human right and an essential component in the protection of human life. This position is deeply rooted in the Church's broader moral framework, which upholds the inviolable dignity of the human person from conception to natural death. Healthcare, therefore, is not merely a service but a moral imperative that safeguards life and ensures human flourishing.

At the heart of the USCCB's position is the assertion that healthcare is a fundamental human right, a claim that significantly shifts the healthcare conversation from market-driven concerns to moral obligations.[113] This foundational claim is not novel; rather, it echoes long-standing teachings within Catholic social doctrine. In particular, Pope John XXIII's encyclical *Pacem in Terris* (1963) articulates principles that serve as theological antecedents to the USCCB's modern healthcare stance. The encyclical affirms that every human being possesses the right to life, to bodily integrity, and to those means necessary for human flourishing—including medical care: "Man has the right to live. He has the right to bodily integrity and to the means necessary for the proper development of life, particularly food, clothing, shelter, medical care, rest, and, finally, the necessary social services."[114] This explicit inclusion of medical care as a right affirms that healthcare is not a commodity, but a moral and social good. More than just a service, it is understood as a condition for human participation in community life and a prerequisite for contributing to the common good. The right to adequate healthcare, then, is inextricably linked to broader notions of human agency, civic inclusion, and social solidarity.

[113] USCCB, *A Framework for Comprehensive Health Care Reform* (1993), 1.
[114] John XXIII, *Pacem in Terris*, no. 11.

At the heart of the USCCB's *Ethical and Religious Directives* is the commitment to protect the sacredness of human life and the dignity of the human person against all threats, whether they arise from systemic inequality or medical overreach. Whether healthcare is basic or advanced, it must align with the Church's unwavering commitment to the right to care**.** The bishops have emphasized the need to translate moral principles into actionable policies**,** warning that: "Access to universal healthcare must not be significantly postponed, since coverage delayed may be coverage denied."[115] Despite the growing recognition of healthcare as a right, several barriers continue to hinder its full realization. These include inadequate coverage**,** rising costs**,** the varied nature of healthcare institutions**,** and social determinants of health such as poverty, education, and geography for which the USCCB spends a lot of time, energy, and resources in efforts to resolve them.

5.8.2 Advocacy for the Vulnerable

The USCCB integrates the principle of the preferential option for the poor as a central moral directive in its advocacy for universal healthcare reform. This principle, rooted in Catholic social teaching, affirms that the needs of the poor and marginalized must take precedence especially in contexts of limited resources.[116] Far from being a charitable suggestion, this is presented as a moral obligation that demands both policy action and structural transformation in healthcare systems.

The preferential option for the poor calls healthcare providers, policymakers, and society at large to begin from a position of need, a concept echoed in contemporary bioethics, which increasingly emphasizes need-based care as a foundational ethical orientation.[117] Within this framework, the moral imperative of universal healthcare demand by the USCCB becomes clear: no individual, regardless of economic or social status, should be excluded from access to quality medical care.[118] Healthcare is not merely a service but a means of affirming human dignity, especially for those whom society tends to overlook, namely: the poor, the uninsured, the unborn, pregnant women, immigrants, and those battling addiction.[119] Fittingly, the USCCB has always advocated for policies and programmes that are intended to expand access to healthcare, reduce health disparities, and promote health equity.

Poverty remains one of the most persistent and damaging barriers to healthcare access. In this context, the Dicastery for the Doctrine of the Faith underscores the urgency of addressing systemic inequality, stating: "Among the many grave violations of human dignity in today's world, we must

[115] U. S. Bishops, "Resolution on Health Care Reform," 100.
[116] John Paul II, *Solicitudo Rei Socialis* (1987), no. 42.
[117] Lysaught and McCarthy, *Catholic Bioethics and Social Justice*, 7
[118] USCCB, *A Framework for Comprehensive Health Care Reform*, 1.
[119] USCCB, *Forming Consciences for Faithful Citizenship* (2015), no. 80.

recognise the scandal of poverty as particularly offensive."[120] This powerful statement reframes poverty not just as a social problem, but as a profound moral scandal, and by extension, any system that limits healthcare based on wealth or social standing as ethically unacceptable. Thus, the USCCB in line with the Church's tradition makes clear that caring for the poor is not optional but it is a non-negotiable moral imperative intricately tied to the defence of human dignity.

The USCCB's approach moves beyond abstract principles into concrete action, engaging in policy advocacy, public statements, and the provision of ethical guidance. By doing so, they aim to reshape the structural conditions that perpetuate injustice. The bishops sustained call for comprehensive reform reflects the belief that poverty is not just a personal misfortune, but often a result of social sin, a concept that highlights how unjust systems can entrench inequality and deny individuals the basic means of survival, including healthcare.[121] In this light, healthcare reform becomes a form of social repentance or a moral correction of institutional failures. Furthermore, prioritizing vulnerable groups in policy, especially those often excluded or devalued in public discourse serves as a concrete manifestation of justice. Such prioritization is not reverse discrimination, but a corrective measure aimed at restoring balance in systems skewed by wealth, privilege, and power. It acknowledges the moral urgency of addressing disparities in access to care and confronts the deeper spiritual and ethical failures of societies that allow such inequalities to persist.

By placing the preferential option for the poor at the centre of its healthcare advocacy, the USCCB articulates a critically engaged, theologically grounded response to one of the most pressing moral issues of our time. Their approach insists that healthcare justice cannot be separated from human dignity, and that systemic transformation is necessary to fulfil the demands of Catholic social teaching. Ultimately, this vision challenges both Church and society to measure their moral integrity by how they treat the most vulnerable among them.

5.8.3 Support for Comprehensive Healthcare Reform.

The United States Conference of Catholic Bishops has positioned itself as a persistent moral voice in the American healthcare debate, advocating for reforms grounded in Catholic social teaching**.** Their active engagement in public policy is not merely political activism but a theological response to the moral imperative of safeguarding human dignity**,** protecting life**,** and addressing the needs of

[120] Dicastery for the Doctrine of the Faith, *Dignitas Infinita*, no. 24.
[121] USCCB, *Economic Justice for All*……

the vulnerable.[122] This advocacy is shaped by a consistent framework that places the dignity of the human person, justice, and the common good at the forefront of any legitimate healthcare reform.

While there has been measurable progress in healthcare accessibility in many countries, such improvements remain uneven across different regions and populations due to disparities in innovation, infrastructure, and affordability. The USCCB's campaign for comprehensive reform does not exist in a vacuum; it is a response to structural inequities within the U.S. healthcare system such as inequities that disproportionately impact the poor, the uninsured, and other marginalized groups. When proposing comprehensive reform, the bishops stated: "We believe reform of the healthcare system which is truly fundamental and enduring must be rooted in values that reflect the essential dignity of each person, ensure that basic human rights are protected, and recognise the unique needs and claims of the poor."[123] To concretise their belief in universal healthcare coverage the bishops outlined eight criteria and four key priority areas. Included in the criteria are: "respect for life, priority concern for the poor, universal access, comprehensive benefits, pluralism, quality, cost containment and controls, and equitable financing."[124] Where the key priorities comprise of "priority concern for the poor/universal access; respect for human life and human dignity; pursuing the common good and preserving pluralism; and restraining costs."[125] By framing healthcare access as a justice issue, the bishops expose the moral shortcomings of systems that prioritise efficiency, profit, or individual autonomy over collective well-being. In doing so, they reframe healthcare not simply as a policy concern, but as a moral litmus test for how society treats its most vulnerable.

Furthermore, the bishops appeal to subsidiarity, a principle that demands that decisions should be made at the most local level capable of addressing them and demands a nuanced approach to reform. It cautions against over-centralization while affirming the legitimate role of government in ensuring universal access to essential services like healthcare.[126] The USCCB's emphasis on subsidiarity reinforces that structures of care must serve people, not abstract institutions or economic interests. Without meaningful reform, these factors risk exacerbating health disparities, especially for the poor and vulnerable.

The USCCB's stance on healthcare reform reflects a rich integration of Catholic moral theology and public responsibility. Drawing upon *Pacem in Terris* and other doctrinal sources, the bishops present a compelling argument for accessible, affordable, and comprehensive healthcare as a basic

[122] Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, no. 184.
[123] USCCB, *A Framework for Comprehensive Health Care Reform* (2003), 2.
[124] USCCB, *A Framework for Comprehensive Health Care Reform* (2003), 2-3.
[125] USCCB, *A Framework for Comprehensive Health Care Reform* (2003), 3-4.
[126] USCCB, *Economic Justice for All*, no. 122.

human right and a moral duty of both individuals and society. While the path to achieving this vision remains fraught with political and ethical challenges, the USCCB continues to provide a critical moral framework that calls the nation to measure its health policies not by cost-efficiency alone, but by how well they uphold the dignity of every human person.

5.8.4 Ethical and Religious Directives for Catholic Health Care Services (ERDs)

The United States Conference of Catholic Bishops provides clear ethical and religious directives for Catholic healthcare institutions, to ensure that they adhere to Catholic moral teaching in their provision of care. The ERDs provide a robust ethical framework grounded in Catholic moral theology, offering guidance on how healthcare providers should respect and protect human dignity in both clinical decisions and institutional policy.[127] These directives address a wide range of issues including end-of-life care, reproductive health, and research. In many cases, the directives are sufficient to guide ethical decision-making and to help practitioners to act in ways that affirm life and minimize moral risk**.** While the application of these directives requires prudence and adaptation to evolving circumstances, they remain a vital resource in ensuring that healthcare practice remains faithful to Catholic teaching.

Agreeably, advances in medical technologies have significantly improved both treatment outcomes and quality of life**.** As acknowledged by the New York State bishops, these developments bring both promise and ethical complexity: “Advances in medical technologies bring with them new means of curing disease and living longer, healthier lives than ever before. But they can also be the source of heightened patient anxiety about a needlessly prolonged, painful and expensive dying process.”[128] This observation highlights a growing tension between technological capability and ethical discernment**.** As innovation accelerates, the Church has at times struggled to keep pace with emerging bioethical challenges**,** risking a lag in applying long-standing moral principles to novel medical contexts. This is the gap USCCB has always endeavoured to minimise through directives and standards, and the main reason for the birth of ERDs.

It must be noted that the organised American Catholic healthcare system operated for many years without codified principles but as a faithful response to the Gospel demand to preach the Kingdom of God and to heal the sick (Luke 9: 2). It is reported that in the United States, “hospitals begun as the great corporal works of mercy of the heroic women religious developed into the Catholic

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[127] John F. Brehany, “The Ethical and Religious Directives: History, Development, and Revision.” *National Catholic Bioethics Quarterly* 23, no. 2 (Summer 2023), 211.

[128] New York State Catholic Conference, *Now and at the Hour of Our Death*, 1.

health care systems that currently serve over 88 million patients annually, providing more healthcare than any entity other than the government. …The first Sisters Hospital being founded in 1830."[129] With advances in medical science and arising complex ethical questions regarding issues like end-of-life care, reproductive technology, and assisted suicide, the bishops saw the need to guide Catholic institutions in making moral decisions. The first document containing ethical and religious directives was published in 1948.[130] Brehany further claims that since their first publication, the ERDs have maintained a provisional status, consistently leaving room for further update, without losing the directorial nature of prescription – calling for moral goodness to be achieved, and proscription – forbidding certain interventions that cause harm.[131] It can be noted that USCCB produced the ERDs to integrate faith and reason in healthcare, ensuring that catholic institutions uphold both the healing mission of Christ and the moral teachings of the Church, particularly in the face of modern medical and ethical challenges.

The USCCB employs several core principles of Catholic social teaching in its healthcare advocacy with the intention to shape a healthcare system that reflects Gospel values and promotes human dignity. These principles are foundational to the Church's approach to social and economic life, including healthcare.[132] Evidently, three principles that have received prominence in the process of the bishops' work are 'the dignity of the human person, the common good, and preferential option for the poor and vulnerable.' The dignity of the human person is the foundational principle, asserting that every human life is sacred and possesses inherent dignity from conception to natural death.[133] This principle underpins the bishops' advocacy for the protection of life at all stages, particularly opposing abortion, euthanasia, and destructive embryonic stem cell research. The principle further informs the bishops' call for respectful and compassionate care for all patients, regardless of their condition.[134] The common good refers to "the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfilment more fully and more easily."[135] This principle promotes working towards policies that ensure that access to necessary healthcare services for everyone, recognising that health is a prerequisite for individuals to participate fully in a society and flourish. The principle of the

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[129] Marie T. Hilliard, "Affordable Health Care: The Nurse, the Poor, and the Vulnerable." *National Catholic Bioethics Quarterly* 14, no. 1 (Spring 2014): 48.

[130] Brehany, "The Ethical and Religious Directives," 212.

[131] Brehany, "The Ethical and Religious Directives," 214.

[132] USCCB, *Forming Consciences for Faithful Citizenship*, no. 5.

[133] Josef. D. Zalot, "Commentary on Revisions to the Ethical and Religious Directives, Part One: The Social Responsibility of Catholic Health Care Services." *The National Catholic Bioethics Quarterly* 23, no. 2 (Summer 2023), 247.

[134] USCCB, *Doctrinal Note on the Moral Limits to Technological Manipulation of the Human Body* (2023), no. 22.

[135] Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, no. 164.

preferential option for the poor and vulnerable calls for special attention to be given to the needs of those who are poor, marginalised, uninsured, or otherwise vulnerable in society. The USCCB has consistently advocated for policies that prioritise the healthcare needs of the poor, the uninsured, and the underinsured. This involves advocating for expanded access to care, affordable coverage, and safety net programmes. For most aspects of justice in healthcare services, the USCCB has frequently employed the above three discussed principles.

However, stewardship, solidarity, and subsidiarity have also received considerable attention in the bishops' application of social principles to healthcare delivery. For instance, stewardship is well listed in the current edition of ERDs. And it reads: "The responsible stewardship of health care resources can be accomplished best in dialogue with people from all levels of society, in accordance with the principle of subsidiarity and with respect for the moral principles that guide institutions and persons."[136] When decisions are made by people closest to the problem, there is a higher chance that wastage will be minimised and efficiency would be improved due to diminished bureaucratic bottlenecks. In relation to stewardship one area of concern regarding healthcare processes is environmental protection. Acknowledging healthcare's contribution to environmental degradation, Hamel stated that "Environmental responsible healthcare should be a distinguishing mark of every Catholic healthcare organisation."[137] It is hoped that the upcoming editions of the ERDs would be enhanced if the care for environment would form part of the section on 'Social Responsibility of Catholic Healthcare Services.'

Noticeably, solidarity and subsidiarity do not appear in the current ERDs. Josef D. Zalot proposes the inclusion of solidarity and subsidiarity in the future edition of the ERDs.[138] This proposal is noteworthy because of the significant impact these principles have on local management of healthcare services and resources. Taking solidarity for example, it is the principle that emphasizes that all people are interconnected and interdependent, and that we are our brothers' and sisters' keepers.[139] Solidarity calls for a commitment to the well-being of all, recognizing that the health of one affects the health of all. In healthcare, this translates to advocating for a system where everyone shares responsibility for ensuring that all have access to care, fostering a sense of mutual responsibility and support across society. Similarly, the principle of subsidiarity holds that decisions should be made at

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[136] USCCB, ERDS, Part One, Introduction, par., 4.

[137] Ron Hamel, "The Ethical and Religious Directives: Looking Back to Move Forward." *Health Progress* 100, no. 6 (November 2019), 69. https://may.idm.oclc.org/login?url=https://www.proquest.com/trade-journals/ethical-religious-directives-looking-back-move/docview/2313056603/se-2

[138] Josef. D. Zalot, "Commentary on Revisions to the Ethical and Religious Directives, Part One: The Social Responsibility of Catholic Health Care Services." *The National Catholic Bioethics Quarterly* 23, no. 2 (Summer 2023), 246.

[139] Pope Francis, *Fratelli Tutti*, no. 116.

the lowest possible level of authority, closest to the people affected, while higher levels of authority should only intervene when necessary to support or coordinate. In healthcare, this principle suggests that individuals and local communities should have a significant role in shaping their healthcare, while larger entities (like the state or federal government) should provide support and ensure equitable access where local efforts are insufficient. It encourages local initiatives and community-based solutions while recognizing the need for broader systemic support.

Universal destination of goods as one of the main principles on which this study is anchored. However, this principle is not listed in the ERDs, and it is not being proposed for inclusion in the next edition. Universal destination of goods is a key principle for the realisation of universal healthcare. The Universal destination of goods asserts that earth's resources are intended for the benefits of all people.[140] This principle supports the concept that access to medical care is not a privilege, but a right that must be equitably shared, especially with the poor and marginalised.

The principle further acknowledges private ownership of property as a right but also admits that the right is not absolute. The Church insists that "private property… ensures the security of life and freedom. But… the universal destination of goods remains primordial."[141] Thus, healthcare systems must be designed to distribute medical goods and services fairly, particularly to meet the needs of every member in society. This understanding reaffirms that denying access to healthcare especially due to poverty violates the universal purpose of creation's goods. In this manner, the common good takes precedence over individual accumulation when the basic needs of others such as food, shelter, water, and healthcare are unmet.

5.8.5 Some Criticisms for USCCB's Application of Principles of Catholic Social Teaching in Healthcare

The *Ethical and Religious Directives for Catholic Health Care Services* (ERDs), developed by the United States Conference of Catholic Bishops (USCCB), serve as authoritative guidelines for Catholic healthcare institutions. These directives aim to uphold fidelity to Catholic moral teaching, especially in the realms of human dignity, the sanctity of life, and the ethical delivery of medical care. However, their application has frequently sparked critical debate over whether strict adherence to doctrinal integrity inadvertently limits comprehensive and equitable healthcare access.

One central point of contention arises from the USCCB's unwavering commitment to Catholic moral tradition, particularly on issues involving the beginning and end of life. The ERDs categorically

[140] Vatican II, *Gaudium et Spes*, no. 69.
[141] *Catechism of the Catholic Church*, no. 2403.

prohibit procedures such as abortion, sterilization, euthanasia, and some reproductive technologies. While this position reflects theological consistency with Catholic teaching on the sanctity of life, it poses significant ethical and practical challenges, especially in regions where Catholic institutions are the sole or primary healthcare providers.[142] According to Jean Deblois, the reach of Catholic healthcare which is second only to the government in terms of scale, means that such prohibitions affect not only Catholic patients but also diverse populations with differing medical and moral needs.[143] This scenario raises serious concerns about justice, patient autonomy, and access, particularly for the underserved or those whose medical needs fall outside the scope permitted by the ERDs.

The challenge is further compounded by what can be seen as selective prioritization within Catholic healthcare advocacy. The USCCB has consistently foregrounded pro-life issues, especially opposition to abortion and euthanasia, often eclipsing other elements of Catholic Social Teaching, such as structural justice and care for the poor. As Ron Hamel recommends that there should be "less attention to sex and reproduction and addressing a number of other issues like service to the poor and underserved."[144] While the bishops' strong defence of life from conception to natural death is doctrinally justified, their public and political engagement tends to emphasize these issues disproportionately. This has resulted in less consistent and less visible advocacy for universal access to healthcare, despite the USCCB's frequent affirmation that healthcare is a basic human right. As a result, the broader principles of Catholic social teaching such as the preferential option for the poor**,** subsidiarity, and the universal destination of goods may be underrepresented in public discourse and policymaking related to healthcare reform.

Moreover, critics have noted that Catholic healthcare institutions often exhibit an institutional preoccupation with identity and ethical integrity, sometimes at the expense of pastoral sensitivity and care. Deblois points out that amidst the ongoing social, political, and ethical challenges, Catholic healthcare organizations tend to prioritize ethical compliance and institutional identity over the more nuanced pastoral needs of patients and staff.[145] This tendency can result in a form of care that, while

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[142] "Lawsuit Says Bishops' Health Care Directives Led to Negligent Care." *National Catholic Reporter* 50, no. 5 (December 31, 2014): 3. https://research-ebsco-com.may.idm.oclc.org/linkprocessor/plink?id=526684a6-be80-3d74-ad54-b29a9b9cb885.

[143] Jean Deblois, "Where the Ethical and Religious Directives Fall Short." *Health Progress* 90, no. 3 (May 2009), 50. https://may.idm.oclc.org/login?url=https://www.proquest.com/trade-journals/where-ethical-religious-directives-fall-short/docview/274484655/se-2.

[144] Ron Hamel, "The Ethical and Religious Directives: Looking Back to Move Forward." *Health Progress* 100, no. 6 (November 2019), 68. https://may.idm.oclc.org/login?url=https://www.proquest.com/trade-journals/ethical-religious-directives-looking-back-move/docview/2313056603/se-2.

[145] Deblois, "Where the Ethical and Religious Directives Fall Short," 48.

ethically consistent with Church teaching, may appear detached or unresponsive to the real-life complexity of patients' situations, especially in pluralistic or secular contexts.

Lastly, critics have increasingly drawn attention to the relative neglect of the role of conscience in the application of the Ethical and Religious Directives (ERDs), despite its central place in Catholic moral theology.[146] As *Gaudium et Spes* asserts, conscience is the "most secret core and sanctuary of a person," where one is alone with God.[147] It is through conscience that individuals are called to make moral judgments in complex situations. Yet, within the practical application of the ERDs, the emphasis on institutional identity and ecclesial authority has, at times, come at the expense of affirming the moral agency of individuals, especially healthcare professionals and patients. This raises serious concerns in cases where directives may not provide clear or exhaustive guidance on a number of emerging areas such as technological advancements, highlighting the need for a nuanced understanding of conscience as an operative moral guide.[148]

Given the rapid evolution of medical practice and technological innovation, healthcare professionals frequently face dilemmas that fall into morally grey areas not explicitly addressed in the ERDs. In such cases, conscience becomes not only a safeguard of personal moral integrity but also a necessary tool for navigating ethical ambiguity. Brehany underscores this point, noting that "Theologians also wanted to emphasize that decisions about implementing the ERDs must be made on a local (hospital) level, subject to the decisions and consciences of physicians and patients."[149] This emphasis does not seek to displace the authority of the magisterium but rather invites a broader dialogue**,** one that incorporates the lived experiences of caregivers, local ethics committees, and pastoral ministers in shaping ethical healthcare responses.

Critics argue that a top-down enforcement of the ERDs, without adequate regard for the diversity of local contexts and moral discernment, can lead to ethical rigidity and a failure to respond pastorally to the complex realities of patient care. Moreover, this tension is amplified in pluralistic societies where Catholic healthcare institutions serve a diverse population whose beliefs and values may not align with Catholic doctrine.[150] Respecting the conscience of both provider and patient in such settings becomes a matter of not only theological fidelity but also justice and inclusivity. The *Catechism of the Catholic Church* affirms that "man has the right to act in conscience and in

[146] Hamel, "The Ethical and Religious Directives: Looking Back to Move Forward," 68
[147] Vatican II, *Gaudium et Spes*, no. 16.
[148] Hamel, "The Ethical and Religious Directives: Looking Back to Move Forward," 68
[149] Brehany, "The Ethical and Religious Directives," 217.
[150] Hamel, "The Ethical and Religious Directives: Looking Back to Move Forward," 66.

freedom so as personally to make moral decisions."[151] This principle calls for a healthcare ethic that is attentive not only to ecclesial norms but also to the primacy of conscience rightly formed. Thus, in recognizing the importance of conscience, the Church is not diluting its moral teaching but is rather deepening its pastoral and theological engagement with the realities of modern healthcare. A more collaborative and dialogical approach, where bishops, ethicists, clinicians, and lay Catholics discern together, could ensure that the ERDs remain both faithful to Catholic tradition and responsive to the needs of contemporary healthcare practice.

5.9 Conclusion

There is much to learn from the United States Conference of Catholic Bishops (USCCB), who have consistently endeavoured to offer authoritative moral guidance on healthcare and bioethics. This study has demonstrated that the right to healthcare is not only a moral imperative within Catholic teaching but also a repeatedly affirmed principle in USCCB documents, especially within the *Ethical and Religious Directives for Catholic Health Care Services (ERDs)*. The USCCB has underscored that the right to healthcare is grounded in the sanctity and dignity of the human person, created in the image and likeness of God.[152] Similarly, the broader Magisterial tradition continues to uphold healthcare as a basic human right integral to the protection of human dignity.

Despite this moral clarity, the application of Catholic Social Teaching (CST) principles in healthcare often remains more theoretical than practical, and in many instances, appears as an add-on rather than an integral foundation. The trend the USCCB have endeavoured to reverse in their many years of advocacy for an all-inclusive healthcare system. Structural determinants of health such as poverty, food insecurity, inadequate housing, unemployment, and inadequate healthcare coverage have been strategically embedded within bioethical or clinical discourse. More urgent social crises such as gun violence, substance abuse, and undocumented migration which are often relegated to legal or political arenas with limited reflection on their implications for health access and outcomes are being considered with greater attention. These factors significantly shape healthcare access and utilization, particularly among vulnerable populations, due to fears of violence, exclusion, or legal repercussions. Issues of justice, access, and quality must, therefore, be recognized not as peripheral, but as core characteristics of Catholic healthcare delivery.

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[151] *Catechism of the Catholic Church*, no. 1782.

[152] United States Conference of Catholic Bishops, *A Framework for Comprehensive Health Care Reform* (June 1993), 1.

Although a siloed relationship between Catholic social teaching and clinical bioethics still persists, the USCCB has made notable progress toward a more holistic and integrated approach. The recent revisions and proposed expansions of the ERDs reflect a growing recognition of the need to incorporate social determinants of health into Catholic healthcare ethics. This evolution signals a paradigm shift, wherein healthcare is increasingly understood not merely as a clinical act, but as a multi-dimensional enterprise involving ethical, social, political, economic, and cultural considerations.

As Alexandre Martins contends, the traditional focus of bioethics on autonomy and the physician-patient relationship is inadequate for addressing the deeper structural inequalities and injustices that shape healthcare systems.[153] Reforms in healthcare must, therefore, include a robust framework for identifying and responding to the often "invisible" health burdens within society, those rooted in social marginalisation, systemic injustice, and poverty. By placing the social responsibility of Catholic healthcare services at the forefront of the ERDs, the USCCB reframes Catholic social teaching as a constructive tool for realizing healthcare as a common good. This repositioning affirms that social justice is not tangential but central to the protection of human dignity, that is, from conception, through every stage of life, to natural death. The need to integrate CST more fully into healthcare is increasingly urgent, especially as health systems face complex global challenges such as economic instability, political fragmentation, technological change, and moral pluralism.[154]

To sum it, Catholic Social Teaching illuminates the interconnectedness of health and social justice, and the USCCB's evolving engagement offers a valuable framework for envisioning more inclusive, equitable, and ethically grounded healthcare systems. The next chapter will explore how the principles and lessons drawn from the USCCB experience can inform and inspire practical proposals for universal healthcare in Zambia, where similar challenges demand morally coherent and socially responsive solutions.

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[153] Alexandre A. Martins, "Theological Bioethics and Public Health from the Margins." *The National Catholic Bioethics Quarterly* 22, no. 2 (Summer 2022), 239.

[154] USCCB, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (Washington, D.C.: USCCB, 2018), Part One, Introduction, par. 1.

CHAPTER SIX

UNIVERSAL HEALTHCARE AND CATHOLIC SOCIAL TEACHING: A CASE FOR ZAMBIA

6.0 Introduction

This chapter has two primary objectives: first, to highlight key areas where the Zambian Catholic bishops have applied the principles of Catholic Social Teaching (CST) to advance the goal of universal healthcare; and second, to propose additional domains where these principles could be further applied. More than sixty years after gaining independence in 1964, Zambia's healthcare delivery system remains significantly underdeveloped and largely inaccessible to the poor. The development of an effective, efficient, and equitable healthcare system is an urgent necessity if the nation is to realize its aspirations of cultivating a healthy and prosperous population. Principles of Catholic Social Teaching can serve as important resources for helping Zambia achieve universal healthcare. Addressing healthcare inequalities, therefore, requires not only an examination of foundational CST principles such as the common good, the preferential option for the poor, and the right to health but also the identification of practical ways in which these moral frameworks can inform policy, institutional reform, and community-based healthcare initiatives.

Since 2006, Zambia has been guided by *Vision 2030*, the government's long-term development framework aimed at achieving universal access to cost-effective, high-quality healthcare. This vision reflects the country's commitment to the global ideal of "healthcare for all," with a particular emphasis on providing free primary healthcare services to all Zambian citizens. In alignment with this national agenda, the Zambia Conference of Catholic Bishops (ZCCB) has, in many of its pastoral statements and advocacy efforts, sought to apply the principles of CST in addressing issues of social justice across Zambia's social, economic, and political spheres.

This chapter will examine specific instances in which the ZCCB has effectively integrated CST principles in its engagement with healthcare policy and practice. It will also identify additional areas where the Church's voice and action could be more strongly mobilized to support the realization of universal healthcare in Zambia. However, the opening section will lay the foundation of CST as a framework for social action.

6.1 Catholic Social Teaching: A Framework for Social Action

Catholic Social Teaching (CST) embodies core concepts such as social welfare, truth, and values derived from divine revelation and natural law. It offers a lens through which the faithful and all people of goodwill can discern meaningful responses to the pressing questions that emerge when religious belief is applied to the challenges of contemporary life.[1] CST is particularly concerned with the social problems that affect humanity within dynamic and often volatile social, economic, and political contexts. The Church draws on the values of the Gospels, often conveyed through biblical narratives, to respond to these challenges and promote justice, human dignity, and the common good in every time and place.

Over time, CST has developed into a comprehensive body of theological doctrine promulgated by the universal Church, particularly through the papal social encyclicals. As Suzanne Mulligan observes, "Beginning with *Rerum Novarum*, the social encyclicals represent an attempt by the Church to offer a more structured response to the 'signs of the times' as they emerged over the past one hundred years or so."[2] Since the publication of *Rerum Novarum* in 1891, the Church has built a rich tradition of reflection and guidance on social, economic, and political issues as teachings that have retained enduring relevance in a rapidly changing global environment.

At various historical moments, the Church's Magisterium has responded to emerging threats to human life and dignity. The popes, often in collaboration with regional episcopal conferences, have contributed to a vast deposit of social doctrine. Notable examples of such regional interventions include the Latin American Bishops' *Medellín Conference* (1968), the *United States Conference of Catholic Bishops* (formerly NCCB) pastoral letter *Economic Justice for All* (1986), and the *Zambia Conference of Catholic Bishops* (formerly *Zambia Episcopal Conference*) pastoral letter *Economic, Politics and Justice* (1990). These interventions reflect the Church's conviction that Christianity entails not only personal faith but also active engagement with the world. As Komakoma explains, Catholic Social Teaching "holds that the essence of Christianity is a call to active involvement in the affairs of this world. … This is why the Church recognises that it has a mission to be involved in promoting the welfare of the human person in all the spheres of life."[3] Through prudential judgment, the Church applies CST's principles to real-life situations, guided by the classic methodology of see–judge–act. As outlined in *Mater et Magistra*, this approach involves analysing concrete realities, evaluating them in

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[1] Joseph Höffner, *Christian Social Teaching* (Cologne: Ordo Socialis, 1997), 16.

[2] Suzanne Mulligan, "Capabilities and the Common Good," *Irish Theological Quarterly*, 75, no. 4 (2010), 388. https://doi-org.may.idm.oclc.org/10.1177/0021140010377739.

[3] Joe Komakoma, *The Social Teaching of the Catholic Bishops and Other Christian Leaders in Zambia*: *Major Pastoral Letters and Statements 1953 -2001* (Ndola: Mission Press, 2003), 2.

light of the Gospel and CST principles, and taking appropriate action to transform unjust structures and promote peace and justice.[4] This call to social transformation is addressed to every member of the Church, in cooperation with all people of goodwill.

Following Komakoma's analysis, the *Zambia Conference of Catholic Bishops* (ZCCB) has engaged with a broad spectrum of issues under the broader themes of socio-political, socio-economic, and moral through the lens of CST.[5] Within this framework, the present chapter focuses on selected CST principles to assess the ZCCB's role in promoting social justice, with particular emphasis on access to healthcare. In addressing the challenges that hinder the realization of universal healthcare in Zambia, Catholic Social Teaching offers a set of interrelated and overlapping principles that guide ethical and practical action. These include: the universal destination of goods, the dignity and sanctity of the human person, the common good, the preferential option for the poor, solidarity, subsidiarity, stewardship, and justice. While this chapter will focus on these specific principles, others may also be referenced as relevant. Each principle will serve as a lens for assessing what has been achieved by the ZCCB in advancing healthcare justice, as well as what more could be done.

The application of these principles aligns with the World Health Organization's call to: "defend the population against what threatens its health, to protect people against the financial consequences of ill-health, to provide equitable access to people-centred care, and to make it possible for people to participate in decisions affecting their health and health system."[6] As De la Porte notes, several social and economic determinants, both directly and indirectly linked to healthcare, can severely impact public health outcomes. These include deficiencies in healthcare infrastructure, shortages of qualified personnel, poor management practices, and inadequate resource allocation. Addressing these systemic issues through the lens of CST is essential if Zambia is to achieve its national goal of universal access to healthcare.

6.2 ZCCB's Engagement with CST in Pursuit of Universal Healthcare in Zambia

Having established a foundation for social action, this study now shifts focus to the practical application of Catholic Social Teaching (CST) by the Zambia Conference of Catholic Bishops (ZCCB)

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[4] John XXIII, *Mater et Magistra* (1961), nos. 236 – 238.

[5] Komakoma, *The Social Teaching of the Catholic Bishops*, 3.

[6] André de la Porte, "Spirituality and Healthcare: Towards Holistic People-Centred Healthcare in South Africa." *Hervormde Teologiese Studies* 72, no. 4 (2016), 2. doi:10.4102/hts.v72i4.3127.

in promoting universal healthcare. While there has been notable clarity and intentional engagement with certain CST principles, in many instances the alignment appears more implicit than explicit. This section will examine those principles that have been directly and deliberately applied in the ZCCB's advocacy and healthcare initiatives. By analysing these explicit applications, the study aims to highlight both the strengths of current efforts and the potential for deeper, more systematic integration of CST values in shaping a just and inclusive healthcare system.

6.2.1 The Principle of the Dignity of the Human Person in Healthcare and the Involvement of the Zambia Conference of Catholic Bishops (ZCCB)

Among the principles of Catholic Social Teaching (CST), the dignity of the human person stands out as the area in which the Zambia Conference of Catholic Bishops (ZCCB) has been most visibly and consistently engaged. This principle, closely related to the sanctity of human life, asserts that every human being possesses inherent worth and value simply by virtue of being human. Such dignity is neither earned nor contingent upon external factors such as social status, achievements, or abilities; rather, it is intrinsic, universal, and inviolable. The inherent nature of dignity means that it does not depend on one's circumstances or condition. Its universality implies that it applies equally to all individuals, regardless of race, gender, age, nationality, or any other socially constructed distinctions. As inviolable, human dignity provides the ethical foundation for human rights, justice, and all forms of equitable and respectful treatment.

This principle occupies a central place in foundational international documents such as the *Universal Declaration of Human Rights*, and it is likewise considered the cornerstone of Catholic Social Teaching, forming the basis upon which all other social principles are built. Furthermore, human dignity represents a key intersection between CST and healthcare ethics: all interventions concerning human life must be guided by this fundamental value.

The recently issued declaration *Dignitas Infinita* further underscores the theological and ontological dimensions of human dignity. It affirms that the nature of human dignity, as a God-given reality, possesses an ontological quality, that is, a value inherent to the very being of the person. This dignity endures regardless of circumstances or conditions. The document elaborates that ontological dignity "belongs to the person as such simply because he or she exists and is willed, created, and loved by God. This is the first and the most important of all. Ontological dignity is indelible and remains

valid beyond any circumstances in which the person may find themselves."[7] Accordingly, any ethical, legal, or medical practice must refrain from violating this dignity at any stage of life, whether at its beginning, throughout its course, or at its end.

The ZCCB has been a strong advocate for the promotion and protection of both the sanctity of life and the dignity of the human person.[8] The Church's stance is evident in its *Declaration on Abortion*, which affirms the sacredness of life from conception, as well as in its ongoing campaign against capital punishment. Furthermore, the widespread presence of Catholic-run healthcare facilities, particularly in rural and underserved regions, demonstrates the Church's commitment to the protection and promotion of human life and dignity. The enduring lack of adequate healthcare for a significant portion of Zambia's population remains a pressing concern for the Catholic bishops. In light of this, the ZCCB continues to prioritize and address specific areas where the principle of human dignity must be defended and realized in practice. Additional areas in which the ZCCB could enhance the application of the principle of the dignity of the human person within the healthcare sector are discussed in the latter section.

6.2.2 The Preferential Option for the Poor in the Context of Zambia's Healthcare System

The principle of the *preferential option for the poor* has long served as a foundational tenet of Catholic social teaching, urging deliberate attention to the needs of the most vulnerable members of society. It is not a statement of superiority of the poor over others, but rather a recognition that their need is greater. This principle calls on those with power, resources, and privilege to make intentional sacrifices, what Pope Paul VI referred to as the renunciation of some rights, so that the goods of society might be placed more generously at the service of others. He explained, "In teaching us charity, the Gospel instructs us in the preferential respect due to the poor and the special situation they have in society: the more fortunate should renounce some of their rights so as to place their goods more generously at the service of others."[9] In this light, the *preferential option for the poor* is not merely an act of compassion or charity, but a systemic mechanism to ensure that every individual has the opportunity to realize their full potential. It places the marginalized such as those economically disadvantaged, the elderly, migrants, and others facing structural barriers, at the centre of social and policy concern. In the context

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[7] Dicastery for the Doctrine of the Faith, *Dignitas Infinita*, no. 7. https://press.vatican.va/content/salastampa/en/bollettino/pubblico/2024/04/08/240408c.pdf.

[8] ZEC, *Declaration on Abortion*, no. 2.

[9] Paul VI, *Octogesima Adveniens* (May 14, 1971), no. 23.

of healthcare, this principle demands that delivery systems be designed to address the specific needs of those who are most at risk of exclusion due to poverty or social vulnerability.

In Zambia, the Zambia Conference of Catholic Bishops (ZCCB) has employed this principle in multifaceted ways through pastoral letters and programmes advocating for systemic change. The Church's mission and mandate, in light of this principle, is to work toward poverty eradication, elevate human dignity, promote social justice, and advance the common good. Poverty in Zambia remains widespread and deeply entrenched. Despite the country's rich natural and human resources, a significant portion of the population continues to live in deprivation. According to the World Bank, as of 2022, more than 60% of Zambia's population lives below the international poverty line of $1.90 per day, with rural poverty rates exceeding 75%.[10] Such poverty is both absolute, where basic needs like food, shelter, and healthcare are unmet, and relative, reflecting the unequal distribution of national resources.

These grim statistics are not merely numbers but translate into daily realities: malnutrition among children, lack of access to education, and significant barriers to healthcare access. The Jesuit Centre for Theological Reflection (JCTR) and Church leaders alike have highlighted these challenges. As noted during the 16th AMECEA Plenary in Lusaka, many people in rural areas and urban shanty compounds remain "badly fed, poorly housed, illiterate and lacking minimum educational, medical and/or other requirements."[11] Such observations underscore the Church's urgent call for poverty eradication and equitable development. The Church in Zambia recognizes that poverty is not only a matter of individual misfortune, but often the structural result of unjust political, economic, and social systems. Therefore, addressing poverty, especially as it relates to healthcare, requires more than goodwill; it demands concrete, justice-oriented policies that uplift the most vulnerable.

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[10] World Bank. https://www.worldbank.org/en/country/zambia/overview#:~:text=Zambia%20ranks%20among%20the%20countries,creation%20and%20declining%20labor%20earnings.

[11] Miniva Chibuye, "Poverty and Social Justice in AMECEA Countries." AFER 51, no. 3 (September 2009): 242–60. https://search-ebscohost-com.may.idm.oclc.org/login.aspx?direct=true&db=lsdar&AN=ATLA0001760596&site=ehost-live. Miniva worked with the Jesuit Centre for Theological Reflection in Lusaka - Zambia. The Jesuit Centre for Theological Reflection (JCTR), a faith based organization that is seeking to see a society where faith promotes justice for all, in all spheres of life, especially for the poor, and has for almost twenty years conducted what is known as the Basic Needs Basket (BNB). The BNB reflects the cost of meeting the basic needs for food, other essentials such as decent housing, health, education, etc. Through this effort, the JCTR has added value to the examination of living conditions within particular context using universal standards. As its name implies, the BNB is constructed in terms of both food and non-food essential items. It was designed to portray an ideal situation that upholds a productive and healthy nation and consequently the promotion of human dignity. The JCTR Basket has been appreciated at both the national and international level as it speaks to the striking and concrete story of how living conditions are profoundly influenced by both internal and external factors such as erratic rainfall patterns, internal political changes, economic shocks, the external wars, externally influenced policies, collapse of industries, etc (Poverty and Social Justice in AMECEA Countries, 245).

Given this backdrop, a central question arises: What are the implications of the preferential option for the poor in Zambia's healthcare delivery system? The Zambia Conference of Catholic Bishops has already invoked this principle in its advocacy for food security, clean water and sanitation, and access to quality healthcare for all. These factors have a direct and indirect impact on the health outcomes of the people. This section explores how this principle has been applied to shape healthcare policy and practice in Zambia, and what role the Church continues to play in this critical national discourse.

6.2.3 Food Security and Agricultural Productivity: Interconnected Challenges in Rural Zambia

In his 2008 annual lecture titled *"Food Security and HIV,"* Professor Michael Kelly highlighted the critical interconnection between food security and health. While his focus was on the relationship between food insecurity and HIV/AIDS, his argument underscores the broader importance of adequate nutrition for overall well-being. He opened his lecture by reaffirming the universally recognized principle that "everyone has the right to access safe and nutritious food, consistent with the right to adequate food, and the fundamental right to be free from hunger."[12] Food security encompasses the availability, accessibility, affordability, quality, and cultural appropriateness of food. Kelly emphasized that food insecurity exists not merely in the absence of food, but also when available food is inadequate, inaccessible due to high costs or transportation barriers, or nutritionally insufficient due to poor quality or lack of diversity.[13]

In rural Zambia, food insecurity is an enduring reality, especially among communities reliant on subsistence farming. Unemployment is pervasive, and many households depend on seasonal agricultural activities for their livelihood and sustenance. However, agricultural productivity in these areas is hindered by multiple factors, including erratic rainfall, outdated farming techniques, limited access to agricultural inputs, and a lack of institutional support.

The challenges were exacerbated when the Zambian government, under the Structural Adjustment Programme (SAP), withdrew its long-standing support for small-scale and peasant farmers. The liberalization of the agricultural sector, a condition of the SAP, severely undermined rural livelihoods. The state's disengagement from agricultural support programs, especially in maize production exacerbated food insecurity for vulnerable populations. Komakoma aptly warned that "the production of food is not an ordinary economic activity, but it has a special character as relating to the

[12] Irish Global Health Network, *From Zambia to Ireland*: *15 Years of Insights on HIV and AIDS*, 22. https://globalhealth.ie/wp-content/uploads/2021/11/From-Zambia-to-Ireland-15-Years-of-Insights-on-HIV-and-AIDS.pdf.

[13] Irish Global Health Network, *From Zambia to Ireland*, 22.

sustenance of life... [and] cannot be treated simply as another marketable item subject to the abstract laws of liberalisation."[14] Maize, as Zambia's staple food, is crucial for the survival of the poor, and the state's withdrawal from its production was effectively an act of marginalization.

The Zambia Conference of Catholic Bishops (ZCCB) further criticized the consequences of liberalized agriculture policies, asserting that these measures diminished people's capacity to feed themselves. The bishops stated: "Food is the most important element in any economy. Consequently, the arrangements to make food readily available to all people take on a very highest priority in a well-ordered society."[15] Political leaders, regardless of ideology, are therefore urged to prioritize food security. The bishops argued for an agricultural policy that genuinely serves the people and defends their right to adequate food.[16]

Lagat and Kamaara observed that, for the poorest communities, wealth is often equated with food security, while poverty is synonymous with food insecurity.[17] Consequently, there is an urgent need to invest in skills development and agricultural knowledge, particularly to discourage the mono-cropping of maize, which increases vulnerability to food crises in the event of crop failure. Investment in alternative agricultural techniques, including irrigation and climate change adaptation, is imperative to reduce dependence on rain-fed agriculture. Without innovation and strategic planning in agriculture, the trend of declining yields will persist. Local farmers frequently lack access to improved farming technologies, and where available, these technologies are often labour-intensive and slow to be adopted. As reported, average maize yields remain as low as 480 kg per acre, significantly below the potential 5,000 kg per acre.[18] This gap reflects not only environmental challenges like droughts and floods but also systemic issues such as underinvestment, poor infrastructure, limited access to technology and inputs, and inadequate land management systems.[19]

Improving farming productivity thus requires both capacity building and equitable access to opportunities. Professor Kelly emphasized the need for comprehensive interventions, including empowerment of individuals, agricultural research, and rural development to enhance food security.[20] In this regard, the *Feed the Future Zambia Mawa Project* (2012), spearheaded by the Diocese of Chipata and Catholic Relief Services (CRS), targeted 20,000 smallholder households in Eastern

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[14] Komakoma, *The Social Teaching of the Catholic Bishops*, 313.

[15] Zambia Episcopal Conference, *Statement on Agriculture and Food Security* (August 10, 1994), no. 18.

[16] Zambia Episcopal Conference, *Statement on Agriculture and Food Security*, no. 23.

[17] Daniel K. Lagat and Eunice Kamaara. "Poverty, Farming Productivity and Gospel Receptivity: Policy Lessons from Christian Impact Mission in Yatta, Kenya." *AFER* 60, no. 1–2 (March 2018), 30. https://search-ebscohost-com.may.idm.oclc.org/login.aspx?direct=true&db=lsdar&AN=ATLAiGU0181217000186&site=ehost-live.

[18] Lagat and Kamaara. "Poverty, Farming Productivity," 30.

[19] Lagat and Kamaara. "Poverty, Farming Productivity," 27.

[20] Irish Global Health Network, *From Zambia to Ireland*, 24.

Province to improve food and economic security. Collaborating with stakeholders such as Women for Change, the Golden Valley Agricultural Research Trust, and University Research Company, LLC, the *Mawa Project* sought to address both agricultural productivity and household income generation.[21]

The project's first objective was to improve food production, diversification, and storage, thereby enhancing nutritional outcomes and public health. By facilitating farmer training in improved technologies and practices, the *Mawa Project* aimed to promote both diversification to mitigate the risks of mono-cropping and intensification, enabling higher yields on smaller land areas without excessive labour.[22] Post-harvest loss reduction and better storage infrastructure were integral to this strategy.

The second major goal was to enhance household incomes among smallholder farmers. These communities often rely on a single annual harvest for food and income, making them vulnerable to both hunger and financial insecurity during off-seasons. Due to inadequate storage and poor market access, farmers are often forced to sell produce prematurely and at low prices. To mitigate this, the project introduced Savings and Internal Lending Communities (SILCs), comprising 15–25 members, to promote microfinance and financial inclusion.[23] SILCs enabled participants to accumulate savings, access small loans, and reduce their dependence on exploitative informal lenders. This financial cushion helped households avoid selling essential food reserves in times of financial distress.

Ultimately, agricultural productivity can and should translate into both food security and financial stability. A successful farming season significantly improves the nutritional and economic status of rural households. Therefore, interventions in agricultural development must aim to increase yields and profitability, even on small plots of land.[24] Key strategies should include expanding access to irrigation systems and constructing water reservoirs to ensure year-round production and mitigate the impact of climate variability.

The Zambia Conference of Catholic Bishops (ZCCB) demonstrates a preferential option for the poor that extends beyond advocacy to encompass practical empowerment initiatives, particularly targeting unemployed youth and rural communities. This commitment is operationalized through the ZCCB's social programme, commonly known as Caritas Zambia, which comprises two key socio-economic commissions: the Catholic Commission for Justice and Peace (CCJP) and the Catholic Commission for Development (CCD).

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[21] Catholic Relief Services (CRS), "Feed the Future Zambia Mawa Project" (2012 – 2017). https://www.crs.org/our-work-overseas/program-areas/agriculture/feed-future-zambia-mawa-project.

[22] CRS, "Feed the Future Zambia Mawa Project."

[23] CRS, "Feed the Future Zambia Mawa Project."

[24] Lagat and Kamaara. "Poverty, Farming Productivity," 31.

The CCJP primarily engages in research and advocacy activities aimed at promoting social justice within Zambian society. In contrast, the CCD adopts a more pragmatic, action-oriented approach through its Development Education Programme (DEP). This programme focuses on skills training with the objective of enhancing food and income security, as well as fostering resilience in the face of potential disasters. The DEP has recorded notable achievements in areas such as conservation farming and the promotion of alternative livelihoods.[25] These include beekeeping, livestock farming, vegetable cultivation, and small-scale entrepreneurship. Implemented at the parish level across the country, the DEP is accessible to all willing participants, irrespective of religious affiliation. It functions as an informal apprenticeship model, particularly catering to young people who have not progressed further in formal education.

In addition to technical skills development, the DEP also incorporates leadership training, thereby fostering a sense of responsibility and community engagement among its participants. This holistic approach reflects the ZCCB's commitment to integral human development through both advocacy and practical support mechanisms.

6.2.4 The Catholic Church's Contribution to Equitable Healthcare Provision in Zambia

The Catholic Church has historically maintained a strong commitment to the provision of equitable social services, particularly in the sectors of education and healthcare. As previously noted, the principle of adequate healthcare for all encompasses services that are convenient, affordable, and accessible. In this context, convenience refers to the ease and simplicity with which individuals are able to obtain healthcare services, minimizing both physical and financial burdens.

Accessibility and convenience in healthcare are closely linked to the geographical distribution and operational efficiency of healthcare institutions such as clinics, hospitals, and pharmacies. The Zambia Conference of Catholic Bishops (ZCCB) has consistently emphasized the importance of supporting governmental efforts to address the challenges related to healthcare access. For instance, poor road infrastructure, long travel distances, and limited transport options continue to hinder access to health services, particularly among vulnerable populations. According to the ZCCB Strategic Plan (2017–2026), although Zambia aims to achieve universal access to cost-effective and quality health services, fewer than 30% of the rural population reside within 1 km of a healthcare facility. Furthermore, 28% live between 6 to 15 km from the nearest facility, distances that far exceed the

[25] Caritas Zambia, *Caritas Zambia Strategic Plan 2018 – 2022* (September 2017), 20.

recommended 5 km radius. This spatial barrier significantly impacts women, expectant mothers, children, the elderly, and economically disadvantaged groups.[26] In effect, the long distances to healthcare centres not only lead to adverse health outcomes but also constitute a major inconvenience.

In contrast, urban areas demonstrate improved treatment adherence and healthcare outcomes, largely due to the higher concentration of healthcare facilities, notwithstanding the reality of over-crowding. Meanwhile, rural regions continue to experience diminished healthcare access. The ZCCB has expressed concern over the slow pace of health centre construction in remote areas. In response, Church leaders have encouraged Christian communities and associations to take an active role in developing self-help initiatives, such as constructing schools, clinics, and rural health centres, rather than relying solely on government efforts.[27] This approach served as a catalyst, as the government became more inclined to invest in areas where there was significant community involvement.

Beyond infrastructure, the presence or absence of diagnostic technologies within healthcare facilities also serves as an indicator of convenience. Timely access to diagnostic and treatment services contributes significantly to early disease intervention and progression management. Additionally, ease of access increases patient satisfaction, which in turn motivates individuals to seek medical attention promptly, potentially reducing the likelihood of long-term complications and healthcare costs. Anticipating delays in government healthcare provision, the ZCCB urged communities to establish self-help healthcare facilities, a strategy that proved effective in several regions. These initiatives brought healthcare closer to underserved populations and ultimately improved access. Building on this success, the Church later championed the implementation of home-based care for HIV/AIDS patients. This approach aimed to reduce the strain on formal healthcare systems and shield patients from the social stigma that might otherwise deter them from seeking continued treatment.[28]

The Catholic Church's contribution to Zambia's healthcare system dates back to the arrival of missionaries in the late 19th century. Many early Church health institutions began as simple infirmaries or parish dispensaries, responding to both the pastoral and social needs of the local communities. Over time, these modest beginnings evolved into fully functional referral hospitals. Healthcare provision has consistently been intertwined with the Church's evangelistic mission, which includes healing, as reflected in Luke 9:1–2. From inception, Catholic-run healthcare facilities have served all individuals, irrespective of religious affiliation. The Church continues to pursue its vision of fostering a healthy Zambian society in which every citizen has the opportunity to achieve personal wellness.

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[26] Zambia Conference of Catholic Bishops, *Strategic Plan 2017-2026* (Lusaka: Kapingila House, 2017), 19.
[27] CCZ, EFZ, ZEC., *Christian Liberation*, *Justice*, *and Development* (February 1987), no. 142.
[28] ZEC, *Choose to Live* (January 1988), no. 4.

Affordability is another barrier to healthcare access in Zambia today. Healthcare is considered affordable when individuals are able to meet the costs associated with medical services without experiencing significant financial hardship. Therefore, promoting affordability involves not only minimizing direct and indirect healthcare costs but also ensuring that no one is denied access to medical services due to a lack of financial resources. In this sense, affordability serves as a foundational element in the pursuit of equitable and universal healthcare.

In 1992, the Zambian government implemented a series of health sector reforms that introduced user fees for healthcare services. These reforms, intended as a cost-sharing strategy between the state and healthcare users, inadvertently alienated a substantial portion of the population, particularly the poor.[29] For vulnerable communities already burdened by long distances to healthcare facilities, the imposition of fees further compounded their inability to access necessary services. While the U.S. Conference of Catholic Bishops has emphasized that healthcare reforms must be both universal and genuinely affordable,[30] Zambia's reforms reflected a cost-saving agenda, largely influenced by the country's economic commitments. As Komakoma observes, the reforms were part of a broader Structural Adjustment Programme (SAP) mandated by the International Monetary Fund (IMF) and the World Bank. These externally imposed economic policies, adopted following the political transition of 1991, brought sweeping changes to Zambia's economy.[31] The SAP included liberalization, privatization, currency devaluation, budget cuts, and the imposition of user fees in essential sectors such as education and healthcare. It also led to widespread retrenchment in both the public and private sectors. Collectively, these measures exacerbated economic hardship for the majority of Zambians, especially those already grappling with poverty.

In effect, the government shifted the burden of healthcare provision onto its most economically vulnerable citizens, rather than working to alleviate their suffering. A critical analysis of the situation at the time suggests that the government's primary objective was to satisfy the conditions set by international financial institutions rather than to address the needs of its people. A similar pattern of underfunding in the health sector re-emerged in 2009 following the global economic downturn. During this period, questions were raised regarding the government's spending priorities, particularly the contrast between insufficient investment in healthcare and the continued extravagant expenditures by Members of Parliament and Cabinet Ministers.[32] Given the persistently high levels of poverty,

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[29] Zambia Episcopal Conference, *The Church as a Caring Family* (Lusaka: Kapingila House, 1997), no. 6.
[30] Bishop Frank Dewane, *Letter to Congress at the Start of 115th Congress* (USCCB, 2017).
[31] Komakoma, *The Social Teaching of the Catholic Bishops*, 10.
[32] ZEC, *State of Affairs in the Health Sector* (July 19, 2009), no. 10.

unemployment, and limited agricultural productivity, the requirement for patients to pay for medical services amounted to an implicit denial of the right to health for many. For the poorest segments of society, the demand for medical fees was tantamount to a death sentence.

A third major challenge to achieving equitable access to healthcare in Zambia is the persistent issue of poor resource allocation. Resource allocation in the healthcare sector refers to the distribution of limited medical resources, including funding, personnel, equipment, and physical infrastructure. Given the nature and complexity of healthcare delivery, this allocation must be both efficient and ethical. Central to the ethical dimension is the principle of *distributive justice*—a concept rooted in moral and social teaching that emphasizes the fair and equitable distribution of goods to meet human needs. Distributive justice evaluates resource allocation based on its impact on individuals whose basic needs remain unmet. It builds upon the principles of *commutative* and *contributive* justice, functioning as the mechanism through which existing societal resources are justly redistributed.

In Catholic social teaching, distributive justice is considered the most tangible application of justice, focusing primarily on the material principle of justice where need is greater. Within a Catholic healthcare framework, the primary criterion for distribution must be need. As Nnadi asserts, "a person who needs could be one who is experiencing a situation of misfortune, physically or mentally disabled, a person or persons going through an unfavourable condition consequent to a past discrimination that was not in their favour, and all those classified as vulnerable."[33] In the Zambian context, although the government's commitment to achieving healthcare equity is commendable, this vision is undermined by insufficient political will, unrealistic policies, and a chronic mismatch between rhetoric and resource allocation. The government remains the primary source of healthcare funding in Zambia, followed by donor contributions and user fees. However, one of the enduring criticisms is that national budget allocations to the health sector remain far below the 15 percent target agreed upon in the 2001 Abuja Declaration.[34]

Due to inadequate funding, many healthcare facilities suffer from chronic shortages of drugs, equipment, and basic medical supplies. The situation is exacerbated by the poor state of infrastructure and a critical shortage of qualified healthcare personnel. Health workers often find themselves unable to provide even basic care due to a lack of essential resources. Furthermore, poor working conditions

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[33] Anthony Okechukwu Nnadi, *Distribution of Resources in the Nigerian Health Care System* (Milton Keynes UK: Lightning Source UK Ltd, 2020), 133.

[34] Human Rights Watch, "African Governments Falling Short on Healthcare Funding," https://www.hrw.org/news/2024/04/26/african-governments-falling-short-healthcare-funding#:~:text=On%20April%2027%2C%202001%2C%20African,budgets%20to%20improve%20health%20care.

demotivate health personnel, further compromising service delivery.[35] The human resource crisis in the health sector is particularly troubling. The doctor-to-patient and nurse-to-patient ratios remain unacceptably high, despite the fact that over 1,500 trained doctors are currently unemployed (Resident Doctors Association of Zambia 2023). This paradox highlights a deeper problem: the lack of political accountability and the failure of public officials to equitably share the burden of limited resources. While healthcare facilities face critical shortages, elected officials continue to benefit from excessive privileges and expenditures, revealing a disregard for the principles of solidarity and the preferential option for the poor.[36]

The crisis in resource allocation is particularly acute in the treatment of non-communicable diseases such as heart disease, kidney failure, and cancer. For a population exceeding 20 million, Zambia reportedly has fewer than ten heart specialists, all centralized in Lusaka at the country's sole National Heart Hospital.[37] Visiting specialists supplement local capacity only periodically, and patient triage for surgical intervention is sometimes based more on personal connections than medical urgency. Current estimates suggest that over 1,000 patients are awaiting heart-related interventions, with little transparency in the prioritization process.

In its pastoral statement on the state of healthcare in Zambia, the Zambia Conference of Catholic Bishops (ZCCB) drew attention to the inconsistent and delayed disbursement of government health funds, which are often insufficient to meet the operational needs of health facilities. Rural health centres, in particular, are disproportionately affected by these delays, further exacerbating inequalities in access to healthcare.[38]

6.2.5 The Common Good in Zambia's Healthcare

The principle of the common good is one of the foundational pillars of Catholic Social Teaching (CST), second only to the sanctity and dignity of the human person. This study explores how the Zambia Conference of Catholic Bishops (ZCCB) invokes the principle of the common good in its advocacy for universal access to healthcare. Rooted in the Gospel, the common good refers to the social conditions that allow individuals, families, and communities to flourish. It is not a static or uniform ideal, but rather a dynamic and context-sensitive principle that evolves in response to historical

[35] Zambia Episcopal Conference, *State of Affairs in the Health Sector* (Lusaka: Kapingila House, 2009), no. 3.

[36] ZEC, *State of Affairs in the Health Sector*, no. 5.

[37] Fromson, Hoah. "Guiding Zambian Cardiac Surgical Team Through Complex Operations." *Michigan Medicine* (University of Michigan, April 2023). https://www.michiganmedicine.org/health-lab/guiding-zambian-cardiac-surgical-teams-through-complex-operations.

[38] ZEC, *State of Affairs in the Health Sector*, no. 5.

and cultural circumstances. As one scholar notes, "The common good is not a static, homogenous principle, but a dynamic, heterogenous principle depending on the historical-cultural situation in which its incarnation is sought."[39] In this sense, it becomes a framework through which society can critically engage with the past, interrogate the present, and envision a just future.[40] Envisioning the future means imagining and planning for a society where the well-being of all especially the most vulnerable is prioritised, and where human dignity, solidarity, and justice guide decision-making at all levels. This vision is rooted in the idea that no one truly flourishes unless everyone has the opportunity to flourish.

Within CST, the common good offers a balanced framework for human self-actualization in relationship with others. It challenges both extreme individualism and excessive collectivism, calling on each person to act in ways that promote the well-being of all. In the Zambian context, this includes confronting structural barriers to healthcare access. A properly realized common good ensures that every individual has the opportunity to thrive physically, socially, and spiritually. As Norman Daniels argues, "The loss of function associated with disease and disability reduces the range of opportunities open to us compared to what it would be were we healthy or fully functional."[41] Access to healthcare, therefore, is not merely a service but a manifestation of the common good, essential for maintaining the functional capabilities of individuals and communities. It underscores the urgent need for accessible primary healthcare facilities in every locality.

Moreover, the common good serves as both a normative goal and a guiding principle for collective action. In a world increasingly marked by inequality and disconnection, the principle calls for stronger leadership and a renewed sense of global solidarity.[42] The Catholic Church continues to be a moral voice in this effort. As articulated in *Fratelli Tutti*, the common good entails a commitment to universal fraternity, justice, and solidarity that transcends national and political boundaries.[43] While all members of society share responsibility, the primary duty to uphold the common good lies with the State. This involves designing and sustaining an economy that prioritizes social justice, reduces inequality, and ensures access to basic needs particularly for the poor and marginalized. Thus, the pursuit of the common good, both locally and globally, demands policies that uphold the dignity of every person and guarantee access to essential services, including healthcare.

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[39] Todd Salzman, "Catholic Social Teaching, the Common Good, and Healthcare in the US: Seeking a Universal Model of Healthcare Coverage." *The Linacre Quarterly* 67, no. 3 (200), 68. Doi:10.1080/20508549.2000.1187754.

[40] Andrea Vicini, "Global Public Health and the Promotion of the Common Good," 2.

[41] Norman Daniels, *Just Health*: *Meeting Health Needs Fairly* (Cambridge: Cambridge University Press, 2008), 20.

[42] Mulligan, "Capabilities and the Common Good," 395.

[43] Pope Francis, *Fratelli Tutti*, no. 116.

6.2.5.1 Socially Controllable Factors and Healthcare Access in Zambia

As a framework for human self-actualisation, the concept of the common good enables individuals to freely pursue their full potential. However, such self-actualisation is unattainable unless social conditions are effectively managed. Socially controllable factors refer to the societal conditions and determinants that can be shaped, influenced, or modified through human decision-making, public policy, and collective social action.[44] These factors significantly impact individuals' well-being, opportunities, and overall quality of life. Key socially controllable factors include access to medical services, household food security and income, environmental protection, and the equitable allocation of resources. Notably, these factors frequently contribute to healthcare inequalities across various social groups, thereby undermining the principle of equality of opportunity.[45]

In the Zambian context, healthcare access is influenced by a range of social determinants, including but not limited to infrastructure, geographic distance to health facilities, availability of healthcare personnel, educational attainment, and resource distribution. While some of these determinants have been addressed in prior discussions, this section focuses specifically on the roles of infrastructure and education in shaping healthcare outcomes.

At the time of independence in 1964, Zambia's healthcare delivery system was largely concentrated in mining towns within the Copperbelt Province, the capital city Lusaka, and towns along the main railway line. In contrast, rural areas primarily depended on district health centres and church-run mission facilities, with the Catholic Church playing a leading role in healthcare provision. Historically, the Copperbelt Province held a disproportionate share of tertiary healthcare services, hosting three of the country's six university hospitals: Kitwe Teaching Hospital, Ndola Central Hospital, and Arthur Davison Children's Hospital. The remaining three tertiary-level hospitals, including the University Teaching Hospital, are located in Lusaka.[46] In recent years, efforts have been made to expand the number of tertiary and specialised hospitals to a total of eighteen, with plans to upgrade all hospitals situated in provincial headquarters to third-level status. Nonetheless, all specialised hospitals remain concentrated in Lusaka and the Copperbelt, creating significant disparities in access. While most district hospitals are being upgraded to level-two status, there is a pressing need to ensure that such upgrades reflect not only changes in designation but also tangible improvements in

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[44] Norman Daniels, *Just Health*: *Meeting Health Needs Fairly* (Cambridge: Cambridge University Press, 2008), 21.

[45] Daniels, *Just Health*: *Meeting Health Needs Fairly*, 21.

[46] Government of the Republic of Zambia (GRZ), Ministry of Health. https://www.moh.gov.zm.

service delivery and infrastructure. Crucially, addressing primary healthcare remains a cornerstone of equitable healthcare delivery. According to the Churches Health Association of Zambia, church-managed health facilities serve over 27% of the population, primarily in rural and hard-to-reach areas.[47] Primary healthcare provision must therefore be supported by adequately resourced provincial and specialised hospitals.

Six decades after independence, Zambia's healthcare system continues to be hindered by inadequate infrastructural development and a persistently low ratio of healthcare personnel to population. Although the government has demonstrated increased commitment to healthcare facility expansion since 2007, particularly the construction and upgrading of clinics and health posts, progress has been inconsistent and often lacks clear timelines and accountability.[48] In many cases, construction has either stalled or resulted in facilities that are not operational due to shortages of qualified staff. In rural areas, the lack or complete absence of trained healthcare personnel remains a severe impediment to service delivery. These regions often present living and working conditions that are not conducive to attracting or retaining healthcare professionals.

Overall, Zambia's healthcare system struggles with several interrelated challenges, including inadequate healthcare personnel-to-population ratios, long distances to health facilities, inconsistent supplies of essential medical commodities, and a shortage of medical specialists to handle complex conditions. As the government has acknowledged:

> "Challenges remained in the delivery of quality health services in respect of consistent supply of essential medical supplies, recruitment and placement of health personnel, as well as in the effective management of non-communicable diseases. Rural communities continued to face more challenges in accessing health services compared to those in urban areas. This was mainly due to a low health-seeking culture among communities, low health personnel to population ratio, long distances to health facilities, inadequate supplies of medical commodities, and inadequate numbers of specialists to deal with complex medical conditions.[49]

Consequently, the rural and peri-urban poor are most affected by the lack of access to adequate healthcare. Unless the existing issues of infrastructure, staffing, and procurement are addressed in a sustainable manner, the goal of achieving the common good through equitable healthcare access will remain elusive. In light of the slow progress toward universal healthcare, it is vital to empower

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[47] Churches Health Association of Zambia (CHAZ). *2020 Annual Report* (Lusaka: CHAZ, 2020), 2. https://www.chaz.org.zm/index.php/download/annual-report-2020/?wpdmdl=2221&refresh=661c532680b291713132326.

[48] ZCCB, *The State of the Nation 2016 -2017*, 23.

[49] Zambia - Ministry of Finance and National Planning. *Eighth National Development Plan*, 1.

vulnerable populations, especially those in rural communities, with initiatives that support health maintenance and disease prevention.

The Zambia Conference of Catholic Bishops (ZCCB) has consistently advocated for the provision of adequate resources for both the expansion of healthcare infrastructure and the operation of existing facilities. When the newly elected government pledged in 2011 to construct 600 new health centres, the ZCCB emphasized the necessity of prioritizing "adequate funding, sufficient medicines, proper staffing levels, and the provision of up-to-date equipment" for current facilities.[50] However, significant government investments have often focused on physical renovations, leaving many facilities underutilized due to the absence of medical supplies and personnel. The bishops have argued that such an approach undermines the broader goal of achieving universal healthcare access.

Furthermore, the government's decision to discontinue funding for hospices, on the grounds that they do not qualify as health facilities, has had detrimental consequences.[51] These hospices, many of which are church-run, played a crucial role in alleviating pressure on hospitals during peak periods of the HIV/AIDS pandemic and more recently during the COVID-19 crisis. Their exclusion from the healthcare system has not only increased the burden on already overwhelmed hospitals but has also limited access to essential palliative care for terminally ill patients.

6.2.5.2 The Impact of National Debt on Healthcare and the Common Good in Zambia

One of the critical socially controllable factors affecting Zambia's ability to provide essential social services such as healthcare, is the burden of national debt. Despite considerable efforts, Zambia's progress toward comprehensive welfare and universal healthcare coverage cannot be achieved in isolation. Like many developing countries, Zambia's healthcare ambitions are significantly influenced by external dynamics, including the global economy, international debt, universal immunisation programmes, and transnational disease outbreaks. In this context, the pursuit of the common good in any single nation is increasingly interconnected with global relations and responsibilities. International relationships, forged through bilateral and multilateral debt and grant agreements, are often initiated with the expectation of mutual benefit and respect.

However, the vision of a global common good is frequently undermined by both theoretical and practical limitations, despite increasing global interdependence. Zambia's ability to fully benefit from global partnerships has been constrained by longstanding and, in some cases, harmful financial

[50] ZEC, *That they May Have Abundant Life* (January 29, 2012), no. 26.
[51]

agreements. These arrangements have often imposed stringent conditions on loan recipients, disproportionately affecting the most vulnerable populations. Mulligan contends that global institutions such as the United Nations, along with its subsidiaries namely, the International Monetary Fund (IMF), the World Bank, and the World Trade Organization have not succeeded in providing an inclusive global governance framework. Such institutions have perpetuated power imbalances, marginalising poorer countries in global decision-making processes.[52] This asymmetry has led to the implementation of externally designed economic and social programmes that often do not reflect the local realities or priorities of the recipient countries. The imposition of such programmes without adequate local consultation represents a desperate concession rather than a voluntary partnership.

Zambia's participation in the global economic system has increasingly exposed it to the adverse effects of what is often referred to as the "debt trap"—a cycle in which developing nations allocate large portions of their national budgets to debt servicing, leaving minimal resources for socio-economic development. Pope Francis has been particularly vocal in his criticism of this global financial architecture. In *Fratelli Tutti*, he calls on lending nations to recognise "the fundamental right of peoples to subsistence and progress," a right which is frequently curtailed by the pressure of external debt obligations. While affirming the legitimacy of repaying acquired debts, Pope Francis insists that such repayment must not compromise a nation's ability to survive and grow.[53] Indeed, in many debt-ridden countries, including Zambia, the obligation to repay debt has eclipsed investments in critical sectors such as health, education, and infrastructure. In such cases, debt serves not as a tool of development but as an instrument of inequality and systemic domination.

Historically, Zambia's debt burden has had a detrimental impact on national development. By 1998, Zambia owed over US$7.1 billion to donor countries, the IMF, and the World Bank. According to Zambia's Church mother bodies, the government had borrowed heavily in the 1970s in response to plummeting copper prices and soaring oil costs, the external shocks that devastated the economy.[54] Internal challenges, such as corruption and financial mismanagement, further exacerbated the situation. As a result, investment in social services stalled, with sectors such as healthcare, education, and agriculture among the most severely affected. Faith leaders in Zambia recognised that the mounting debt was unpayable, economically debilitating, and an obstacle to future progress.[55] A turning point came in 2005 when, following a robust campaign led by Jubilee-Zambia, the country's external debt

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[52] Mulligan, "Capabilities and the Common Good," 395.
[53] Pope Francis, *Fratelli Tutti*, no. 126.
[54] ZEC, CCZ, and EFZ, *Jubilee 2000*: *Cancel Zambia's Debt* (August 7, 1998), no. 4.
[55] ZEC, CCZ, and EFZ, *Jubilee 2000*: *Cancel Zambia's Debt*, no. 9.

was reduced from US$7.1 billion to US$1.5 billion. The principle advocate for Zambia's Jubilee 200 debt cancellation campaign was the late Cardinal Medardo Mazombwe, former Archbishop of Lusaka. This debt relief, which involved the cancellation of more than 66% of Zambia's debt, was a landmark demonstration of international solidarity and a significant contribution to the global common good.

However, the relief was short-lived. Zambia once again accumulated unsustainable levels of debt. According to CEIC Data, as of September 2024, the country's external debt stood at approximately US$23.1 billion, with a debt-to-GDP ratio exceeding 100% in 2023, placing Zambia in a high-risk category for debt distress.[56] This has reintroduced a vicious cycle wherein national development is consistently hindered by the obligation to service debt. Once again, essential social services, including healthcare and education, have been severely impacted.

In response to this growing crisis, the Zambia Conference of Catholic Bishops (ZCCB) has renewed its campaign for debt cancellation, echoing calls for economic justice, transparency, and responsible debt management. The bishops argue that Zambia's crippling debt burden is impeding the delivery of essential services and undermining the ability of citizens to improve their quality of life. Drawing upon Pope Francis's moral appeals to global leaders, the ZCCB affirms that debt cancellation is not only an economic imperative but a moral necessity.[57] The bishops further argue that funds released from debt relief must be prudently managed to promote sustainable development, reduce poverty, and rectify exploitative debt arrangements.

As an illustrative example, in May 2025, the Zambian government allocated 35% of its US$275 million public service delivery budget to debt servicing.[58] Such expenditures significantly limit the government's capacity to address inequalities in healthcare access. Any progress made in reducing the proportion of public funds directed toward debt repayment directly contributes to improving access to healthcare and other social services. Effective advocacy must therefore be coupled with transparent and accountable governance. Debt relief alone is insufficient unless accompanied by robust debt management strategies. These should include clearly defined short-term interventions, medium-term goals, and long-term solutions to ensure fiscal sustainability and development planning. A commitment to these measures would not only enhance public trust but also help align national policies with the principles of justice, equity, and the common good.

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[56] https://www.google.com/search?q=what+is+zambia%27s+current+external+debt&oq=What+is+the+Current+Zambia%27s+ext&gs_lcrp=EgZjaHJvbWUqCAgBEAAYFhgeMgYIABBFGDkyCAgBEAAYFhgeMg0IAhAAGIYDGIAEGIoFMg0IAxAAGIYDGIAEGIoFMgoIBBAAGIAEGKIEMgcIBRAAGO8FMgoIBhAAGIAEGKIEMgcIBxAAGO8F0gELMTcwMTc1ajBqMTWoAgiwAgHxBeio5-jtgCZ3&sourceid=chrome&ie=UTF-8

[57] Sandra Kunda, "ZCCB Urge Debt Cancellation in Line with Pope Francis' Jubilee Year 2025." *AMECEA Social Communications* (February 2025).

[58] Government of the Republic of Zambia, *Ministry of Finance and National Planning*.

6.2.6 The Practice of Solidarity by the Zambia Conference of Catholic Bishops

While the principles of the common good and the preferential option for the poor often emphasize the government's obligation to create conditions conducive to human flourishing, the principle of solidarity carries a complementary connotation: it focuses on what individuals and communities can achieve collectively, within their means, to improve their conditions. The Church's enduring definition of solidarity captures both what it is and what it is not. As articulated in *Sollicitudo Rei Socialis*, solidarity "is not a feeling of vague compassion or shallow distress at the misfortune of so many people. On the contrary, it is a firm and persevering determination to commit oneself to the common good; that is to say, to the good of all and of each individual, because we are all really responsible for all."[59] This definition frames solidarity as both a virtue and a moral imperative. In the social context, it brings people together to respond proactively and voluntarily to shared challenges. It encourages responsible action in service of the common good, rooted in the awareness that an individual's actions inevitably affect others.

Solidarity also embodies the principle of mutual interdependence among nations, communities, and individuals, while affirming the Christian mandate that we are indeed our "brother's and sister's keeper."[60] It manifests not only in addressing immediate concerns but also in building long-term structures that promote human dignity. A tangible example of solidarity occurred when the southern region of Malawi was devastated by Cyclone Freddy, resulting in a severe humanitarian crisis. In a swift and compassionate response, Catholic Christians in Zambia, through the ZCCB, mobilized financial and material resources in solidarity with the Episcopal Conference of Malawi (ECM) to assist with emergency relief.[61] The support included food, clothing, blankets, and medicines. Additional contributions came from individual dioceses such as Ndola and Chipata.[62] Notably, this Church-led initiative also inspired the involvement of the Zambian government in the rescue and recovery mission, which followed the loss of over 400 lives. This joint effort by Church and State illustrated the deep cultural and linguistic affinity between the peoples of Zambia and Malawi and exemplified grassroots solidarity in action.

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[59] John Paul II, *Solicitudo rei Socialis*, no. 38.

[60] Salzman, "Catholic Social Teaching, the Common Good," 70.

[61] Agnes Aineah, "Catholic Bishops Recognise Zambia-Malawi 'Strong Ties,' Laud Support After Cyclone Freddy. *ACIAfrica* (April 2023).

[62] Stella Zulu, "Chipata Diocese Donates Relief Items to Cyclone Freddy Survivors in Malawi." *Malawi Conference of Catholic Bishops* (May 5, 2023).

Solidarity also implies a commitment to systemic transformation. Its fundamental mission is to interrogate and challenge the structures that hinder human flourishing. When systems and institutions fail to promote human dignity, they become what the Church refers to as structures of sin. These structures are created and perpetuated by human sinfulness, manifested in greed, indifference, selfishness, and hatred, often become embedded in the social fabric.[63] Participation in such structures may be direct or complicit. Solidarity, as a Christian virtue, stands in opposition to these forces and calls for communal action to dismantle them and promote justice.

A pertinent example of this application can be seen in Zambia's healthcare system, which continues to suffer from inadequate infrastructure, particularly in rural and peri-urban areas. In response, the ZCCB, in collaboration with other Christian leaders, has encouraged community-driven self-help initiatives for the construction of health posts and clinics.[64] This approach promotes local participation in development and seeks to correct the dependency mindset that emerged post-independence, the belief that the government alone is responsible for all development. The bishops, at the time of Zambia's independence, warned against such expectations, stating that independence should not be seen as "a magic medicine to cure all ills (poverty, disease, and ignorance), but an incentive and a call to work, dedication, and service."[65]

Many such projects have successfully transitioned into government-supported institutions. For example, Mwaziputa Primary School in Katete District began as a community school after residents recognized the high dropout rates due to the long distances to the nearest government schools. Although the community did not meet the official criteria for government support at the time, they, with assistance from the Church, established and managed a school staffed by volunteer teachers. Over two decades later, the school now operates with full government support, serving as a testament to the power of solidarity and resilience in overcoming structural injustice.

Such stories are not isolated. Across Zambia, similar community-led efforts, often supported by the Church have led to the establishment of clinics and schools that now benefit from public funding. These examples resonate with the call of theologian Michael Kelly, who urged communities in crisis to "speak out with one voice: [that you] have reached your limit."[66] Solidarity empowers individuals and communities to work together in dismantling oppressive systems and advocating for inclusive socio-economic development.

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[63] Corkery, *Companion to the Compendium*, 19.

[64] CCZ, EFZ, ZEC., *Christian Liberation*, *Justice*, *and Development*, no. 142.

[65] ZEC, *Statement from the Catholic Bishops of Zambia to Mark Zambia's Independence Day* (October 24, 1964), no. 3.

[66] Irish Global Health Network, *From Zambia to Ireland*, 78.

Ultimately, solidarity affirms the right of the poor to live in dignity and the duty of the wealthy and civic leaders to provide for their needs.[67] This obligation includes advocating for national policies that guarantee access to essential social services such as quality healthcare, particularly through the transformation of unjust structures. As both a virtue and a principle of social action, solidarity remains an indispensable tool in the Church's mission to foster human dignity, justice, and sustainable development.

6.3 Key Areas for Strengthening the ZCCB's Application of CST in Healthcare

Building on existing initiatives, the following discussion explores additional and more impactful strategies through which the Zambia Conference of Catholic Bishops (ZCCB) can deepen and broaden the integration of Catholic Social Teaching (CST) in the healthcare sector. While certain principles and efforts have already been acknowledged, their implementation remains limited and uneven. A more comprehensive, coordinated, and intentional application of CST is essential to ensure that healthcare delivery is not only technically sound but also ethically grounded and socially just. By addressing current gaps and reinforcing its commitment to CST values such as universal destination of goods, human dignity, subsidiarity and stewardship solidarity, the ZCCB can play a transformative role in shaping a healthcare system that better serves the needs of all, especially the most vulnerable.

6.3.1 The Universal Destination of Goods and Its Implication for Universal Healthcare

The principle of the universal destination of the earth's goods is a foundational tenet of Catholic Social Teaching (CST) that supports the moral argument for universal healthcare. It affirms that the earth's resources are intended for all people and should be shared equitably. As the Second Vatican Council affirms: "God intended the earth with everything contained in it for the use of all human beings and peoples. Thus, under the leadership of justice and in the company of charity, created goods should be in abundance for all in like manner."[68] This universal purpose is rooted in the Genesis narrative where God commands humanity to "fill the earth and subdue it" (Gen 1:28). Interpreting this verse, Paul VI argued that creation is entrusted to human beings, not for exclusive use, but "to give it meaning by [their] intelligent activity, to complete and perfect it by [their] own efforts and to [their] own advantage."[69] Thus, the goods of this world are intended for all, to support the sustenance and

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[67] Salzman, "Catholic Social Teaching, the Common Good," 70.
[68] Second Vatican Council, *Gaudium et Spes* (December 7, 1965), no. 69.
[69] Paul VI, *Populorum Progressio* (March 26, 1967), no. 22.

flourishing of individuals and families, without unjust favouritism to any person, group, or nation.[70] These goods support basic goods, namely: food, water, shelter, education, and healthcare, which are not luxuries but human rights.

The Catholic Church, therefore, teaches that no individual or group holds absolute ownership over the earth's goods, and that private property must serve the common good. The universal destination of goods provides a normative framework for advocating equal access to essential goods and services, including healthcare. As such, the right to use earth's resources is not a privilege granted by human law, but a natural right, inscribed in the dignity of the human person. It follows, therefore, that: "All other rights, including property rights and the right of free trade, must be subordinated to this norm; they must not hinder it but rather expedite its application."[71] While private ownership is legitimate, it must always be balanced against the needs of the community, and especially of the poor. The common good remains the guiding norm.

In the Zambian context, the Zambia Conference of Catholic Bishops (ZCCB), along with other Christian leaders, has occasionally invoked this principle, though often only implicitly. One explicit reference occurred in opposition to the Zambian government's attempt to introduce scientific socialism as a compulsory subject in the national education curriculum from primary to tertiary level. The government promoted scientific socialism as a vehicle for achieving a classless society through humanism and the communal ownership of production.[72] The ideology of scientific socialism was grounded in Marxist philosophy which also had threatened the right to religious belief.

In response, the ZCCB and other Christian leaders acknowledged that socialism aligns with Christianity only insofar as it seeks fair distribution of wealth through public ownership. However, in Zambia's context—characterized by weak governance and centralization of power such policies risked concentrating resources in the hands of a few political elites, thereby undermining the principle of universal destination of goods.[73] Consequently, they emphasized that the right to property must be subordinated to the common good, but not entirely abolished.[74] A just society must promote both equitable access to resources and respect for lawful ownership, ensuring that private property contributes to social justice and human flourishing.

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[70] Vivencio O. Ballano, "Analysing the Morality of Owning and Suspending Patent Rights for Covid-19 Vaccines in the Light of Catholic Social Teaching." *The Lincare Quarterly* 89, no. 1 (2022),

[71] Corkery, *Companion to Compendium*, 70.

[72] Christian Council of Zambia (CCZ), The Evangelical Fellowship of Zambia (EFZ), and the Zambia Episcopal Conference (ZEC), *Marxism*, *Humanism*, *and Christianity* (Lusaka, 1979), no. 9.

[73] Komakoma, *The Social Teaching of the Catholic Bishops*, 107

[74] CCZ, EFZ, and ZEC, *Marxism*, *Humanism*, *and Christianity*, no. 12.

This principle has practical implications. For instance, during the COVID-19 pandemic, India and South Africa petitioned the World Trade Organization (WTO) to suspend vaccine patent rights, allowing low and middle-income countries to produce affordable vaccines locally. Although the request was ultimately denied, the appeal was morally justifiable under the principle of the universal destination of goods.[75] In situations where property rights obstruct access to life-saving resources, expropriation or suspension of those rights can be morally warranted. As CST teaches, in extreme cases where the proprietor disregards the social function of property and exacerbates poverty, the common good may dictate the need for redistribution or expropriation.[76] Even when property is expropriated, the dignity and rights of the owner must always be respected. Expropriation that results in the unjust impoverishment, marginalisation, or persecution of the owner is morally illegitimate.

The principle of the universal destination of the goods of the earth is not opposed to private ownership. Rather, the Church holds that while private property is legitimate, it is not an absolute right and must be subordinate to the moral principle of the common good. As Corkery notes, “the right to private property is not absolute and is subordinate to the moral principle of universal destination of earth’s goods.”[77] This balance between private ownership and the universal destination of goods reflects the Catholic tradition’s nuanced approach to property and justice.

The right to private property plays an important role in promoting responsibility, dignity, and liberty. The *Compendium of the Social Doctrine of the Church* teaches that private ownership fosters personal responsibility and creates the necessary conditions for civil liberty.[78] This understanding is grounded in the theology of work. According to *Populorum Progressio*, work is both a divine calling and a source of dignity; through work and intelligence, individuals participate in creation and, in a real sense, make part of the earth their own.[79] Without human labour, natural resources remain undeveloped. Work gives value to goods and allows their distribution and access, which are essential aspects of the universal destination. Pope Leo XIII expressed this clearly: “When man thus spends the industry of his mind and the strength of his body in procuring the fruits of nature, by that act he makes his own that portion of nature’s field which he cultivates – that portion on which he leaves, as it were, the impress of his own personality.”[80] In this sense, private ownership, including the ownership of

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[75] Ballano, “Analysing the Morality of Owning and Suspending Patent Rights,” 47.
[76] Vatican II, *Gaudium et Spes*, no. 71.
[77] Corkery, *Companion to the Compendium*, 71.
[78] Pontifical Council for Justice and Peace, *Compendium for the Social Doctrine*, no. 176.
[79] Paul VI, *Populorum Progressio*, no. 27.
[80] Leo XII, *Rerum Novarum* (May 15, 1891), no. 7.

intellectual property, inventions, and patents, can be morally justified as the fruit of individual labour and creativity. The Church affirms the legitimacy of private ownership and encourages broad access to it. As Leo XIII further stated: "Private ownership must be held sacred and inviolable. The law, therefore, should favour ownership, and its policy should be to induce as many as possible of the people to become owners."[81] Through work (manual, intellectual, formal, informal) individuals can share what they privately own with the rest of humanity.

Modern scholarship reinforces this understanding. Ballano, for example, argues that private property allows the owner "exclusive power to use, consume, or change the object owned," granting both freedom and responsibility in its use.[82] Encouraging innovation and creativity contributes to the common good by generating goods and services essential to human development and dignity. However, a clear distinction must be maintained between ownership and use. The Church insists that private property is not an end in itself but rather a means to serve the broader principle of the universal destination of goods. As the *Compendium* notes: "Private property, in fact, regardless of the concrete forms of the regulations and juridical norms relative to it, is in its essence only an instrument for respecting the principle of the universal destination of goods; in the final analysis, therefore, it is not an end but a means."[83] Accordingly, private ownership has a social function. It must aim at increasing accessibility to material and social goods for all people. Even patentees, who hold rights to innovations and inventions, cannot claim absolute ownership, since such developments often rely on public resources, collaboration, and societal infrastructure.[84] As Corkery observes, "individual persons should not use their resources without considering the effects that this use will have... they must act in a way that benefits not only themselves and their family but also the common good."[85] Private property, therefore, implies responsibility and not merely privilege.

Moreover, technological innovations and the knowledge economy have introduced new forms of goods that extend beyond material resources. Corkery emphasizes that "the scope of what constitutes earth's goods has expanded to include the 'new goods' which are the result of knowledge, technology, and know-how (skill)."[86] These non-material goods are now central to global wealth and development, and they too fall under the principle of the universal destination of goods. This has implications not only for intellectual property but also for access to essential services such as healthcare. As

[81] Leo XII, *Rerum Novarum*, no. 47.
[82] Ballano, "Analyzing the Morality of Owning and Suspending Patent Rights," 50.
[83] Pontifical Council for Justice and Peace, *Compendium for the Social Doctrine*, no. 177.
[84] Ballano, "Analyzing the Morality of Owning and Suspending Patent Rights," 50.
[85] Corkery, *Companion to Compendium*, 71.
[86] Corkery, *Companion to Compendium*, 72.

the *Compendium* declares: "New technological and scientific knowledge must be placed at the service of mankind's primary needs, gradually increasing humanity's common patrimony."[87] States and institutions committed to social justice must ensure that scientific and technological progress serves all people, not just those in wealthy nations. This is especially important in healthcare, where advances in medical technology must be made available and accessible globally.

The implication of the principle of universal destination of goods for this study is clear: all people must have equal access to adequate healthcare. According to the University of Missouri: "Healthcare access is the ability to obtain healthcare services such as prevention, diagnosis, treatment, and management of diseases, illness, disorders, and other health-impacting conditions. For healthcare to be accessible, it must be affordable and convenient."[88] With regards to healthcare, convenience is served by the location and efficiency of clinics, hospitals, and pharmacies. Despite remarkable advancements in medical science and technology, much of this progress remains out of reach for people in low-income countries. In Zambia, for example, significant disparities persist in the availability and quality of primary healthcare, particularly for the poor and marginalized. The principle of the universal destination of goods challenges these inequalities. It calls for healthcare systems that are not only technologically advanced but also equitable and inclusive, ensuring that the most vulnerable are not left behind. Technology and innovation in medicine must serve the common good and be shared globally to promote human dignity and integral development.

6.3.2 Essential Areas for Advancing the Principle of Human Dignity in Healthcare

The Church's vision for achieving universal healthcare coverage is both compelling and deeply rooted in its moral and theological framework. This vision is not merely aspirational but is grounded in a set of core principles and enduring values drawn from Catholic Social Teaching (CST). These foundational elements must provide a moral compass and strategic direction for the Zambia Conference of Catholic Bishops (ZCCB) as it advocates for a healthcare system that is inclusive, equitable, and accessible to all, especially the poor and marginalized. Below are some of the key CST values and principles that can underpin and strengthen the ZCCB's commitment to advancing universal healthcare in Zambia.

[87] Pontifical Council for Justice and Peace, *Compendium for the Social Doctrine of the Church*, no. 179.

[88] University of Missouri, "Healthcare Access." https://medicine.missouri.edu/centers-institutes-labs/health-ethics/faq/health-care-access#:~:text=Health%20care%20access%20is%20the,have%20access%20to%20adequate%20healthcare.

Firstly, the right to healthcare is a fundamental gap in Zambia's legal framework. Admittedly, one of the most pressing gaps in Zambia's healthcare delivery system is the absence of the right to healthcare in the country's constitutional and statutory frameworks. While Zambia has ratified several international and regional instruments that affirm health as a fundamental human right, these commitments have not been fully translated into enforceable national legislation. Consequently, the nation lacks a robust legal foundation that guarantees universal access to healthcare as a right for all citizens.

Although Zambia has endorsed key protocols such as the United Nations' Declaration on the Right to Health, which obligates member states to pursue the progressive realization of universal healthcare, these obligations remain largely unimplemented and un-operationalised. The failure to domesticate these international standards reflects a deeper issue: the absence of corresponding constitutional provisions that would recognize and enforce these liberties at the national level. Zambia is also a signatory to the African Charter on Human and Peoples' Rights, which articulates a clear legal standard for the right to health in Article 16. The Charter affirms that: "Every individual shall have the right to enjoy the best attainable state of physical and mental health," *and further mandates that state parties* "shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."[89]

This right is situated within a broader framework of individual and collective rights and responsibilities that emphasize human dignity and the value of life. However, the absence of domestication of this Charter into Zambia's constitutional or statutory law significantly weakens its enforceability. The Zambian Constitution, in its current form, does not explicitly recognize the right to healthcare. While Article 12 provides for the right to life, prohibiting the intentional deprivation of life, including that of the unborn, except under specific legal conditions, but it stops short of affirming healthcare as a fundamental prerequisite to safeguarding that life. Efforts to correct this gap were included in the proposed amendment to the Bill of Rights during the 2016 referendum. Notably, this draft included the right to healthcare as a justiciable provision. However, the proposal was rejected by the electorate due to unrelated contentious provisions, and the healthcare guarantee has since remained dormant in draft form.

The failure to establish the right to healthcare as a constitutional entitlement undermines both advocacy efforts and policy implementation. Without a binding legal commitment, healthcare remains vulnerable to political fluctuations, budgetary constraints, and unequal service provision,

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[89] *African Charter on Human and People's Rights,* Article 16.

especially in rural and underserved communities. In light of these realities, the Zambia Conference of Catholic Bishops (ZCCB) can draw valuable lessons from the United States Conference of Catholic Bishops (USCCB), which has consistently maintained that: "Every person has a right to adequate healthcare... Healthcare is more than a commodity; it is a basic human right, an essential safeguard of human life and dignity."[90] This perspective firmly roots the right to healthcare in the principle of the dignity of the human person, a foundational tenet of Catholic Social Teaching (CST). According to CST, the right to health is not merely a matter of policy but of moral obligation. As such, healthcare must be universal, inclusive, and accessible at all stages of life, with particular attention to the poor, the vulnerable, and the marginalized. It is therefore imperative that all actors in society, government officials, civil and traditional leaders, healthcare professionals, and human rights advocates, recognize the right to healthcare as essential to human development and social justice. A nation's healthcare system should be rooted in values that uphold human dignity, protect life, and promote the flourishing of all persons, irrespective of socio-economic status.

In this regard, the ZCCB must take a more deliberate and vocal role in advocating for the constitutional recognition of the right to healthcare. This involves not only reinforcing the moral arguments but also engaging in legislative dialogue and public mobilization to support legal reforms. Without a constitutional mandate, advocacy for universal healthcare lacks the legal grounding necessary to ensure accountability and sustainability. A firm legal recognition of the right to healthcare would provide a stronger foundation for the Church's continued engagement in health service delivery, and more importantly, serve as a concrete expression of Zambia's commitment to human dignity and the common good**.**

Secondly, it is important to underscore that the Zambia Conference of Catholic Bishops (ZCCB) has yet to explicitly assert universal healthcare as a non-negotiable and inalienable right, grounded in the Church's moral and theological tradition. Within the broader vision of Catholic Social Teaching (CST)**,** access to healthcare is not merely a desirable goal or policy option, it is a matter of social justice, intimately linked to the inherent dignity of the human person and the moral fabric of society. CST affirms that justice in healthcare is achieved when all individuals, regardless of socio-economic status, have equitable access to essential health services that preserve life and promote well-being.

Social justice, as emphasized in CST, envisions a society where institutions, especially the State, guarantee access to basic rights, including healthcare, in recognition of the universal destination

[90] U. S. Bishops, "Resolution on Health Care Reform." *Origins* 23, no. 7 (July 1, 1993), 99.

of goods and the common good. Adequate healthcare is therefore not an act of charity, but a duty of justice, rooted in the understanding that every human being is created in the image of God and thus possesses intrinsic value. It follows that the State has a paramount and irreplaceable obligation to provide, regulate, and oversee equitable healthcare delivery, especially for the poor and vulnerable. This responsibility remains binding even in the absence of constitutional recognition, because it derives from the State's social contract and ethical commitments.

As established earlier in Chapter Four of this study, healthcare is best understood as a positive right, that is, a right which requires proactive provision through social structures, including taxation and redistribution mechanisms.[91] This right implies that individuals and families, when confronted with illness or injury, are entitled to receive prompt, primary, and life-sustaining interventions in a manner that is accessible, available, and affordable. It is, therefore, incumbent upon policymakers to ensure that healthcare systems are structured to meet this demand sustainably and justly.

The rising demand for healthcare resources, driven by demographic changes, advances in medical technologies, and emerging disease burdens, calls for responsive, equitable policy frameworks. Yet, in Zambia, there has been a tendency, especially since the 1992 health reforms, to shift the burden of healthcare financing onto citizens through cost-sharing and user fees.[92] While such measures may be driven by fiscal pressures, they risk excluding the poorest from essential care, thereby undermining the very purpose of a public healthcare system. In cases involving extraordinary illnesses or chronic conditions, the financial demands are often higher, and healthcare systems must be structured to absorb and respond to such needs without compromising human dignity. Withdrawal of treatment, particularly for reasons of cost-efficiency, must always be guided by the sanctity of life principle, rather than market-driven considerations.

In Zambia, there remains a troubling tendency among state actors to treat the right to healthcare as a rhetorical aspiration rather than a concrete legal or policy imperative. While healthcare is frequently invoked in political speeches and strategic plans, it lacks the binding legal framework necessary for enforceability. In this context, the ZCCB has a critical role to play in advocating for the codification and protection of the right to healthcare within Zambia's legal and constitutional architecture. To that end, the ZCCB should advocate for a healthcare system that is not only available and affordable, but also ethical, inclusive, and just, a system that upholds the sanctity and dignity of every human life.[93] The moral force behind the right to healthcare is anchored in natural

[91] Bradley, "Positive Rights, Negative Rights and Health Care," 838.
[92] ZEC, *The Church as a Caring Family* (1997), no. 6.
[93] U. S. Bishops, "Resolution on Health Care Reform," 101.

law, Gospel values, and CST principles. It is a reflection of the Church's commitment to the flourishing of every person and the building of a just society. The reality in Zambia, however, is that multiple barriers, especially poverty, continue to impede access to healthcare for a significant portion of the population. Demanding payment from those already burdened by structural disadvantage not only exacerbates existing inequalities but violates the principle of preferential option for the poor. Therefore, the call for universal healthcare is not simply about expanding services, it is about reorienting the moral compass of the nation's health policy.

In alignment with CST and drawing upon the principle of the universal destination of the earth's goods, this study proposes that the ZCCB adopt a more categorical and assertive stance**:** universal healthcare coverage must be recognized as non-negotiable. Such a position would not only reinforce the Church's moral teaching but would provide a consistent and credible standard against which public policies and political decisions could be evaluated. In doing so, the ZCCB would remind the State and society at large that healthcare is not merely an economic concern, subject to the whims of political ideology or fiscal convenience. Rather, it is a moral obligation, a social responsibility, and a cornerstone of human dignity. Unlike short-term economic policies that may change with shifting political priorities, the right to healthcare demands long-term institutional commitment and structural investment. Only through such deliberate and sustained action can Zambia move towards a healthcare system that truly serves all its people.

Thirdly, the need for a framework for comprehensive healthcare reform. A major challenge in Zambia's healthcare delivery system lies in the absence of a coherent and principled framework for comprehensive reform. Historically, healthcare reforms in Zambia have been largely piecemeal, experimental, and reactive, often shaped more by economic constraints than by an ethical commitment to the inherent dignity of the human person. This lack of a clear moral and structural foundation has led to inconsistencies in policy implementation and a failure to meet the healthcare needs of the most vulnerable segments of the population.

For example, the government has experimented with multiple financing mechanisms for healthcare delivery. One of the earliest reforms was the introduction of user fees, a system that required patients to pay out-of-pocket at the point of service. Although exemptions were introduced for children under five and older adults above sixty-five, the fee-based model resulted in widespread inequities, with many people, particularly in rural areas, foregoing timely medical treatment due to unaffordability.[94] This outcome is not surprising, as a significant portion of the rural population lacks

[94] Henriot, "Zambia: A Case Study of Economic Reform," 5.

reliable income streams and lives in persistent poverty. Imposing financial barriers to access healthcare, especially in a context of socioeconomic disadvantage, undermines the very objective of a health system that is meant to protect and promote life. Moreover, Zambia is currently implementing a prepaid national health insurance scheme, which, while progressive in theory, has yet to prove its effectiveness in addressing access and equity gaps. Both the user-fee and insurance models have been largely driven by economic and political considerations, rather than being guided by enduring ethical principles or human-centred development values.

In this regard, the Zambia Conference of Catholic Bishops (ZCCB) has an important role to play in advocating for a comprehensive healthcare reform framework rooted in Catholic Social Teaching (CST) and moral theology. CST offers a robust foundation for health policy that upholds human dignity, prioritizes social justice, and seeks the common good. The United States Conference of Catholic Bishops (USCCB) has provided a compelling model for such a framework, offering guiding principles for just and comprehensive healthcare reform, which the ZCCB could adapt to the Zambian context. These principles include:[95]

1. A truly universal healthcare policy grounded in respect for human life and dignity, excluding practices that threaten life such as abortion and euthanasia.

2. Equitable access to healthcare for all, with a particular emphasis on the needs of the poor, marginalized, and legal immigrants.

3. Commitment to the common good, ensuring that pluralism and freedom of conscience are respected, and that individuals and institutions can choose from a range of ethical options in healthcare provision.

4. Cost containment and equitable financing, ensuring that the burden of healthcare expenses is distributed fairly across different income groups and stakeholders.

These principles move beyond economic efficiency to address ethical and social imperatives. They reflect a vision of healthcare as a basic human right, not a market commodity, and emphasize that the delivery of health services must be affordable, accessible, and ethically sound.[96] If adopted by the ZCCB, such a framework would challenge the Zambian government to move away from market-driven reforms and politically expedient decisions, and instead adopt a long-term, people-centred approach. This would also strengthen the Church's advocacy by situating it within a globally recognized moral tradition that insists on healthcare as a matter of justice, solidarity, and human flourishing.

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[95] USCCB, *Letter to Congress on Health Care Reform* (July 17, 2009), 1. https://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/health-care-murphy-letter-congress-2009-07-17.pdf

[96] USCCB. A *Framework for Comprehensive Health Care Reform* (June 1993), 3-4.

6.3.3 The Principle of Subsidiarity and Local Empowerment in Healthcare

The principle of subsidiarity affirms that decisions and actions should be taken at the most immediate and local level capable of addressing a given issue. In the context of healthcare, this principle recognizes the agency of individuals, families, and communities in maintaining and protecting their own health, while also acknowledging the supportive role of higher institutions when local capacity is insufficient. Subsidiarity is grounded in the conviction that individuals and communities possess the inherent capacity to be agents of change, and that sustainable development emerges when they are empowered to participate actively in their own advancement. As Salzman aptly observes, "True solidarity entails not only providing for the poor but also making them active participants in their own destiny, participants in the attainment and fulfilment of human dignity."[97] Subsidiarity, therefore, is not merely an administrative tool, but a moral imperative aimed at uplifting the disadvantaged through autonomy, responsibility, and participation. Pope Pius XI's classical articulation of this principle remains foundational: "Just as it is gravely wrong to take from individuals what they can accomplish by their own initiative and industry and give it to the community, so also it is an injustice… to assign to a greater and higher association what lesser and subordinate organisations can do."[98] This hierarchical logic insists that larger structures, such as the State, should intervene only when absolutely necessary, and always in ways that reinforce, rather than replace, the capacity of local actors.

Critically, subsidiarity must not be confused with disengagement or abandonment. Rather, it demands that interventions from higher levels of authority serve to strengthen local capability and promote self-sufficiency. Charitable assistance alone is insufficient; what the poor most urgently need are means of empowerment are skills, education, financial support, and access to information, that enable them to pursue and sustain a dignified life. As Hubbard rightly argues, "the poor are our principal dialogue partners, those from whom we have the most to learn, to whom we need to listen out of a duty of justice, and from whom we must ask permission before presenting our proposals."[99] Effective healthcare reform, then, must be rooted in community participation, with special attention to how the poor can become protagonists in shaping their own health outcomes. Development models that marginalize local voices or resist community leadership fail not only ethically, but practically. Any agency, state or non-state, that resists the empowerment of local actors risks undermining the very

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[97] Salzman, "Catholic Social Teaching, the Common Good," 70.

[98] Pius XI, *Quadragesimo Anno* (May 15, 1931), no. 79.

[99] William Hubbard, "The Preferential Option for the Poor and Participation: A Challenge for Catholic Health Care" in *The National Catholic Bioethics Quarterly* (Spring 2023), 63.

change it seeks to promote. It is therefore fundamental to promote decentralisation and to strengthen local efforts.

To begin with, decentralisation and the principle of subsidiarity are important processes in healthcare reform. The concept of decentralisation is intrinsically connected to the Catholic Social Teaching (CST) principle of subsidiarity, which prioritises local participation, community empowerment, and decision-making at the most immediate level. According to the Civil Society for Poverty Reduction-Zambia (CSPR-Zambia), "respect for involvement … can be seen to be a contemporary expression of the traditional Catholic Social Teaching principle of subsidiarity, i.e., the requirement that decisions should be made at the closest possible level to the people affected."[100] CSPR rightly argues that the eradication of poverty and advancement of social justice cannot be achieved without drawing on the lived experiences and insights of local communities. Subsidiarity insists that higher authorities should not usurp responsibilities that can be effectively managed at lower levels.[101] Rather, it promotes a devolution of power and authority, ensuring that governance and service delivery are responsive, relevant, and rooted in local contexts.

This principle entails the existence and empowerment of institutions below the State level, not only to execute policies but also to influence their design and implementation.[102] CSPR-Zambia highlights that "the equal dignity of each human person demands that decisions that affect persons must involve those persons in the process of decision-making."[103] Such an approach acknowledges the intrinsic value and unique contribution of every individual, family, and intermediary group. Neglecting subsidiarity diminishes initiative, erodes freedom, and results in inefficient governance.[104] In practical terms, subsidiarity means that citizens and local communities should have the authority to define, implement, and manage their own development priorities, grounded in their knowledge, values, and experiences.[105]

In healthcare policy and practice, subsidiarity implies that primary care units, community health workers, and local clinics should be entrusted with both decision-making authority and adequate resources, unless their capacity is overwhelmed. Decentralizing healthcare responsibilities

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[100] Civil Society for Poverty Reduction (CSPR) - Zambia, "Catholic Social Teaching and Poverty Eradication: Key concepts and issues." *Southern African Regional Poverty Network*. https://sarpn.org/CountryPovertyPapers/Zambia/Catholic/page3.php.

[101] Catholic Bishop's Conference of England and Wales, *The Common Good and the Church's Social Teaching* (1996), no. 51. https://cbcew.org.uk/plain/wp-content/uploads/sites/3/2018/11/common-good-1996.pdf.

[102] Catholic Bishop's Conference of England and Wales, *The Common Good and the Church's Social Teaching*, no. 52.

[103] CSPR-Zambia, "Catholic Social Teaching and Poverty Eradication."

[104] Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine*, no. 187.

[105] CSPR-Zambia, "Catholic Social Teaching and Poverty Eradication."

enhances efficiency, responsiveness, and cost-effectiveness, and fosters a stronger sense of local ownership over health outcomes. The U.S. bishops, in their pastoral letter *Health and Health Care*, stress the importance of individual, family, and community involvement in healthcare decisions, while also affirming the essential role of institutional and government support.[106] It is imperative that individual contribution always takes precedence.

In the case of Zambia, however, the healthcare system remains heavily centralised, with limited autonomy granted to local institutions. The Zambia Conference of Catholic Bishops (ZCCB), frustrated by chronic delays and irregular government funding to Church-run healthcare facilities, has in the past appealed to donors and cooperating partners to consider direct funding mechanisms.[107] This appeal aimed to circumvent bureaucratic inefficiencies and corruption, ensuring timely access to essential resources. Yet, these stopgap measures do not address the root issue: the lack of a coherent decentralisation framework guided by the principle of subsidiarity.

The ZCCB could take a more proactive stance by advocating for the localisation of critical healthcare management functions, such as recruitment, procurement, and in-service training. While uniform standards in healthcare delivery are essential, day-to-day operational challenges vary greatly across institutions and regions. The centralised, one-size-fits-all approach often proves ineffective. Long delays in procurement have, in some cases, led to the delivery of near-expired drugs or total wastage of resources. In contrast, subsidiarity offers a practical and ethical alternative: devolving responsibilities to capable local entities can improve responsiveness, reduce bureaucratic bottlenecks, and enhance service quality.[108] Nationally designed healthcare frameworks may be necessary for setting overarching goals and standards, but their success often hinges on local ownership and adaptability. Through subsidiarity, local communities can identify specific health challenges, design appropriate interventions, and implement sustainable solutions. To realise this vision, the Zambian government must begin a deliberate process of shifting decision-making authority and resources to local levels, thereby fostering efficiency, reducing waste, and promoting human dignity in healthcare delivery.

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[106] USCCB, *Health and Health Care*, 6.
[107] ZEC, *The State of Affairs in the Health Sector*, no. 7.
[108] Catholic Medical Association, *Applying Catholic Principles*, no. 114.

6.3.4 Safeguarding Ecological Integrity Through Environmentally Responsible Healthcare

This section examines the concept of integral ecology, the escalating issue of medical waste, particularly within the healthcare sector. To begin with, any comprehensive analysis of stewardship in healthcare would be incomplete without a focused engagement with integral ecology. Rooted in Catholic Social Teaching (CST), integral ecology provides a holistic framework that underscores the interdependence between human well-being, social systems, and the natural environment. As Pope Francis articulates in *Laudato Si'*, integral ecology is not merely an environmental concern but a socio-environmental ethic, demanding a unified response to both ecological degradation and human suffering.[109]

Ecological integrity, a foundational and evolving principle in Catholic Social Teaching (CST), has gained urgency considering the global climate crisis. Climate change is not merely the result of natural cycles but largely a consequence of human activity.[110] This ecological disruption directly impacts public health, food security, and water availability, particularly harming the world's poorest communities. Pope Benedict XVI emphasized that creation is not merely raw material to be exploited but a gift that must be wisely managed. He outlined a threefold human responsibility toward the environment: to the poor, to future generations, and to humanity at large.[111] This theological framework underscores that environmental stewardship is inseparable from social justice. As Pope Francis affirms in *Laudato Si'*, ecological responsibility requires an integrated approach that hears "both the cry of the earth and the cry of the poor."[112] Environmental degradation often destroys the natural resources upon which the poor depend, effectively dismantling their livelihoods.

CST thus insists on a moral duty to act: to regulate resource use, combat environmental harm, and advocate for policies that prioritize ecological integrity. As theologian Lisa Sowle Cahill argues, the Church must not only protect the environment but also influence national and international frameworks to ensure equitable and sustainable development, especially for vulnerable populations.[113] Ecological integrity also demands a future-oriented perspective. As the proverb states, "We do not inherit the earth from our ancestors, we borrow it from our children." This calls for a shift from exploitative practices toward models that preserve resources, nurture ecosystems, and promote intergenerational justice. Pope Francis warns against technocratic paradigms that ignore natural limits

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[109] Pope Francis, *Laudato si*, no. 48.
[110] Pope Francis, *Laudato si*, no. 23.
[111] Benedict XVI, *Caritas in Veritate*, no. 48.
[112] Pope Francis, *Laudato si*, no. 49.
[113] Cahill, "Benedict's Global Reorientation," 304.

and foster a dangerous illusion of limitless progress.[114] Ultimately, stewardship in healthcare and beyond requires ethical governance, inclusive participation, and concrete measures to protect our common home, not just for today, but for generations to come.

Sacred Scripture lays the theological foundation for this stewardship. In Genesis 2:15, it is written: "The Lord God took the man and put him in the garden of Eden to till it and keep it." This passage signifies humanity's primary vocation as caretakers of creation. However, this divine mandate has often been distorted into a justification for exploitation and domination, rather than care and preservation. Integral ecology calls for a reorientation of this relationship, urging humanity to withdraw from the destructive practices that contribute to pollution, climate change, and the erosion of life-sustaining ecosystems. Mitchell, Andreoni, and Hatchett elaborate that, "Ecology is all about relationships, and an integral ecology amplifies the focus on human relationships with each other and with our built and natural environments; affirming that 'everything is closely related.'"[115] This framework acknowledges that while both built and natural environments are essential to human life, the natural environment must take precedence due to its foundational role in sustaining all forms of life. In this light, the healthcare sector must critically examine its own practices, especially concerning medical waste management and the consumption of natural resources. Integral ecology demands that healthcare systems not only prioritise patient well-being but also minimise ecological harm, thereby reinforcing a broader commitment to social justice, public health, and environmental sustainability.

Zambia has already suffered significant ecological damage, much of it resulting from inadequate waste management practices. The mining sector, in particular, has been the primary source of the country's major environmental challenges. These ecological disasters have caused long-term harm to both livelihoods and ecosystems, yet they have rarely led to meaningful accountability for the perpetrators. While the impacts of environmental degradation are widely documented, three cases remain especially prominent: the Kabwe lead poisoning crisis, the Chingola sulphur dioxide emissions disaster, and the recurrent pollution of the Kafue River. More recently, a new threat has emerged in the form of increasing contamination of local rivers, primarily driven by unregulated and illegal small-scale gold mining activities.

[114] Pope Francis, *Laudate Deum*, no. 21.

[115] Cory D. Mitchell, Armand Andreoni, and Lena Hatchett, "Integral Ecology in Catholic Health Care: A Case Study for Health Care and Community to Accelerate Equity" in *Catholic Bioethics and Social Justice*: *The Praxis of US Health Care in a Globalised World*, edited by M. Therese Lysaught and Michael McCarthy (Collegeville, Minnesota: Liturgical Press Academic, 2018), 83-84.

In the Kabwe case, the damage was caused by the closed lead and zinc mining. After the closure of the mine no major effort has been made to mitigate the effect of the waste by trying to cover the dump. To this day, lead dust from the vast, uncovered waste dumps left by the former mine continues to spread into surrounding residential areas, contaminating homes, school grounds, roads, and open spaces, and exposing an estimated 200,000 people to serious health risks.[116] Studies by medical researchers indicate that more than 95 percent of children living nearby have dangerously high levels of lead in their blood, with nearly half in urgent need of medical intervention. The United Nations has characterized Kabwe as a "sacrifice zone," where entire communities endure severe pollution and toxic exposure as explained:

> Kabwe, the capital of Zambia's Central Province, is one of the most lead-polluted places in the world because of contamination from a former industrial lead and zinc mine and smelter. Lead is a heavy metal that is highly toxic to humans when ingested or inhaled, particularly to children and women during pregnancy. The mine, which was established during the British colonial period and officially closed in 1994, has never been cleaned up. Decades of mining and smelting operations have resulted in an estimated 6.4 million tons of lead-bearing waste piles.[117]

With global demand for lead and zinc remaining high, individuals seeking to extract these minerals from waste dumps have inadvertently exacerbated the spread of toxins by transporting contaminated materials to various sites within the town. Monitoring of these activities remains minimal, with limited regulatory oversight or enforcement mechanisms in place. As a result, the environmental and public health damage continues to escalate, often unnoticed until the effects become severe. The lack of systematic surveillance not only allows the unchecked spread of toxins but also undermines accountability, enabling both individuals and corporations to engage in practices that compromise community well-being. Strengthening monitoring systems and enforcement capacity is therefore critical to mitigating further harm and ensuring sustainable management of natural resources.

Chingola has experienced recurrent sulphur dioxide leaks from the Konkola Copper Mine (KCM). The most recent major incident occurred in 2019, leading to the hospitalization of more than 200 schoolchildren and over 40 mine employees.[118] Beyond such immediate health crises, the community has also endured long-term consequences. One of the most notable has been the inability of

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[116] Poisonous Profit (March 5, 2025). https://www.hrw.org/report/2025/03/05/poisonous-profit/lead-waste-mining-and-childrens-right-healthy-environment-kabwe

[117] Poisonous Profit.

[118] "Zambia: Minister Wants Tough Action Against Mining Company Responsible for Sulphur Dioxide Leak Incident," *Business and Human Rights Resource Centre* (November 2019). https://www.business-humanrights.org/en/latest-news/zambia-minister-wants-tough-action-against-mining-company-responsible-for-sulphur-dioxide-leak-incident/

households to cultivate vegetables in their backyards, a once common practice in the town, due to the lasting effects of soil and air contamination.

The Kafue River has long suffered recurrent pollution, particularly from industrial and mining operations in Zambia's Copperbelt region. Decades of contamination have taken a heavy toll on both environmental and human systems. On 18 February 2025, this chronic issue culminated in a catastrophic tailings dam collapse at a Chinese-owned copper mine. The breach released approximately 50 million litres of toxic, acidic waste directly into the Kafue River system, inflicting severe ecological and community harms.[119] Reports indicated that the effects of the contamination were detected at 100 kilometres downstream. The spill represents a serious crisis, endangering both human populations and wildlife along the Kafue River, which stretches over 1,500 kilometres (930 miles) through the centre of Zambia.

The cases outlined above underscore the critical principle that prevention is better than cure. Had government agencies responsible for environmental protection and surveillance adopted a more proactive approach, many of these incidents could have been avoided. Instead, inadequate monitoring and weak enforcement mechanisms have allowed environmental hazards to escalate, leaving the nation to bear the heavy costs in terms of human health, biodiversity loss, and long-term ecological damage.

In this vein, attention needs to be drawn to the growing issue of medical waste management. The Zambian healthcare system has institutionalised the role of the Environmental Health Technician (EHT), a crucial figure in realising the principles of integral ecology. EHTs operate at the intersection of environmental management and public health, with responsibilities spanning sanitation, disease surveillance, food safety, healthcare waste management, water quality monitoring, occupational health, and health education. According to regulatory guidelines, EHTs are tasked with "monitoring and implementing a system to correct any errors in disposing healthcare waste," thereby ensuring compliance with environmental health standards.[120] Within healthcare delivery, the EHT serves as the primary liaison between health facilities and the community, particularly in matters of disease prevention and outbreak response. Their embedded role within the hospital's catchment area makes them the first point of contact during public health emergencies and a vital agent in community health education and mobilisation. In contexts of healthcare facility development or expansion, EHTs also

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[119] Richard Kille and Jacob Zimba, "A River 'Died' Overnight in Zambia After an Acidic Waste Spill at a Chinese-Owned Mine." *AP News* (March 15, 2025). https://apnews.com/article/mining-pollution-china-zambia-environment-93ee91d1156471aaf9a7ebd6f51333c1.

[120] Colleen Leonard, Chipwaila Chunga, Justine Nkaama, Kutha Banda, Chilekwa Mibenge, Victor Chalwe, et al. "Knowledge, Attitudes, and Practices of Healthcare Waste Management Among Zambian Healthcare Workers." *PLOS Glob Public Health* 2(6) (2022), 11. https://doi.org/10.1371/journal.pgph.0000655.

play a pivotal role in coordinating community involvement, thereby promoting ownership and sustainability. Ultimately, EHTs contribute to community resilience and environmental stewardship, making their function indispensable to the broader aim of integral ecology in Zambia's healthcare system.

Due to the rapid evolution of healthcare, there has been a corresponding rise in medical waste, particularly as a result of the growing demand for intensive care and long-term care services. Modern medical procedures involve the extensive use of rubber, plastics, synthetic chemicals, metals, radioactive substances, and disposable packaging. These materials are not only non-biodegradable but also contribute heavily to environmental pollution. The intensity of resource usage is even more pronounced in long-term care settings, particularly in cases involving comatose or end-of-life patients.

Although Zambia's accumulation of medical waste has not yet reached critical levels, the planned upgrading of hospitals to second- and third-level facilities across the country will inevitably increase the volume of such waste. Since many Zambians are not accustomed to accepting the termination of futile treatment, the number of patients receiving prolonged critical care is likely to increase. This trend will, in turn, contribute to higher levels of medical waste generation and greater energy consumption within healthcare facilities. This development presents an important opportunity for the Zambia Conference of Catholic Bishops (ZCCB) to raise a prophetic voice, advocating for sustainable healthcare practices and responsible medical waste management. The bishops should raise awareness among both healthcare personnel and families about the emerging ethical concern of minimizing medical waste generated through prolonged life-sustaining treatments that offer minimal therapeutic benefit. Such reflection is necessary not only for ecological protection but also for the promotion of the common good.

The management of medical waste presents a growing ethical concern in Catholic Social Teaching (CST), particularly through the lens of stewardship. Cahill provocatively raises the issue of whether it is justifiable to continue expensive end-of-life interventions in cases where recovery is highly improbable, especially when such care consumes disproportionate resources that could otherwise serve broader public health needs.[121] This dilemma becomes especially relevant when juxtaposed with global healthcare disparities. The continuation of intensive care for terminally ill, insured individuals in wealthy contexts often contrasts sharply with the absence of basic healthcare for millions worldwide. Thus, decisions to forgo futile medical interventions may not only reflect medical prudence but also constitute an ethical commitment to ecological and social justice. Such a stance

[121] Cahill, *Theological Bioethics,* 90.

aligns with a broader understanding of stewardship that integrates environmental sustainability with the equitable distribution of healthcare resources.[122]

In addition, the Zambia Conference of Catholic Bishops needs to strengthen its advocacy for integral ecology, particularly in relation to the dignity, wellbeing, and participation of women. Because women are often among those most affected by environmental degradation, poverty, food insecurity, and lack of access to clean water, any serious commitment to integral ecology must intentionally address their experiences and needs. Following repeated incidents of river contamination and the destruction of farmlands in several parts of the country, the Zambia Catholic Bishops rightly observed that "These environmental injustices cause both immediate and long-term health issues, destroy ecosystems, and wipe out the source of livelihood for those dependent on farming and fishing."[123] Their statement captures the harsh reality that environmental damage is never merely an ecological problem; it is also a profound social and economic crisis. In Zambia, the burden of such injustices falls disproportionately on already marginalised communities, especially poor women, children, and young people living in rural areas.[124] These groups often depend directly on land, water, farming, and fishing for survival. When rivers are polluted, crops fail, or soils are degraded, they lose not only income but also food security, health, and dignity. Women, who frequently bear primary responsibility for household care, food provision, and water collection, are particularly affected. Children face malnutrition, disease, and disrupted education, while young people encounter unemployment, displacement, and reduced prospects for the future.

This situation reveals a clear and inseparable connection between poverty and environmental degradation. Ecological destruction deepens poverty, and poverty in turn limits communities' ability to protect and restore their environment. In many rural communities, women carry primary responsibility for securing water, cultivating family food gardens, caring for children, and sustaining household livelihoods. When forests are depleted, rivers polluted, or farmlands destroyed, the burden placed on women increases significantly. They are forced to travel longer distances for water and firewood, work harder to secure food, and manage the health consequences of contaminated environments within their families. Yet despite bearing these costs, women are frequently underrepresented in decision-making processes concerning land use, environmental protection, and development policies. In this sense, there

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[122] Kenny, "Moral Distress in a Pandemic," 235.

[123] Zambia Conference of Catholic Bishops, *On Pollution and Environmental Degradation in Zambia*: *A Call to Enhance Environmental Stewardship* (Lusaka, August 22, 2025), no. 5.

[124] Government of the Republic of Zambia (GRZ), *National Policy on Climate Change* (Lusaka: Ministry of Lands, Natural Resources and Environmental Protection, 2016), ii.

is always a poverty-environment nexus. Those with the fewest resources are often the least responsible for environmental harm, yet they suffer its gravest consequences.

For this reason, the Bishops' Conference should promote a more explicit ecological justice agenda that recognises women not merely as victims of environmental harm, but as key agents of transformation, resilience, and stewardship. This would include advocating for women's inclusion in environmental governance, supporting women farmers with sustainable agricultural initiatives, defending women's land rights, and amplifying women's voices in public policy debates on mining, pollution, deforestation, and climate change. Such advocacy would be fully consistent with the Church's vision of integral ecology, which insists that care for creation must be inseparable from care for human dignity and social justice.[125] Strengthening attention to women within ecological advocacy would therefore not be an optional addition, but an essential dimension of building communities where both people and the environment can flourish together.

Furthermore, the ZCCB can raise the issue of the finite nature of both natural resources and medical interventions.[126] While modern medicine has made tremendous advances in alleviating suffering, it cannot eliminate all illness, disability, or death. Therefore, stewardship must include regular ethical evaluations of treatment efficacy, particularly in cases where continued care no longer serves a meaningful therapeutic purpose.[127] This includes recognising when medical interventions transition from healing to mere prolongation of biological life without dignity or benefit. In this light, medical waste is not merely a logistical or technical issue but a profound moral concern. Healthcare systems must ensure that treatment protocols, especially those involving extensive use of disposable materials and energy, do not become contributors to environmental degradation. A revised approach to medical stewardship must incorporate sustainability as a core value, promoting both ecological integrity and justice in healthcare delivery.

6.3.5 Stewardship and Sustainable Resource Management in Zambia's Healthcare

Prudent management of resources is fundamental component of healthcare for effective and efficient service delivery. One characteristic of healthcare is the exponential increase in cost. Healthcare administrators and managers must look for ways of reducing cost without compromising quality of care. The U. S. bishops pointed out that "stewardship demands that we address the duplications, waste,

[125] Pope Francis, *Laudato Si'*, no. 48.
[126] Irish Catholic Bishops' Conference, *Code of Ethical Standards for Healthcare*, 31.
[127] Irish Catholic Bishops' Conference, *Code of Ethical Standards for Healthcare*, no. 7.

and other factors that make our system so expensive."[128] In terms of procurement, prudent management and application of resources urges more freedom of operation to be granted to those closest to the challenges in the spirit of subsidiarity. Subsidiarity is a way of enhancing stewardship of resources and also an antidote against the perennial challenge of waste. Wastefulness can be committed in a variety of ways. It happens when health departments rush to purchase equipment that promises great efficient diagnostic or treatment processes at a great cost because it was decided at higher level, only to be accessed by few people who can afford the fees for such services. It is a huge disservice by the healthcare facility to install any system at great cost which is inaccessible to most patients due to cost implications. Universal healthcare coverage is largely undermined when there are restrictive benefits arising from inability to pay for the installed equipment. In some cases, the cost of such equipment can wreck the annual budget completely.

Another kind of waste is when centrally procured medical supplies remain disused because they do not match with urgent local needs or simply duplicated. Centrally procured resources may be the best, but they may not be the most urgent. In the circumstances where the much-required supplies still have to be procured, a new budget will inevitably be drawn which automatically creates a new cost. Such miscalculations do not help to reduce the cost of healthcare. Strategic systems must be designed to contain costs in healthcare to make it more affordable.[129] Locally planned and budgeted for items are likely to be more useful and well-spent, than the centrally acquired ones. The USCCB argues that "the responsible stewardship of healthcare resources can be accomplished best in dialogue with people from all levels of society, in accordance with the principle of subsidiarity and with respect for the moral principles that guide institutions and persons."[130] The technical nature of healthcare demands that local organisations are adequately supported in their decision-making processes.

One of the most damaging forms of resource waste in Zambia's healthcare sector is the widespread abuse and mismanagement of medical resources, primarily through theft and corruption. While the national healthcare budget remains severely constrained, it is the systemic corruption that most critically undermines effective service delivery. The diversion of public health funds for private gain constitutes a grave form of social sin and highlights the urgent need for structural reform.

A striking example was provided by the Governor of the Bank of Zambia, Dr. Denny Kalyalya, who used the funeral eulogy for his late wife to publicly denounce corruption in the health sector. He stated, "People are dying prematurely because the country's health system has broken down as public

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[128] U. S. Bishops, "Resolution on Health Care Reform," 99.
[129] U. S. Bishops, "Resolution on Health Care Reform, 101.
[130] USCCB, *Ethical and Religious Directives*, Part One, Introduction, par. 4.

officials dip their hands into resources meant for healthcare."[131] This courageous statement, made in the presence of the President, underscores the severity of the issue and the urgency of reform. Persistent reports of corruption and procedural irregularities at the Ministry of Health have further revealed deep institutional decay. The Jesuit Centre for Theological Reflection (JCTR) emphasized that the theft of life-saving medications constitutes a violation of human dignity and reflects a profound failure of ethical stewardship.[132] Justice and accountability are key to safeguarding the available scarce resources in Zambia's healthcare delivery system.

The consequences of this corruption extend beyond national borders. On May 9, 2025, U.S. Ambassador to Zambia, Michael Gonzales announced the suspension of $50 million in medical aid due to inadequate responses to systemic theft. This aid cut, which amounts to nearly a third of Zambia's annual healthcare expenditure, followed a three-year investigation uncovering the illegal sale of donated life-saving drugs by over 95% of the 2,000 investigated pharmacies nationwide.[133] Ambassador Gonzales stated, "After more than a year of little tangible action by Zambian authorities to address this systematic theft... the United States can no longer justify to the American taxpayer continuing to provide such massive levels of assistance."[134] Africa Health and Economic Transformation Initiative (AHETI) asserts that the theft of life-saving medicines constitutes a moral catastrophe, stating that 'behind every stolen medicine is a life endangered, and behind every aid cut is a community pushed closer to the brink of collapse.[135] The government's failure to prosecute high-level perpetrators has only reinforced public suspicion of complicity. Opposition figures, such as Chishala Kateka of the New Heritage Party, have accused the government of shielding those responsible, thereby allowing the criminal network to operate with impunity.[136] Such inertia suggests collusion at the highest levels and reflects a broader failure of governance.

The theft and mismanagement of medical aid disproportionately harm Zambia's most vulnerable populations, who rely heavily on public healthcare provisions. The Jesuit Centre for Theological

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[131] Chamuka Shabubala, "BoZ Governor Vents: People Are Dying Because We're Dipping Our Hands in Money Meant for Healthcare," *News Diggers* (December 4, 2024), 1.

[132] Sandra Kunda, "Jesuits in Zambia Urge Government to Act Swiftly After US Cut $50 Million in Medical Aid." *AMECEA Social Communications* (May 16, 2025). https://communications.amecea.org/index.php/2025/05/16/zambia-jesuits-in-zambia-urge-government-to-act-swiftly-after-us-cut-50-million-in-medical-aid/.

[133] U. S. Embassy in Zambia, *United States to Cut $50 Million in Medications and Medical Supplies Support*. https://zm.usembassy.gov/united-states-to-cut-50-million-in-medications-and-medical-supplies-support/#:~:text=After%20more%20than%20a%20year,stock%2Douts%20of%20these%20medications.

[134] U. S. Embassy in Zambia, *United States to Cut $50 Million in Medications*.

[135] Charles Chilufya, "When the Poor Pay Twice: The Moral Catastrophe of Zambia's Stolen Medicines and Aid Cuts." *AHETI* (May 9, 2025). https://aheti.org/2025/05/09/when-the-poor-pay-twice-the-moral-catastrophe-of-zambias-stolen-medicines-and-aid-cuts/

[136] Natasha Mwila and George Zulu, "UPND Shielding Drug Cartel." *The Mast* (May 10, 2025), 3.

Reflection observed that "This crisis undermines the dignity and sanctity of life, betraying public trust and the fundamental principles of Catholic Social Teaching. It is not merely a policy failure but a moral collapse that affects the poorest and most vulnerable citizens—those who depend on free HIV, malaria, and TB medication."[137] While public clinics and hospitals across Zambia remained understocked, donated essential medications—including HIV antiretrovirals, tuberculosis drugs, and malaria treatments, which serve as lifelines for the most vulnerable—were illicitly diverted and sold in private pharmacies. Without decisive action to confront and eradicate corruption, no amount of foreign aid or budgetary reform will suffice. The JCTR has issued a series of critical recommendations aimed at addressing systemic weaknesses within Zambia's healthcare governance. These include the public release of the full forensic audit to ensure transparency and accountability, the establishment of robust protections for whistleblowers to encourage the reporting of malpractice, and the expedited prosecution of individuals implicated in corruption. Additionally, JCTR advocates for the implementation of a comprehensive digital drug tracking system to enhance oversight and reduce pilferage. Central to these recommendations is the call to develop a resilient, domestically anchored healthcare infrastructure capable of protecting the nation's most vulnerable populations from systemic neglect and exploitation.[138] Therefore, tackling corruption must be the foremost priority in any effort to improve Zambia's healthcare system. Real reform will require political will, legal enforcement, and a cultural shift toward transparency and accountability.

6.4 National Health Insurance and Equity in Zambia's Healthcare System

To expand healthcare coverage, the Government of the Republic of Zambia enacted the National Health Insurance Act No. 2 of 2018, establishing the National Health Insurance Management Authority (NHIMA). NHIMA is tasked with implementing and managing the scheme, accrediting healthcare providers, developing a comprehensive benefits package, and facilitating access to insured services for the poor and vulnerable.[139] The overarching goal is to establish a sustainable financing model that advances universal access to quality healthcare. The scheme pools contributions from the entire population to enable accredited facilities to procure medical supplies and services for all Zambians and

[137] Jesuit Centre for Theological Reflection (JCTR), "JCTR Urges Government Action as US Withdraws $50 Million in Medical Aid Over Drug Theft Scandal" (May 14, 2025). https://jctr.org.zm/en/jctr-responds-to-us-aid-cut-over-drug-theft/.

[138] JCTR, "JCTR Urges Government Action as US Withdraws $50 Million in Medical Aid."

[139] Government of Republic of Zambia (GRZ), *The National Health Insurance Act 2018* (The Parliament of Zambia), Part II, no. 5. https://www.parliament.gov.zm/node/7517.

established residents. Solidarity, a foundational principle of Catholic Social Teaching and social justice, underpins the scheme's rationale, design, and implementation.

The benefit package includes outpatient consultations, pharmaceutical and blood products, surgical procedures, maternal and paediatric care, inpatient services, rehabilitation, vision care, dental services, and mental health interventions.[140] These services are accessible through over 370 healthcare facilities, including government, mission, and private hospitals, as well as laboratories and pharmacies. The scheme allows members to access services that were previously unaffordable for most, such as advanced diagnostics and specialized treatments. Nonetheless, eligibility restrictions apply. Contributors must be aged 18 to 65, while persons below 18, above 65, mentally challenged, or classified as poor and vulnerable are exempt.[141] As of recent government estimates, only 29% of the population—approximately 5.6 million out of 20 million Zambians—are enrolled, generating an estimated $4 million in monthly contributions. While the number of subscribers has increased, especially among the unemployed, defaults in subscription remain a persistent challenge, and universal coverage appears unlikely in the current model.

Despite its conceptual merits, the scheme faces serious practical challenges. Firstly, the fund is currently riskily under subscribed but overdrawn. With government employees contributing 2% of their salaries and allowed to register spouses and dependents under 18, the financial strain is significant. Given that the average Zambian household comprises five to six members, the fund has become overdrawn, especially due to rising claims for specialized services. In response, NHIMA announced changes to the benefit package on April 30, 2024, removing coverage for items such as spectacles, ophthalmic injections, renal consumables, and scan contrasts. Co-payments were introduced for services like eye and dental care, while other services, including chemotherapy, mental health, and maternal health, were added.[142] Concurrently, the waiting list for specialized local and overseas treatment continues to grow.

Moreover, more than 70% of Zambians remain without health insurance, largely as a result of poverty and widespread unemployment. These individuals are often either denied access to subsidized care or compelled to register on the spot in order to receive it, a practice that overlooks their financial constraints and exacerbates their vulnerability. Furthermore, disparities among subscribers persist, as urban residents access more comprehensive services than their rural counterparts, thereby

[140] National Health Insurance Management Authority, “NHIMA Benefits Package.” https://www.nhima.co.zm/download/document/0cc33260ff202106024ae44f75.pdf.

[141] GRZ, *The National Health Insurance Act 2018*., Part III, no. 18.

[142] NHIMA, *Notice of Modification to the National Health Insurance Scheme Benefits Package.*

monopolizing the fund's resources. Its current structure risks reinforcing inequality rather than promoting equity. Furthermore, the present status of NHIMA undermines the very principle of solidarity on which the scheme is founded.

The nation has a fundamental duty to guarantee that every citizen has access to quality healthcare, irrespective of their socio-economic status. Fulfilling this obligation requires the development of more sustainable and equitable mechanisms of healthcare financing. Strengthening financial models, whether through progressive taxation, expanded insurance coverage, or innovative public-private partnerships—can help to reduce the disproportionate burden borne by the most vulnerable populations. In this way, healthcare financing becomes not only a technical issue of resource allocation but also a moral imperative rooted in justice, solidarity, and the protection of human dignity.

The ZCCB has a mandate to urge the government to reflect and to respond with the same level of concern and commitment that international donors have demonstrated in supporting the most vulnerable. Zambia's health budget has long relied heavily on international donor support. However, donor funding for healthcare has declined sharply in recent years, leaving the most vulnerable populations at greater risk. The solidarity once demonstrated by international donors has not been matched by the government's own spending priorities.[143] The ZCCB has an opportunity as they have done before to evoke and interpret solidarity as a tool for supporting the most vulnerable. One way to apply the principle of solidarity is by adjusting national budget allocations. However, some argue that Zambia's national budget is already inadequate across all sectors, making it difficult to reallocate funds without undermining essential services. On the other hand, this argument is challenged when one considers the government's pattern of lavish spending, such as the frequent replacement of expensive cars for officials, which suggests that resources could be redirected toward more pressing national needs.[144]

One possible area that has not been fully explored is the potential contribution of the mining and industrial sectors to healthcare services. The ZCCB could advocate for the introduction of a dedicated mining and industrial health tax. If properly structured and directed exclusively to the health sector, such a tax could provide a sustainable source of funding to address some of the persistent financial challenges facing healthcare delivery in Zambia. This proposal is not only financially viable but also ethically justifiable. Mining companies and industries are among the largest contributors to ecological degradation in the country, including air and water pollution, land destruction, and

[143] Komakoma, *The Social Teaching of the Catholic Bishops*, 12.
[144] ZEC, *Economics*, *Politics*, *Justice*, no. 10.

hazardous waste.[145] These environmental impacts have well-documented negative effects on public health, ranging from respiratory diseases and cancers to waterborne illnesses. It is therefore reasonable to require that the sectors most responsible for these health risks also contribute directly to mitigating them. In this way, a mining and industrial health tax would operationalize the principle of environmental justice and corporate social responsibility, while at the same time strengthening the country's capacity to deliver equitable and sustainable healthcare services.

At the community level, solidarity can serve as a powerful tool to help families who struggle to keep up with their National Health Insurance Management Authority (NHIMA) subscriptions. In the past, the Zambia Conference of Catholic Bishops (ZCCB) has successfully supported community mobilization initiatives to address challenges such as the lack of education and healthcare infrastructure in underserved areas of the country.[146] A similar approach could be adopted to strengthen access to health insurance. Under the guidance of traditional leaders and local community structures, households could pool resources on an annual basis to collectively cover NHIMA subscription fees for vulnerable families. This system of shared responsibility would ensure that no family is excluded from essential healthcare services simply because of financial limitations. Beyond financial contributions, such initiatives could also foster greater community cohesion, build trust in health systems, and promote the principle of mutual care. If well-coordinated, this grassroots solidarity could complement government efforts, reduce the number of uninsured households, and enhance universal health coverage in Zambia.

Corruption, however, poses the most serious threat to the scheme's viability. The Minister of Health confirmed systemic abuse of the fund. Fund managers have reportedly colluded with private hospitals, laboratories, and pharmacies to submit inflated or fraudulent claims.[147] In some cases, service providers have over-prescribed treatments or conducted unnecessary procedures solely to increase reimbursement amounts. Another concern is biased accreditation, where facilities linked to fund managers or those offering kickbacks are preferentially registered.[148] The proliferation of private laboratories and diagnostic centres near major public hospitals, largely driven by NHIMA reimbursements, further suggests a shift towards commercial rather than patient-centred objectives. To curb such corrupt practices, the government could establish standardized pricing for drugs and services across all hospitals and pharmacies accredited by the National Health Insurance Management Authority

[145] Kille and Zimba, "A River 'Died' Overnight in Zambia After an Acidic Waste Spill."

[146] CCZ, EFZ, ZEC., *Christian Liberation*, *Justice*, *and Development*, no. 142.

[147] Barnabas Zulu, "NHIMA in Red Because of Private Sector Abuse-Masebo," *News Diggers* (May 2, 2024), 5.

[148] Zulu, "NHIMA in Red Because of Private Sector Abuse-Masebo," 5.

(NHIMA). In addition, implementing a more rigorous vetting and accreditation process would help eliminate unscrupulous vendors and strengthen accountability within the system.

In conclusion, the NHIMA framework offers a promising foundation for achieving universal healthcare in Zambia. However, its potential remains unrealized due to structural limitations, mismanagement, and corruption. Without urgent reforms to address governance, expand enrolment, and ensure equitable access across urban and rural populations, the scheme risks becoming a mechanism of exclusion rather than inclusion in Zambia's healthcare system.

6.5 Conclusion

This chapter has examined how the Zambia Conference of Catholic Bishops (ZCCB) has engaged the principles of Catholic Social Teaching (CST) as resources for advancing universal healthcare in Zambia. Notably, the ZCCB has emphatically upheld the principle of the dignity of the human person, particularly through its firm stance on abortion and its sustained campaign against the death penalty. Furthermore, the principles of the preferential option for the poor, the common good, and solidarity have consistently shaped the ZCCB's social justice advocacy. These principles affirm the belief that individuals can flourish within their communities when provided with the necessary conditions and support. However, systemic injustices, described in CST as "structures of sin," continue to obstruct human development. In the context of healthcare, urgent priorities must include ensuring universal access to nutrition, clean water, sanitation, affordable medical services, and sustainable livelihood opportunities. While these elements are acknowledged in various government policies, their practical implementation remains inconsistent and inadequately defined and funded.

Despite these efforts, the ZCCB must articulate a more nuanced and robust stance on the right to healthcare as intrinsically linked to human dignity. Greater emphasis is needed on CST principles that are currently underutilized in healthcare discourse, such as the universal destination of goods, subsidiarity and decentralization, stewardship, and environmental responsibility. Strategic engagement with these principles could contribute to the establishment of legal and institutional frameworks that compel the government to allocate resources equitably and develop healthcare infrastructure progressively and transparently.

This study recommends CST as a critical evaluative lens through which to assess the justice and efficacy of healthcare interventions. Principles such as the universal destination of goods, preferential option for the poor, the common good, solidarity, subsidiarity, stewardship, and participation collectively offer a relational vision of human flourishing. These principles serve as correctives to the

structural injustices that impede access to essential services and as preconditions for equitable distribution of goods and services within society. Mutual respect, as a manifestation of solidarity, becomes both a shared good and a foundation for societal well-being. Ultimately, the pursuit of universal healthcare in Zambia must be grounded in a shared ethical responsibility to manage human, financial, and material resources for the benefit of all inhabitants, in line with the common good.

Another significant gap in the pursuit of utilising the resources of Catholic Social Teaching lies in the limited explicit consideration of women in many of the interventions issued by the ZCCB. Although these statements often address justice, dignity, and the protection of vulnerable communities, they frequently do so in broad and gender-neutral terms that overlook the distinct ways in which women experience social, economic, and environmental injustices. This omission is particularly significant given that women, especially in poor and rural communities, often bear a disproportionate share of the burdens associated with poverty, inadequate healthcare, food insecurity, and environmental degradation.

A vital example can be found in the most recent ZCCB statement on pollution and environmental degradation. While the document acknowledges the harmful effects of pollution on vulnerable communities, it does not explicitly identify the particular impact on women. This is a notable limitation, since women are often the primary managers of household water, food preparation, family health, and caregiving, making them especially exposed to contaminated water sources, poor sanitation, and pollution-related illnesses within the home and community.[149] In many cases, environmental degradation also increases women's unpaid labour, as they must travel further to collect clean water, secure fuel, or care for sick family members.

Moreover, the absence of a gender-conscious perspective risks rendering women's experiences invisible within the Church's social response. Catholic Social Teaching strongly upholds the dignity of every human person and the preferential option for the poor and vulnerable; therefore, a more explicit recognition of women's realities would deepen the prophetic force of such statements. It would also align the Church's advocacy with the lived experiences of many Catholic women who are at the forefront of sustaining families and communities under difficult conditions. Consequently, future ZCCB interventions would be strengthened by intentionally integrating women's voices, experiences, and leadership into their analysis of social and ecological crises. Doing so would not only make these statements more inclusive, but also more faithful to the transformative vision of justice and human dignity at the heart of Catholic Social Teaching.

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[149] Zambia Conference of Catholic Bishops, *On Pollution and Environmental Degradation in Zambia*, no. 10.

General Conclusion

7.0 Introduction

This thesis has been guided by a central research question**:** To what extent has the development of Catholic moral theology beyond the manualist tradition reshaped bioethics into a framework that, informed by Catholic Social Teaching (CST), can ground and guide the pursuit of universal healthcare under conditions of economic and structural constraint, as in the case of Zambia? A closely related follow-up question has also informed the study**:** Which resources within Catholic Social Teaching can be leveraged to help Zambia achieve universal healthcare? In response to these questions, the thesis has argued that the development of Catholic moral theology beyond the limits of the manualist tradition has significantly expanded bioethics from a narrow focus on individual acts, clinical dilemmas, and rule-based reasoning into a richer and more socially engaged moral framework. In dialogue with Catholic Social Teaching, bioethics becomes capable of addressing not only bedside decisions but also the structural, political, economic, and ecological conditions that determine access to health and human flourishing. This broader vision is especially relevant in contexts such as Zambia, where healthcare challenges are deeply intertwined with poverty, inequality, institutional limitations, and environmental pressures.

The thesis has therefore maintained that the integration of bioethics with CST provides a robust, coherent, and persuasive moral foundation for advancing universal healthcare in Zambia. Central to this framework are the foundational principles of CST: the inherent dignity of every human person, the universal destination of created goods, the common good, the preferential option for the poor, solidarity, subsidiarity, and justice. Particular attention has been given to the way these principles can be mobilised in Zambia's context. The dignity of the person requires that no one be excluded from essential healthcare because of poverty or geography. The common good demands investment in public health systems that benefit all, especially in underserved rural communities. The preferential option for the poor insists that policy decisions prioritise those most at risk of exclusion. The universal destination of goods challenges inequitable distribution of medical resources and medicines. Solidarity calls for shared responsibility among citizens, Church institutions, civil society, and the state, while subsidiarity supports the empowerment of local communities and faith-based providers in healthcare delivery. Justice, in turn, requires transparent governance, equitable financing, and accountability in service provision. These principles offer not merely abstract ideals, but practical moral resources for shaping equitable healthcare systems, prioritising vulnerable populations, guiding fair resource allocation, and ensuring that healthcare is recognised as a social good rather than a market privilege.

7.1 Evidence of Integration of Bioethics and Catholic Social Teaching

The integration of bioethics and Catholic Social Teaching (CST) is an evolving dimension of the Church's theological and pastoral reflection. Central to both frameworks is the inviolable dignity of the human person. *Dignitas Personae* affirms this foundational principle, asserting that every human being possesses inherent dignity from conception to natural death.[150] Accordingly, both bioethics and CST advance values that prioritize the promotion, defence, and protection of human life against all forms of harm and neglect. The United States Conference of Catholic Bishops (USCCB) has significantly advanced this integration by adopting Pope John Paul II's concept of the "culture of life," which articulates an obligation to protect innocent life from direct attacks and to defend it whenever it is threatened or diminished.[151] This commitment extends beyond contentious issues such as abortion and euthanasia to encompass care for the poor, the marginalized, and the vulnerable, thereby affirming a holistic vision of human dignity that informs both bioethical discourse and social justice advocacy.

A key example of this integration is the USCCB's *Ethical and Religious Directives for Catholic Health Care Services* (ERDs). Part One of the ERDs is dedicated to the social responsibility of Catholic healthcare institutions. While these principles may not be exhaustive, their inclusion acknowledges the multifaceted challenges facing contemporary healthcare—economic, technological, moral, and social.[152] The USCCB has consistently developed this rapprochement between CST and bioethics through documents such as *Health and Health Care: A Pastoral Letter of the American Bishops* (1982), *A Framework for Comprehensive Health Care Reform* (1993), *Economic Justice for All* (1997), and *Forming Consciences for Faithful Citizenship* (2008). These texts address themes such as justice, the right to healthcare, stewardship, advocacy for policy change, and equitable resource allocation. Collectively, they affirm the Church's responsibility to promote human dignity through healthcare that is inclusive, just, and compassionate.

Among academic contributions, two notable works that form the basis of the third chapter are Lisa Sowle Cahill's *Theological Bioethics: Participation, Justice, Change* (2005) and *Catholic Bioethics and Social Justice: The Praxis of US Health Care in a Globalized World* (2018), edited by Therese Lysaught and Michael McCarthy. Cahill employs CST to expose social inequalities and systemic barriers in healthcare delivery, advocating for global and local policies that respond

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[150] Congregation of the Doctrine of the Faith (CDF), *Dignitas Personae*: *Instruction on Certain Bioethical Questions* (September 8, 2008), no. 1.

[151] United States Conference of Catholic Bishops (USCCB), *Forming Consciences for Faithful Citizenship*: *A Call to Political Responsibility from the Catholic Bishops of United States* (Washington D. C.: USCCB, 2015), no. 40.

[152] USCCB, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (Washington D. C.: USCCB, 2018), Part One, Introduction, Paragraph 1.

effectively to poverty, disease burdens, and structural disparities.[153] Lysaught and McCarthy, in their edited volume, provide a thorough analysis of how bioethics and CST intersect to confront systemic injustices and shape just healthcare policies. The text emphasizes the need for reforms that prioritize universal access, safeguard vulnerable populations, and promote human dignity—especially in cases involving trafficking victims and survivors of gun violence.[154] The practical applicability of these frameworks makes the work a valuable resource for policymakers, healthcare practitioners, and advocates.

In the Zambian context, the integration of bioethics and CST remains relatively underdeveloped. Nonetheless, the Zambia Conference of Catholic Bishops (ZCCB) has long championed social justice in healthcare, particularly with regard to rural and marginalized communities. While issues such as food insecurity, poverty, housing, and lack of clean water have been addressed, these have often been treated in isolation rather than through a cohesive bioethical-CST lens. A notable exception was the Church's advocacy for the free distribution of antiretroviral drugs (ARVs) to people living with HIV/AIDS. This campaign, bolstered by the tireless work of Professor Michael Kelly, significantly advanced public understanding, reduced stigma, promoted home-based care, and secured treatment accessibility.[155]

More recently, in the African context, Anthony Nnadi's *Distribution of Resources in the Nigerian Health Care System* has advanced the conversation by applying the principle of distributive justice to healthcare. Nnadi argues that the allocation of healthcare resources must prioritize need, especially among vulnerable populations affected by disability, marginalization, or historical injustices.[156] He emphasizes that distributive justice is not merely a theoretical construct but a practical obligation, compelling governments and institutions to ensure equitable access. In contexts where scarcity is acute, both patients and healthcare professionals suffer—patients from untreated illness and providers from moral distress due to resource limitations.

To address these challenges effectively, healthcare systems in Africa must be designed to ensure affordability, availability, accessibility, universality, and equity. The integration of bioethics and

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[153] Lisa Sowle Cahill, *Theological Bioethics*: *Participation*, *Justice*, *and Change* (Washington: D. C.: Georgetown University Press, 2005.

[154] Alan Sanders, Kelly H. Herron, and Carly Mesnick, "Catholic Bioethics and Invisible Problems: Human Trafficking, Clinical Care, and Social Strategy." *Catholic Bioethics and Social Justice*: *The Praxis of US Health Care in a Globalised World*, edited by Therese Lysaught and Michael McCarthy (Collegeville: Minnesota: Liturgical Press Academic, 2018), 48.

[155] Irish Aid and Irish Global Health, *From Zambia to Ireland*, 10.

[156] Anthony Okechukwu Nnadi, *Distribution of Resources in the Nigerian Health Care System* (Milton Keynes UK: Lightning Source UK Ltd., 2020), 133.

CST offers a comprehensive and morally grounded framework for achieving these goals and for fostering healthcare systems that truly serve the common good.

7.2 Integration of Bioethics and Catholic Social Teaching: A Framework for Moral Healthcare

The integration of bioethics and Catholic Social Teaching (CST) offers a robust moral framework that enhances ethical reflection and guides decision-making in healthcare and biomedical research. Both traditions are rooted in the Church's unwavering commitment to uphold human dignity, promote the common good, and ensure that healthcare policies and practices are grounded in moral and social responsibility. This study reveals that CST principles advocate for healthcare systems that prioritize accessibility, affordability, and equity, thereby safeguarding the rights of the poor and marginalized. Simultaneously, bioethics complements this vision by addressing the moral complexities of healthcare, including patient autonomy, resource allocation, and clinical decision-making. By synthesizing these frameworks, healthcare professionals are reminded of their moral obligation to treat patients with compassion and respect, fostering environments that uphold the intrinsic worth of every individual.[157]

First, this integration provides a comprehensive framework for navigating complex moral dilemmas in clinical practice and research. CST emphasizes the formation of a well-informed conscience, an essential element in making ethical decisions in situations such as end-of-life care, use of emerging technologies, and the distribution of limited medical resources.[158] This holistic approach extends beyond clinical concerns to consider social and structural determinants of health, including poverty, inequality, environmental degradation, and systemic violence. CST thus calls for ethical scrutiny in all processes of healthcare policy, planning, and implementation to ensure alignment with justice and human dignity.

Second, the convergence of CST and bioethics strengthens advocacy for the common good. CST underscores the necessity of advancing societal well-being, especially for the vulnerable and underserved. When bioethics is situated within this framework, it encourages healthcare systems to promote justice and inclusivity.[159] Effective advocacy involves not only policy reform but also increased civic engagement, coalition building, and dialogue among healthcare professionals, ethicists,

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[157] USCCB, *Doctrinal Note on the Moral Limits to Technological Manipulation of the Human Body* (March 20, 2023), no. 22.

[158] CDF, *Dignitas Personae*, no. 10.

[159] USCCB, *Ethical and Religious Directives*, General Introduction, par. 10.

and the broader community. This inclusive discourse fosters innovative, compassionate, and just responses to contemporary healthcare challenges.[160]

Moreover, this integration instils a profound sense of stewardship among healthcare providers. Medical professionals are called not only to be caregivers but also to act as stewards of scarce and essential resources. Responsible management of healthcare materials and institutional assets is vital to sustaining care delivery and minimizing waste. Many decades ago, McFadden underlined the importance of responsibility by every healthcare professional to protect hospital resources against theft and unjust damage.[161] Stewardship, however, must also extend to environmental ethics. Echoing Pope Francis' concept of integral ecology, the U.S. bishops have emphasized that care for creation is a dimension of faith and justice.[162] Healthcare institutions, therefore, bear the responsibility to reduce medical waste and mitigate environmental harm as part of their mission to protect human life and dignity.

Pope Francis' teachings, particularly in *Laudato Si'*, call for an integrated approach to human and ecological health, recognizing the interconnectedness of social, economic, and environmental dimensions of well-being.[163] His address to the Pontifical Academy for Life reiterates that human dignity cannot be fully respected without addressing environmental injustice and its impact on health.[164] This vision deepens the ethical mandate of healthcare by highlighting the importance of ecological sustainability alongside clinical care.

In conclusion, the integration of bioethics and Catholic Social Teaching enriches the ethical landscape of healthcare by promoting human dignity, guiding moral decision-making, advocating for social justice, and fostering stewardship and integral ecology. This comprehensive framework aligns healthcare practices with the values of the Catholic tradition while responding to the practical realities of medical care. It is a compelling model for healthcare systems seeking to uphold the common good and serve all persons, especially the poor, with justice and compassion.

7.3 The Purpose of Medicine and the Role of the Government

Aligning universal healthcare initiatives with the principles of Catholic Social Teaching (CST) carries significant implications for health policy. Medicine is fundamentally a service to life, oriented toward

[160] USCCB, *Forming Consciences for Faithful Citizenship*, no. 40.
[161] McFadden, *Medical Ethics*, 344.
[162] USCCB, *Forming Consciences for Faithful Citizenship*, no. 51.
[163] Pope Francis, *Laudato Si*, no. 70.
[164] Pope Francis, *Address to Participants in the Plenary Assembly of the Pontifical Academy for Life* (June 25, 2018), 3.

promoting the comprehensive well-being of individuals—physically, mentally, and spiritually. As such, medicine's purpose transcends curative treatment; it includes alleviating suffering and fostering healing, even when a cure is not achievable. This conception stands in contrast to profit-driven models of healthcare and instead promotes a vision grounded in solidarity, the intrinsic dignity of the human person, and the ethical imperative to address health disparities.

A core implication of this understanding is the assertion that healthcare is a fundamental human right. *A Catechism for Health Care*, particularly Question 124, affirms this view by drawing on numerous Church documents that underscore the Catholic Church's consistent teaching on the right to healthcare.[165] Among these, the United States Conference of Catholic Bishops (USCCB) has powerfully declared that the right to healthcare flows directly from the sanctity and dignity of human life.[166] Pope John XXIII similarly recognized healthcare as a key component of social justice, a justice that must be both distributive and contributive.[167] The Pontifical Council for Pastoral Assistance to Healthcare Workers likewise emphasizes inclusivity and the promotion of the common good, insisting that no one be excluded from access to health services.[168]

Pope Francis further reinforces this teaching, acknowledging that although healthcare is widely recognized as a human right and an essential element of integral human development, in practice, it remains inaccessible to large segments of the global population.[169] His observation serves as a moral imperative for societies to ensure universal access to adequate healthcare. As a right, access to healthcare is not a privilege or charity but a demandable obligation—one which society, through its public institutions, is morally and legally bound to fulfil. This brings the discussion to Question 125 of *A Catechism for Health Care*, which directly addresses the issue of responsibility for upholding this right.

According to Catholic teaching, society bears the primary responsibility for ensuring access to healthcare, with government playing a leading role.[170] Governments are called to structure political and economic systems that guarantee equitable access to medical care for all citizens. The function of politics is not merely administrative but deeply ethical: to generate and distribute social and economic goods, with healthcare being chief among them. While healthcare systems vary globally in structure

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[165] Stephen Napier and John M. Travaline, eds., *A Catechism for Health Care*: *Insights from Catholic Teaching on Human Life*, *Medical Ethics*, *and Love of Neighbour* (Washington DC: The Catholic University of America Press, 2024), 145.

[166] USCCB, *Ethical and Religious Directives*, Part One, Introduction.

[167] John XIII, *Pacem in Terris* (April 11, 1963), no. 11.

[168] Napier and Travaline, eds., *A Catechism for Health Care*, 146.

[169] Napier and Travaline, eds., *A Catechism for Health Care*, 146.

[170] The Holy See, *Catechism of the Catholic Church* (Dublin: Veritas Publications – Libreria Editrice Vaticana, 1994), no. 2288.

and operation, their underlying goal must be the same: to affirm human dignity by ensuring access to affordable, quality care for everyone.[171] Despite this ethical mandate, many governments fall short of providing universal healthcare. A commonly cited reason is the need to allocate limited resources across competing social needs. While such concerns are not unfounded, they do not absolve governments of their moral responsibility to prioritize public welfare. Assertions of resource scarcity ring hollow when juxtaposed against evidence of extravagant government expenditure on luxury items and official privileges, while health and education sectors remain underfunded. Even in the face of limited resources, governments must demonstrate a sustained, incremental commitment to achieving universal healthcare. Mulligan insightfully observed that although establishing a society's desired level of healthcare may require years, there are clear, actionable steps that can guide the process toward that objective.[172] It is especially troubling when previously effective healthcare systems decline due to a lack of deliberate and strategic policy planning.

Another obstacle to universal healthcare lies in the prevailing model in which the government sees itself as one provider among many rather than the principal guarantor of health services.[173] While the involvement of private providers can complement public efforts, an overreliance on market mechanisms often results in healthcare being treated as a commodity rather than a public good. The pursuit of profit tends to overshadow the mission of care, leading to inequities in access and quality. Pope John Paul II criticized such rigid capitalist approaches, particularly those that treat private ownership and market primacy as untouchable dogmas.[174] He insisted that medicine must not be subjugated to profit motives but should remain fundamentally a service to people. Echoing this sentiment, Pope Francis has unequivocally rejected economic systems that marginalize the poor and vulnerable. He stated, "Just as the commandment 'Thou shalt not kill' sets a clear limit in order to safeguard the value of human life, today we also have to say 'thou shalt not' to an economy of exclusion and inequality. Such an economy kills."[175] This powerful indictment reaffirms that the purpose of medicine is not limited to physical care but encompasses the full flourishing of the human person—psychologically, spiritually, and socially. Healthcare must serve all people, not only those with means or market merit.

Ultimately, healthcare is a common good, integral to the dignity and development of individuals and society alike. Accordingly, governments have a moral duty to prioritize universal healthcare and to

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[171] Catholic Bishops' Conference of England and Wales, *Cherishing Life* (2004), no. 158.
[172] Mulligan, "Capabilities and the Common Good," 391.
[173] Häring, *Medical Ethics*, 29.
[174] John Paul II, *Laborem Excercens*, no. 14.
[175] Pope Francis, *Evangelii Gaudium* (November 24, 2013), no. 53.

design systems that place the human person, not profit, at the centre. Such prioritization requires long-term commitment, transparent governance, and a policy framework rooted in solidarity and justice. Only then can healthcare truly fulfil its purpose as a service to life.

7.4 Foundational Principles for Universal Healthcare in Catholic Social Teaching

This study proposes that the realization of universal healthcare is best guided by foundational principles rooted in Catholic Social Teaching (CST). Among the many values CST offers, three principles stand out as essential to the implementation of universal access to healthcare: the universal destination of the earth's goods, the preferential option for the poor, and the common good. While all three are vital, this study argues that the principle of the universal destination of goods holds a preeminent position, offering the most comprehensive ethical foundation for the equitable distribution of healthcare.

The Universal Destination of the Earth's Goods: The principle of the universal destination of goods affirms the fundamental theological and moral claim that the goods of the earth are intended for the benefit of all people. This principle is not merely about economic justice, but a profound expression of human solidarity, affirming that all individuals have an equal right to access resources necessary for their flourishing. In the context of healthcare, it asserts that medical services must be accessible, affordable, and of high quality for everyone. This principle undergirds both the common good and the preferential option for the poor, serving as their moral and philosophical foundation. It supports the equitable distribution of resources and challenges any system that privileges private accumulation over communal well-being. Although a degree of tension may exist between private ownership and the public good, CST resolves this by emphasizing that the use of goods must always prioritize common benefit.[176] When the demands of justice require it, private property may be subject to expropriation i.e., transferred lawfully to public authorities to serve broader social purposes, including public health.[177] In healthcare, this principle calls for policy frameworks that recognize health as a shared good, rejecting systems that commodify care or render it inaccessible to the poor. Its ethical pre-eminence lies in its universal orientation: addressing systemic inequality, fostering social justice, and advancing the common interest of all, especially the most vulnerable. Henceforth, the ZCCB is called to vigorously and explicitly promote the foundational principle of the universal destination of goods. This involves advocating for concrete measures that ensure the earth's resources, intended by God for the sustenance

[176] John Paul II, *Laborem Exercens* (May 15, 1981), no. 14.
[177] Paul VI, *Populorum Pregressio* (March 26, 1967), no. 24.

of all humanity, genuinely benefit everyone, especially the poor and marginalized, thereby fostering greater justice and human dignity.

The Preferential Option for the Poor: A second foundational principle is the preferential option for the poor, which obliges both institutions and individuals to prioritize the needs of society's most disadvantaged members. This principle is grounded in the inherent dignity and rights of every person and demands that those in positions of power and influence work actively to dismantle structural injustices that marginalize the poor. The preferential option for the poor is intrinsically linked to the universal destination of goods, emphasizing that no one should be left behind in the pursuit of health and well-being. As a theological and ethical imperative, it calls for policies that directly confront inequalities in healthcare access and quality. Pope John Paul II emphasized that love for others, especially the poor, must be expressed not only in personal charity but through the promotion of justice within institutions and structures.[178] This principle highlights the collective responsibility of society to ensure that economic status does not determine access to care. Universal healthcare, grounded in the preferential option for the poor, entails a proactive commitment to equity—directing resources and services toward those most in need and correcting systemic imbalances. It compels both public policy and private action to be oriented toward inclusion, justice, and human dignity. The ZCCB should explicitly advance the teaching on the preferential option for the poor because it is a fundamental and intrinsic aspect of the Church's mission, deeply rooted in the Gospel and essential for authentic Christian witness and the promotion of justice and human dignity in society. Jesus explicitly identified himself with the poor, the hungry, the sick, the imprisoned, and the marginalized, stating, "As you did it to one of the least of these my brethren, you did it to me" (Mt 25:40). The preferential option for the poor must guide healthcare services and policies by prioritising the needs of the most vulnerable and ensure equitable access to care. This principle is rooted in the belief that every human life has incomparable worth and that Christ identified Himself with the poor and suffering

The Common Good: The third essential principle is the common good, which provides both the goal and the ethical framework for organizing society. Defined as "the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfilment more fully and more easily," the common good is an expression of the dignity, unity, and equality of all people.[179] In the realm of healthcare, the common good entails the creation of systems that enable everyone to attain and maintain health as a basic precondition for human flourishing. It incorporates three core elements: (1) respect for and promotion of the fundamental rights of the person; (2) the development of

[178] John Paul II, *Centesimus Annus* (May 1, 1991), no. 58.
[179] Pontifical Council for Justice and Peace, *Compendium for the Social Doctrine of the Church*, no. 164.

both material and spiritual well-being; and (3) the peace and security of the broader community.[180] Health is not simply a private concern; it is a communal good that enables participation in social, economic, and spiritual life. The pursuit of the common good places a particular burden on public authorities, who bear the primary responsibility for creating conditions in which healthcare is accessible to all.[181] However, it also calls upon individuals and institutions to contribute to building a just health system. The non-exclusionary nature of the common good demands that no segment of the population is denied care. In this sense, universal healthcare is a concrete manifestation of the common good, reflecting a society's commitment to justice, inclusion, and shared responsibility.

Going forward, the Zambia Conference of Catholic Bishops (ZCCB) should more vigorously employ the language of the common good in its advocacy. The principle of the common good demands that essential services, including basic healthcare, be made accessible to all without discrimination. It requires that healthcare systems be grounded in the principles of universality, equity, and solidarity, thereby ensuring that every person, particularly the most vulnerable, has access to adequate care. In this light, the ZCCB is called to consistently affirm the importance of a free and inclusive healthcare system, while explicitly cautioning against models in which access to healthcare is restricted to those with the means to pay.

Together, the principles of the universal destination of goods, the preferential option for the poor, and the common good form a compelling ethical and theological framework for advocating universal access to healthcare. These principles challenge systems based on profit, exclusion, or indifference, and instead promote policies rooted in justice, solidarity, and respect for human dignity. By aligning healthcare systems with these foundational values, societies can move toward a more just, humane, and inclusive model of care—one that affirms health as not merely a service or commodity, but a right that flows from the very nature of the human person and the moral order of creation.

7.5 Ecological Engagement and Integral Ecology in Zambia

This section examines Zambia's engagement with ecological issues through the lens of integral ecology, emphasizing the moral responsibility of stewardship and its implications for both environmental sustainability and human health. The Catholic Social Teaching principle of stewardship holds that care for creation is not merely an environmental concern, but an ethical obligation intrinsically linked to human well-being. In *Laudato Si'*, Pope Francis emphasizes that

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[180] *Catechism of the Catholic Church*, no. 1925.

[181] Catholic Bishops' Conference of England and Wales, *The Common Good and the Catholic Church's Social Teaching* (1996), no. 70.

environmental degradation has severe consequences for human life, especially for the poor and vulnerable. He calls for protection not only of the "physical ecology" but also of a "human ecology" that safeguards the dignity, health, and spiritual well-being of all individuals.[182] Pope Francis stresses that any authentic effort to protect the environment must be rooted in profound lifestyle transformation and educational reform. He advocates for an educational and cultural approach to integral ecology—one that transcends theory and fosters new habits, values, and behaviours conducive to sustainability.[183] Such an approach is essential to nurturing a culture that resists consumerism and prioritizes harmony with creation. Education, therefore, becomes a vital instrument in building ecological consciousness and action.

Zambia began implementing environmental education as early as 1972, when the Ministry of Education, in collaboration with the World Life and Environmental Conservation Society of Zambia, introduced the Chongololo and Chipembele Wildlife Clubs in schools. The term *Chongololo*, meaning "millipede" in Chewa, designates clubs for primary school students (Grades 1–7), while *Chipembele*, meaning "rhinoceros" in Bemba, caters to secondary school learners. These clubs aim to instil ecological awareness in children, helping them understand wildlife conservation and sustainable environmental practices from a young age.[184] Although many students are initially drawn by the prospect of free trips and access to national parks, the underlying educational goal is to develop habits and attitudes of environmental responsibility. These programs are grounded in the theological understanding that creation is a gift from God, and humanity is called to exercise responsible stewardship. Today, the Conservation Society of Zambia oversees over 1,000 active wildlife clubs across the country, contributing significantly to national ecological education and advocacy.[185] It would be insightful to determine what percentage of former conservation club members continue to apply their knowledge in protecting the environment in their current lives.

At the governmental level, the Ministry of Green Economy and Environment, through the Zambia Environmental Management Authority (ZEMA), has taken the lead in setting environmental policy, particularly in regulating land use and natural resource management. However, Zambia has experienced environmental disasters that have severely affected both human health and ecological integrity, with the mining sector being the primary source of these challenges. This

[182] Pope Francis, *Laudato Si*, no. 5.
[183] Pope Francis, *Querida Amazonia* (February 2, 2020), no. 58.
[184] Chongololo and Chipembele Conservation Clubs in Zambia, https://conservationzambia.org/environmental-education/.
[185] Chongololo and Chipembele Conservation Clubs in Zambia.

underscores the urgent need for stronger enforcement of environmental protection laws and more sustainable mining practices.

The most notable contribution of the Zambian Catholic Church to ecological discourse was the 2016 *Laudato Si'* Conference, held in Lusaka from 24–26 April. This was the first such conference in Africa following the release of *Laudato Si'*, and it brought together participants from various sectors across the country. The conference provided a platform to assess the extent of ecological degradation in Zambia and to formulate Church-based responses. The conference proceedings identified several key drivers of environmental degradation and climate change in Zambia, including deforestation, charcoal production, logging, unsustainable agriculture, and mining.[186] These activities have significantly contributed to air and soil pollution, deforestation, and biodiversity loss. Notably, mining operations have been cited for extensive tree clearing to facilitate infrastructure development.

Caritas Zambia, under the Zambia Conference of Catholic Bishops, co-organized the conference and has since taken a leading role in ecological initiatives. These include integrating environmental concerns into development programs, promoting sustainable livelihoods, and facilitating lifestyle conversion toward environmentally responsible behaviour.[187] Key activities involve training local communities, promoting alternative sources of energy, and advocating for sustainable land use practices. In recent years, Caritas Zambia has intensified its efforts to reclaim degraded forests by supporting diocesan and parish-based tree planting campaigns. These reforestation efforts include both indigenous species and fast-growing exotic trees, aiming to restore ecological balance while engaging communities in long-term environmental stewardship.

While the Zambia Conference of Catholic Bishops (ZCCB) has made commendable strides in advocating for improved healthcare access and hygiene practices, there remains a noticeable gap in their engagement with the environmental dimensions of healthcare delivery. Thus far, the bishops have consistently urged Catholic health institutions to uphold hygiene standards and ensure access to safe drinking water within their operational catchments. However, these efforts, though laudable, do not sufficiently address the broader ecological implications of healthcare systems. The growing impact of medical waste, particularly in major public and private hospitals, has emerged as a pressing concern. The improper disposal of biomedical waste not only poses direct health risks but also threatens local ecosystems and water sources. Despite existing oversight by statutory bodies such as the Zambia

[186] Zambia Conference of Catholic Bishops, Summary Report on The Laudato Si Conference (Lusaka 2016).

[187] Caritas Africa, *Response to Laudato Si in Africa Region* (May 2021), 10. https://caritas-africa.org/wp-content/uploads/2021/09/Laudato-Si-Report-2021_EN.pdf.

Environmental Management Agency (ZEMA), the scale and complexity of the challenge necessitate a more vocal and active stance from faith-based actors.

The ZCCB is uniquely positioned to integrate environmental stewardship into its health advocacy, drawing on the teachings of *Laudato Si'*, which calls for a profound ecological conversion and care for our common home. The Church's voice should not recede but instead grow stronger in championing sustainable healthcare practices, including proper waste management, use of environmentally friendly medical supplies, and investment in green technologies for hospital infrastructure. For the future, the ZCCB should explicitly emphasize that ecological responsibility is now recognized as a moral issue with far-reaching implications for all spheres of life, including the economy, industry, healthcare, transport, and education. Therefore, the Zambian bishops may consider launching dedicated initiatives or partnerships focused on the intersection of healthcare and environmental sustainability. This may include promoting environmental audits of Catholic health institutions, training personnel on sustainable practices, and engaging in national policy dialogues on eco-health integration. By doing so, the bishops would not only fulfil their pastoral mission but also contribute meaningfully to the holistic well-being of communities and the environment alike.

7.6 Future Directions for Catholic Social Teaching Application on Healthcare in Zambia.

Catholic social teaching unequivocally affirms that access to universal healthcare is a fundamental human right rooted in the dignity of the person and the common good. However, it often remains underdeveloped in articulating the mechanisms through which such healthcare should be financed. In the Zambian context, while the Catholic bishops have consistently upheld the principle that healthcare is a right, it is imperative that they move beyond declarative statements and engage in tangible advocacy. Specifically, they should call for the establishment of a robust legal framework that enshrines the right to healthcare and mandates its provision through enforceable policy measures.

A critical area requiring attention is the statutory definition and regulation of healthcare financing. The Catholic bishops, in collaboration with theologians, economists, and policy experts, should engage in a comprehensive exploration of ethically justifiable levels of taxation and permissible limits on private property to support equitable healthcare delivery. This would align with the Church's broader commitment to the preferential option for the poor and the principle of distributive justice.

Moreover, in an era characterized by increasing convergence between political and economic elites, the Church has a unique opportunity and responsibility to foster strategic alliances that promote

healthcare as a common good. Encouraging political and business leaders to champion public health initiatives resonates with the Church's social doctrine and can catalyse systemic change. Looking ahead, the cultivation of sustained dialogue and collaborative partnerships among faith-based organizations, civil society, and governmental institutions represents a promising avenue for meaningful reform. The ongoing commitment to these efforts could significantly enhance access to healthcare and advance the realization of social justice in Zambia and beyond.

7.7 The Importance of Good Politics

The nature of politics is a decisive factor in the realization of universal healthcare. In the Zambian context, the health system has struggled to become truly inclusive, in part due to the dynamics of political culture and governance. In the vision of Catholic social teaching, politics represents a high vocation and a privileged form of charity, to the extent that it aims at fostering the common good.[188] In his message for the 52nd World Day of Peace, observed on January 1, 2019, Pope Francis affirmed that "good politics is at the service of peace."[189] He argued that political life, when properly understood, is a fundamental instrument for building just and inclusive societies. Politics, in this vision, is not merely the exercise of power or the pursuit of sectional interests, but a vocation to serve the common good through the promotion of justice, human dignity, and solidarity, as he warns "When the exercise of political power aims only at protecting the interests of a few privileged individuals, the future is compromised and young people can be tempted to lose confidence."[190] Therefore, when politics is marked by corruption, exclusion, and the neglect of the most vulnerable, it ceases to serve the common good and becomes a form of "bad politics." By framing politics as a moral and social vocation, Pope Francis places responsibility on political leaders and institutions to ensure that governance becomes a means of fostering peace, equity, and integral human development.

By contrast, Zambian politics has too frequently been characterized by partisan and sectional considerations, which in turn undermines sustained investment in public goods such as health. As a result, healthcare provision has been marked by disparities in access, recurrent shortages of essential medicines, and uneven distribution of health resources, particularly between urban and rural areas. Therefore, the realization of universal healthcare in Zambia requires not only adequate financing and technical reforms but also a transformation of political will towards genuine commitment to the

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[188] Pope Francis, *Fratelli Tutti*, no. 180.

[189] Pope Francis, *Message on 52nd World Day of Peace* (January 1, 2019), no. 3. https://www.vatican.va/content/francesco/en/messages/peace/documents/papa-francesco_20181208_messaggio-52giornatamondiale-pace2019.pdf.

[190] Pope Francis, *Message on 52nd World Day of Peace*, no. 5.

common good, in line with both Catholic social teaching and the Sustainable Development Goals' emphasis on equity and inclusion. Good policy becomes good politics when it responds effectively to pressing social and economic concerns such as student debt, fair wages, inflation, access to healthcare, and the creation of decent jobs.[191] Such measures reflect a form of politics that is genuinely oriented toward the promotion of the common good and the advancement of social justice, ensuring that governance is not reduced to the pursuit of narrow interests but is instead directed toward the equitable flourishing of all members of society. Pope Francis' vision of good politics rejects both populism and the pursuit of self-interest, emphasizing instead that authentic political leadership is measured by its capacity to serve the common good, promote justice, and safeguard the dignity of every person.[192] Good politics must be directed toward the elimination of all forms of inequality and should be pursued in a tangible, incremental manner, without unnecessary delay or postponement.

Voters in an election have a moral duty to evaluate candidates based on whether their proposed policies genuinely serve the common good, particularly by addressing pressing social and economic challenges in a manner consistent with human dignity and Catholic social teaching.[193] This evaluation should consider how policies impact the fundamental rights of all persons, especially families and the disadvantaged, and whether they foster conditions that allow individuals and groups to achieve their full human potential. Citizens are called to exercise their right to vote responsibly, ensuring that their choices contribute to a political community that promotes justice, solidarity, and peace for the entire human family.

7.8 Concluding Statement

The integration of bioethics and Catholic Social Teaching (CST) presents a compelling and transformative framework for the advancement of universal healthcare. Grounded in the recognition of healthcare as a fundamental human right, this approach prioritizes compassion, equity, and justice—core values that respond directly to contemporary health disparities and systemic exclusion. CST asserts that healthcare systems must serve the common good by ensuring inclusion, particularly of the vulnerable and marginalized, and by eliminating economic and structural barriers that prevent access to care.

In the Zambian context, such barriers are deeply embedded in economic, social, and political inequalities. The Catholic Church, as the largest non-governmental provider of healthcare in Zambia,

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[191] Mark G. Shepherd, "Good Policy is Good Politics." *Chicago Policy Review* (August 15, 2024).
[192] Pope Francis, *Fratelli Tutti*, no. 157.
[193] Vatican Council II, *Gaudium et Spes*, no. 75.

plays a critical role in addressing these disparities. Many mission-founded healthcare institutions, initially sustained by overseas support, continue to operate in rural and underserved communities where state infrastructure is minimal or absent. The Church's sustained presence and service in these areas reflects its theological and moral commitment to human dignity, the preferential option for the poor, the common good, and solidarity.[194] This vital contribution by the Church ought to be complemented and strengthened through deeper collaboration with the Zambian government and other non-governmental actors. Supporting Church-run healthcare initiatives, especially in remote areas, would significantly improve healthcare coverage and equity. Furthermore, the principles of CST offer a normative framework through which systemic reforms can be conceived and implemented.[195] CST is not static; it is a living tradition, responsive to historical and cultural contexts, yet anchored in the unchanging values of the Gospel. The *Compendium of the Social Doctrine of the Church* underscores this dynamic character: "The Church's social doctrine does not depend on different cultures, ideologies or opinions. It is a constant teaching that remains identical in its fundamental inspiration, in its principles of reflection, criteria of judgment, and basic directives for action, above all in its vital link with the Gospel."[196] As a framework for advocacy and reform, CST speaks across cultures and disciplines. When applied consistently to policymaking, planning, and implementation, it provides a robust ethical foundation for dismantling the barriers that inhibit healthcare access. This study maintains that healthcare reform in Zambia must be rooted in CST because it embodies a "dynamic, lived, and living" tradition, deeply rooted in Scripture, the experience of the early Church, and over two millennia of moral reflection.[197]

Moreover, CST's dialogical and participatory nature, which aligns closely with the ethos of bioethics, encourages inclusive engagement with all stakeholders. This participatory spirit is essential for fostering collective responsibility and sustainable reform. Ultimately, the pursuit of universal healthcare is a matter of social justice, which is both distributive (ensuring fair access to services) and contributive (calling on communities to actively participate in shaping and sustaining health systems that serve their needs).

The presence and growth of private hospitals in Zambia further illustrate the persistent inequality in healthcare access. These facilities often provide superior services compared to their public

[194] Lysaught and McCarthy, *Catholic Bioethics and Social Justice*, 4.

[195] Lysaught and McCarthy, *Catholic Bioethics and Social Justice*, 9.

[196] Pontifical Council for Justice and Peace, *Compendium of the Catholic Social Doctrine* (Dublin: Veritas Publications, 2004), no. 85.

[197] Michael Czerny, "In Times of unprecedented Crises: How can Catholic Social Teaching [CST] Help us to Navigate Fragility and lead us to Local Power and Global Justice?" in *The Furrow* (May 2023), 263.

counterparts yet remain accessible only to a privileged few. The Zambian government, as the country's largest employer, indirectly sustains this imbalance by enabling civil servants and officials to utilize private healthcare while public facilities stagnate or decline. Addressing this disparity requires a firm commitment to elevating the quality, efficiency, and accessibility of public healthcare, ensuring that all citizens, regardless of socioeconomic status, can receive care of comparable standards.

In conclusion, by grounding healthcare reforms in the principles of Catholic Social Teaching—especially human dignity, solidarity, the common good, and justice, Zambia can take meaningful steps toward realizing a just and inclusive healthcare system that truly serves all its people. Such an approach would not only ensure equitable access to medical services but also address the deeper social and economic determinants of health. In doing so, Zambia would move closer to building a healthcare system that safeguards life, promotes human flourishing, and reflects the moral responsibility of society to care for its most vulnerable members.

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