Commission of Inquiry: First Report

January 2016

Prepared for HMEH the Prince and Grand Master
Frà Matthew Festing

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Signed on behalf of Commissioners by Dr Neil Weir

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Abbreviations and Acronyms

AAA	Arkangelo Ali Association
AIDS	acquired immunodeficiency syndrome
APHIA	AIDS, Population and Health Integrated Assistance
ART	Anti- retroviral therapy
BMZ	Bundesministerium fürwirtschaftliche Zusammenarbeit Und Entwicklung – Federal Ministry of Economics and Development
CAFOD	Catholic Agency for Overseas Development
CDF	Congregation for the Doctrine of the Faith
CCF	Christian Children's Fund
ECHO	European Community Host Organization
GS	General Secretariat
HIV	human immunodeficiency virus
ID	institutional donors
MI	Malteser International
NARESA	Network of AIDS Researchers in East and Southern Africa
NFP	natural family planning
NGO	Non-governmental organization
PSI	Population Services International
'RH'	'reproductive health'
RBs	Regional Branches [of MI]
SG	Secretary General
SOM	Sovereign Order of Malta
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UNDP	United Nations Development Programme
UNHCR	Office of the United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

1. The Commission of Inquiry was appointed on 29 May 2015 by His Most Eminent Highness, the Prince and Grand Master, Frà Matthew Festing (HMEH Frà Matthew) in response to a serious matter brought to his attention towards the end of 2014 concerning the apparent systematic distribution, for some years, of contraceptive devices by Malteser International (MI) in various parts of the world; a practice which had not reached the knowledge of HMEH Frà Matthew.

2. This First Report relates to the first task assigned to the Commission that is to review the practices of MI which might be in conflict with the teaching of the Catholic Church in recent years and at present.

3. The Commission wishes to thank those individuals listed in Appendix 4 who have willingly assisted them in the Inquiry. The Commission fully recognises the professionalism of MI and the extent of their operations in 24 countries worldwide. It was impressed by the commitment of the leadership and the workers in the field to assist their fellow human beings in their time of need, sometimes in the most harrowing and difficult circumstances. Those projects involving 'Reproductive Health' ('RH') and HIV and AIDS, which have given rise to moral concerns, account for a small part of the whole and were confined to the countries of Myanmar, Kenya and South Sudan.

4. MI, founded in 2005, is a complex multi-tiered organization headed by the MI e.V. Board of Directors (see pp. 42-46). The General Secretariat (GS) provides strategic leadership and worldwide management through four Regional Branches (RBs) – Europe, Africa, Asia and the Americas. With the exception of the RB (Americas) all the other RBs are presently housed, with the GS, in the MI Headquarters in Cologne, Germany. Important to this Inquiry is the organizational structure of the RB Europe which for the time being services RB Africa and RB Asia whose team leaders report to the Programme Director/ Deputy Executive Director who in turn reports to the Executive Director. The holders of the latter two posts are respectively also the Deputy Secretary General and the Secretary General of the GS of MI. This chain of command ensures that project information is well disseminated.

5. Within the *Guidelines for Governing MI* (2012) there are two important and relevant documents which although mentioned have yet to be published. These are the *Principles of Partnership* and the *Catalogue of exclusion criteria in relation to Institutional Donors* (IDs). The former will define the principles for co-operation of the RBs with their partners and the latter will lay down the standards for collaboration with IDs and Benefactors (see pp.15-16). In the absence of these governing documents there has been little guidance which has required assessment of projects to identify activities in which MI might find itself in conflict with the teaching of the Catholic Church.

6. Clear evidence of the involvement of MI in health projects (HIV and AIDS prevention, other STIs and Birth Spacing) which have included contraceptive practices contrary to the teaching of the Catholic Church is shown on website searches, a note for files and concerns raised at public meetings (pp.17-19 and in Appendix 3, pp.37-40).

7. In late 2013 the Board of MI's response to evidence raised at a recent meeting of the US Federal Association of the SOM (see p.12) included the preparation and subsequent publication of '*Bioethics – Basic Principles on Birth Spacing and Reproductive Health*'. The MI HIV and AIDS policy document had originally been written in 2004 (when part of Malteser Germany) and with one modification in 2006 remained in operation until being replaced by the new publication.

8. MI's current policy in respect of 'RH' and HIV and AIDS prevention is inconsistent with the teaching of the Catholic Church in holding the following:

    - That it is acceptable to provide contraceptives for birth spacing;
    - That it is acceptable to distribute condoms to prevent transmission of STIs;
    - That MI should educate people in the use of contraceptives for birth spacing and in the use of condoms as an option for preventing STIs;
    - That in certain situations MI has to depart from the Church's teaching when it perceives its 'medical and moral responsibility' to be at odds with that teaching.

9. The Commissioners should emphasise that the Board and management of MI have been led to adopt these positions on the basis of theological advice from their Spiritual Adviser and from other theologians (see Section 5, p.25).

10. The Commissioners have been made aware that during the timescale covered by their report those activities of MI relating to the fields of 'RH', HIV and AIDS and other STIs which are deemed to be inconsistent with the Church's teaching have not been adequately reported, through the Grand Hospitaller, to HMEH Frà Matthew and the Sovereign Council.

Recommendations

1. *It is possible for MI to work in the area of 'reproductive health' consistent with Catholic teaching if:*

- The distribution of contraceptives **is avoided**;
- Advice on the use of contraceptives **is avoided**;
- Formal co-operation or objectionable forms of material co-operation with partner organizations involved in promoting the use of contraceptives **is avoided**;
- MI's contribution to necessary birth spacing were to consist exclusively in **well-informed teaching of NFP**;
- MI were to concentrate its work in RH in supporting **morally sound Catholic initiatives**, as for example the work of MaterCare International, an international group of obstetricians and gynaecologists that has adopted a preferential option for poor women and children.[1]

2. *It is possible for MI to continue to work in the field of HIV prevention if*:

- Both education in the use of condoms and the distribution of condoms **are avoided** and
- MI concentrates exclusively on **formation in behaviour change (abstinence before marriage and fidelity in marriage)** as exemplified in the highly effective 'Youth Alive' programme pioneered by Sister Miriam Duggan FMFA in Uganda.[2]

For MI to undertake the kinds of approach outlined above it would need in the first instance to implement an **in-depth educational programme** for all levels at which MI operates to impart **well-informed convictions about what is consistent with Catholic teaching and what is inconsistent**. MI might then consider running a pilot programme preferably in conjunction with an established Catholic body. Only after a thorough audit at the end of 2-3 years should the pilot programme be either deemed successful and replicated or if unsuccessful abandoned.

[1] For information on the work of MaterCare International consult its website www.matercare.org/who-we-are/mission

[2] For one description of her work in Africa, see Sr Dr Miriam Duggan, 'Combating the spread of AIDS', in Luke Gormally (ed) *Culture of Life – Culture of Death* (London: The Linacre Centre, 2002), pp.257-267.

3. *If MI considers itself* ***unable to accept*** *the above positive recommendations it should* ***cease to work*** *in the areas of 'reproductive health' and HIV and AIDS prevention.*

4. *In any future* Bioethics Policy *MI must* ***exclude*** *as morally unacceptable*:

- The provision of contraceptives for birth spacing;
- The provision of condoms for prevention of STIs;
- The provision of advice on the use of contraceptives for birth spacing or on the use of condoms in prevention of STIs;
- Formal or objectionable material co-operation with partner organizations engaged in activities contrary to the Church's moral teaching

5. *All partnership projects should be subject to* ***detailed ethical evaluation by a competent ethics committee.***

6. *The* ***present Ethics Committee of MI appears to be inadequate*** *and should be replaced* ***at the earliest opportunity*** *by a committee composed, at least in substantial part, of moral theologians who are faithful to the Church's authoritative moral teaching.*

7. *All activities in the name of the Order of Malta are ultimately under the responsibility of HMEH Frà Matthew supported by the Sovereign Council. Therefore the activities of MI should be reported to the Sovereign Council by the Grand Hospitaller at least twice a year and more frequently if any of those activities give rise to concerns that the reputation of the Order may be at risk.*

1. Introduction

1.1 The Commission

The Commission of Inquiry was appointed on 29 May 2015 by His Most Eminent Highness, the Prince and Grand Master, Frà Matthew Festing (HMEH Frà Matthew) in response to a serious matter brought to his attention towards the end of 2014 concerning the apparent systematic distribution, for some years, of contraceptive devices by Malteser International (MI) in various parts of the world; a practice which had not reached the knowledge of HMEH Frà Matthew.

HMEH Frà Matthew consulted the Congregation for the Doctrine of the Faith (CDF) to seek guidance on the relevant Church teaching, particularly as set out in the Charter for Healthcare Workers published by the Pontifical Council for Pastoral Assistance to Healthcare Workers (1995). Whilst the CDF well understands the pressures under which MI workers currently operate it nevertheless has advised the Sovereign Order of Malta (SOM) to review all its current humanitarian practices to make certain that the SOM is fully compliant with the teachings of the Catholic Church.

The Commission of Inquiry was charged:

1. To review the practices of MI which might be in conflict with the teaching of the Catholic Church in recent years and at present,

2. to formulate a properly constructed ethical policy which will be followed in the future by all parts of the Order and its agents,

The Commission will concentrate initially on the operations of the SOM in low and middle income countries but will, in addition, later review the Order's practices and policies [in respect to other hospitaller work], in particular with elderly people, in the more developed parts of the world.

Once this part of the Commission's work is complete it will then proceed to advise on the establishment of a standing committee, which will in the future monitor all the hospitaller works of the Order worldwide to make certain that in future they are compliant with the teachings of the Catholic Church.

1.2 The Members of the Commission

Professor John Haas, PhD, STL, M Div., Knight of Magistral Grace, who is President of the National Catholic Bioethics Centre, Philadelphia, USA, a consultor to the Pontifical Council for Pastoral Care to Health Workers, and a member of the Governing Council of the Pontifical Academy for Life, and of the International Association of Catholic Bioethics (IACB).

Professor Luke Gormally, KSG, PhL, former Director of the Linacre (now Anscombe

Bioethics) Centre (1981-2000), and Research Professor (2001-2007) at the Ave Maria School of Law in Ann Arbor, Michigan, USA. He is an Ordinary Member of the Pontifical Academy for Life.

Dr Neil Weir, MD, MA (Bioethics), FRCS, Knight of Magistral Grace in Obedience, Otolaryngologist, member of the Governing Council of the International Association of Catholic Bioethicists. Appointed Chairman of the Commission.

Whilst two members of the Commission are members of the SOM and one (Dr Neil Weir) is a Trustee of the Orders of St John Care Trust (OSJCT), the main hospitaller activity of the British Association of the Order of Malta (BASMOM), none of the members have had any connection with Malteser International. Inevitably some of those whom we interviewed were known personally to one or more of the Commission; where this was the case, it was disclosed to colleagues.

The Chairman is satisfied that the Commission has worked transparently and honestly and that no conflict of interest has interfered with that process.

1.3 Methodology

The Commission has been supplied with many background papers from MI and from individuals and has referred to relevant documents of the Magisterium. (A list of those who have participated in the Inquiry is to be found in Appendix 4, p.41).

The members of the Commission travelled to Cologne (August 5-6, 2015) to visit the MI General Secretariat (GS) to learn of the structure and work of the organisation and to speak with the Vice-President, the Secretary General, the Deputy-Secretary General and the Head of Policy Planning, to Rome (September 9-10, 2015) to meet with the recently appointed Prelate of the SOM, His Excellency Bishop Jean Laffitte to discuss a draft of their preliminary findings and to Paris (October 6, 2015) to meet the President and the Immediate Past President of MI e.V. and the President of MI Europe.

The members of the Commission took the view that it was not necessary to make 'field' visits to MI projects, particularly in Southern Sudan and Myanmar. The reason for this decision was in part logistical and in part because a good description of the field work was given to the Commission members by the MI team. Dr Neil Weir has worked extensively 'in the field' with his own charity, the Britain Nepal Otology Service (BRINOS) which helps the deaf and hard of hearing in remote areas of Nepal, and therefore has gained much experience of delivering aid in a low and middle income country.

1.4 The Principal Initial Task

The Commission was asked firstly to determine whether *in recent years* Malteser International had condoned practices, either in relation to the care of persons suffering from HIV and AIDS or in the field of reproductive health (RH), that are contrary to the teaching of the Catholic Church.

To this end the Commission sought to understand the work of MI from the GS to the field worker; the methods by which those contracts that included healthcare delivery were sought with donors and, if successfully achieved, were enacted; the ethical challenges offered by such contracts; the extent to which members of the organisation at all levels were aware of the significance of these ethical challenges and, if so, what actions they took to ensure that they were not acting contrary to the teaching of the Catholic Church; and which tier of management was responsible for those taking these actions.

With this evidence the Commission identified those current positions of MI on ethical issues which are objectionable.

The Commission also sought to investigate the advice given by ecclesiastical and other advisors to MI.

1.5 The Timeline

2004 First HIV and AIDS policy document published. Apart from a modification in 2006, following establishment of MI in 2005, this document has formed the MI policy on HIV and AIDS until November 2013.

2003-2005 HIV and AIDS project in Thailand

2004-2015 HIV and AIDS projects in Myanmar and Kenya

2004-2015 'RH' projects in Myanmar and Thailand

2013-2015 'RH' projects in South Sudan

2013 October. Questions were raised at a meeting of the US Federal Association of the SOM about two US-based agencies - Pathfinder and JHIPIEGO [NGO affiliated with John Hopkins University, USA] which were funding MI in Kenya [HIV and AIDS prevention project] and South Sudan [Primary Health Care , 1/2013-2/2015]. Both these donors had positions on abortion and practical family planning methods contrary to the teaching of the Catholic Church.

2013 November. The Secretary General ordered a comprehensive assessment of all relevant projects with respect to their compliance with the teaching of the Catholic Church.

2013 December. MI Board Meeting at which it was decided that a Working Group would be formed to discuss and create new ethical guidelines. The Board issued the following instructions that:

- New projects will not be opened if there are doubts about their alignment to the teachings of the Catholic Church.

- Running projects that are not in line with the teachings of the Catholic Church will be closed unless by doing so the target population will be harmed; should this be the case the project will continue until a solution is found.
- Once new ethical guidelines are ready, an evaluation [of the projects] will be done: if the projects are then proven to be incompatible with the new guidelines, an exit strategy will be developed, making sure that it does no harm to the target groups. If as a result harm is expected, the project will not be closed until a solution is found.

At the same meeting His Excellency the Grand Hospitaller asked the Board to act in a responsible way and to keep this discussion only internally, as "this is an extremely sensitive matter that, without an appropriate background and know-how, could lead to serious misunderstandings".

2014 January. 'A Special Meeting: Ethics on Reproductive Health' was held in Troyes under the chairmanship of Bishop Marc Stenger, the MI Spiritual Adviser. At this meeting the fundamental structure of the new document was discussed.

2014 May. The first draft of the document entitled '*Bioethics – Basic principles on Birth Spacing and Reproductive Health*' was presented to the MI Board at Lourdes.

2014 September. A further revision was presented to the MI Board.

2014 October. At the Asia Pacific Conference of the Order of Malta, held in Hong Kong, further concern was raised about the use of contraceptives in MI projects in South Sudan and Myamar. This concern was relayed to the Grand Master.

2015 January. *Bioethics – Basic principles on Birth Spacing and Reproductive Health* was issued by the Board and was rolled out as the new 'RH' / HIV and AIDS policy in March 2015.

2015 May. HMEH Frà Mathew announced the formation of a Commission of Inquiry.

2015 July. Further modifications to the RH document were made following additional professional moral theological input. *(All comments by the Commission relate to this most up to date version)*

2. Malteser International (MI)

Malteser International (MI) evolved from Malteser Germany in 2005 to become the worldwide relief agency of the SOM for humanitarian aid within the sphere of responsibility of the Grand Hospitaller of the SOM. [The Grand Hospitaller forms the direct link with HMEH Frà Matthew and the Sovereign Council].

The purpose of MI is the provision of aid to people affected by humanitarian disaster, the provision of means of protection against disaster, the provision of mutual development and, the training and further development of operations personnel in the above mentioned fields as well as the procurement of resources required in order to fulfil those tasks.

In 2014 MI was operating 126 projects in 24 countries worldwide. Of these the major 'reproductive health' and HIV and AIDS projects were in Myanmar, Kenya and South Sudan.

MI acts in the spirit of the principles of the SOM and according to the humanitarian principles of independence, impartiality and neutrality. It provides aid in cases of humanitarian need and development co-operation irrespective of the ethnicity, gender, age or religious or political persuasion of the people involved.

MI (legally: Malteser International e.V.) is governed by the General Assembly of MI which is made up of the Board of Directors, the Regional Branches: MI Europe which presently also services MI Africa and MI Asia based in Cologne, and MI Americas based in Miami (for full details see Appendix 5, pp. 42-46) and the 26 National Associations and Priories of the Sovereign Order of Malta who support MI within their jurisdictions. The General Assembly, which in addition to the above representation includes the Grand Hospitaller, the Chaplain (Spiritual Adviser), the Secretary General and the Vice Secretary General, meets annually and is responsible for electing and discharging the Board of Directors, accepting the annual accounts, ordering financial audits as well as passing amendments to by-laws.

Crucial to this Inquiry is the organizational structure of the Regional Headquarters of MI Europe which for the time being services MI Africa and MI Asia whose team leaders report to the Programme Director/ Deputy Executive Director who in turn reports to the Executive Director. The holders of the latter two posts are respectively also the Deputy Secretary General and the Secretary General of the General Secretariat of MI.

Guidelines for Governing Malteser International (2012)

The following organizational statements have been extracted and referenced from this document:

- The GS has the task of strategic leadership and worldwide management of the MI General Association, by order of the MI e.V. Board of Directors. (p.1 B I).

- The Regional Branches (RBs) are responsible for carrying out all MI's relief actions in their respective regions. The Regional Headquarters take on the operational leadership of all relief projects and the management of the MI network in their respective regions. (p.2 C II).

- Within the framework of the MI General Association, each Association level supervises its subordinate level. Supervision is understood to mean making spot checks, either routinely or checks for a specific perceived reason, regarding whether rules, binding regulations, approved plans and agreements are being adhered to.

  All levels are responsible for making information available to all those affected or involved promptly, comprehensively and in a suitable form; and conversely, for collecting all information needed in the same way.

  The close interconnection of levels and consensus-orientated work are necessary prerequisites for the successful work of the General Association and therefore should be reflected in organizational terms; the obligation to implement these prerequisites should be embedded in the job descriptions of the relevant managers.

  In the case of deviation from the rules and/or the existing planning, unusual events and also when the circumstances can have influences on other Association structures, an obligation to report and inform always applies. The obligation to report always applies towards the superordinate Association level. (p. 3/4 E I).

- RBs ensure that all legal and donor guidelines are implemented in their area in a complete and proper manner;
  that the regulations of the institutional donors (IDs) with whom they are registered, are kept up to date throughout the organization, and ensure that regular further training courses on this issue are offered for their employees and the employees of partner associations. (p. 5/6 V).

- The GS is responsible for authorizing the medium-term programme plans for RBs.

- The RBs are responsible for identifying, planning and implementation of the programmes in their region. Namely:
  They draw up medium-term programme plans with 3-year planning frameworks and provisional budgets for their region. (p. 6 VI).

- In the event of a suddenly occurring humanitarian disaster, the GS initiates the operation; should a RB be already active [in country] where the catastrophe occurs the operation is [immediately] initiated or the GS commissions a RB to carry out emergency relief relative to its available financial and personnel capabilities. (p. 6/7 VII).

- In respect of partners, the GS has to define the Principles of Partnership *[this document had not been finalised at the end of October 2015]* for the co-operation of RBs with partners.

- RBs set up the partner collaborations at regional and programme level according to the Principles of Partnership. They decide autonomously if their partners fulfil the requirements of the Principles of Partnership at regional and programme level and carry out programme-related dialogue with their partners at a working level, and ensure visibility in all press, public relations and fundraising activities, as per agreements made with the partner. (p. 8 IX).

- In respect of IDs, the GS is tasked to compile a catalogue of *exclusion criteria* for IDs and benefactors *[this document had not been completed at the end of October 2015]* lay down standards for the collaboration with IDs and benefactors developing them further and initiating consultations within the expert committees necessary for this purpose, co-ordinate the access RBs have to IDs, whose overall control of collaboration is held by another RB, check and approve new IDs, approve new or modified agreements with IDs and use spot checks to check the compliance of RBs actions with the obligations towards the donors. (p. 8 X).

- The RBs assume overall control in the collaborations with IDs with whom they are registered as implementation partners; identify and acquire new donors; if concrete indications are present, check private donors on the basis of catalogue exclusion criteria; ensure adherence to received obligations towards the donors by monitoring programmes and projects and exchanging information on a continuing basis; support their partners in the implementation of obligations towards donors in project development and through further training offers; initiate new registration requests and update existing registrations, agreements and contracts with donors; prepare internal and external audits and support them and incorporate their experience with donors into the work of the expert committees. (p. 9 X).

- RBs should implement the risk management and controlling system according to the requirements of the GS. (p. 9 XI).

3. Evidence for the involvement of MI in health projects which include HIV and AIDS care, Sexually Transmitted Infection (STI) and Birth Spacing.

3.1 Website searches

The USAID-funded AIDS, Population and Health Integrated Assistance (APHIA II) Nairobi/ Central Project is led by **Pathfinder International** and brings together the Christian Children's Fund (CCF), **Malteser International**, the Network of AIDS Researchers in East and Southern Africa (NARESA), and Population Services International (PSI) to implement an integrated programme of assistance to government, private nongovernmental and faith-based partners in Nairobi and Central Provinces. APHIA II NC focuses on HIV and AIDS, TB, RH, and family planning and supports a wide range of activities addressing prevention, care, treatment, and support for people living with HIV, their families and communities. ***Pathfinder International advocates the use of contraceptives in their RH programmes***. [Report August 2008]

The **MI Report 2008** refers to a project (2006-2011) in Kenya which involved training Community Health Workers (CHWs) in home based care of patients with HIV and AIDS and TB. This project was funded by BMZ, **Pathfinder International** and others.

The Global Fund to fight AIDS, TB and Malaria (GFATM) managed by UNDP
2010 report shows **MI** to be in Round 5 TB/HIV grant started in 2006 for 5 years.
MI was a Sub-Recipient together with Arkangelo Ali Association (AAA) and the World Health Organization (WHO).
With a target of 80,000 condoms distributed the programme actually distributed 239,763 – a percentage achievement of 300%.

Myanmar. The Three Diseases Fund. Project 2007-2011. **MI** was a Sub-Recipient responsible for the prevention and treatment of STI – HIV and AIDS in Wa special region 2 and Shan special Region 4, Shan State. Among the list of key activities number 4 describes condom promotion and distribution among vulnerable groups. The condom distribution figures were: Sex workers: 13,000, men and women of reproductive age: 104,000, workers: 32,000, truck drivers: 25,700, uniformed personnel: 20,000. ***[This project was continued for a further year with the consent of the MI Spiritual Adviser, Bishop Marc Stenger. It was concluded on 31 December, 2014 see Appendix 3A for detail].***

Myanmar. In 2010 a vacancy for a Counsellor (HIV and AIDS) was advertised by **MI**. Within the job description was 'counselling on correct and consistent use of Condom'.

Myanmar. Global Fund/Save the Children HIV Grant 2013-2016. **MI** was a Sub-Recipient given a grant of $2.1M to provide treatment and support for HIV and STI in Northern and Eastern Chan. This project included the provision of prevention packages (condom promotion and distribution, health education on HIV, STI*). **[This project is ongoing and is***

considered by the GS to be compliant with the MI Bioethics Policy, see Appendix 3B for detail].

3.2 Note for files. NTF/CO/2014/006

This Note for the files, dated 4 September 2014, from MI's Country Coordinator for Myanmar to the Programme Director of the General Secretariat was sent through the Programme Director Myanmar, Head of the Asia Team and was signed as read by the Secretary General on 5 September 2014, i.e. after the formulation of the Bioethics Policy, which is referred to in the note.

"**MI** is implementing a Primary Health Care program with special emphasis on Maternal and Child Health in the northern part of Rakhine State in Myanmar funded by UNHCR (2409-31) and ECHO (2408-20). **MI sees a strong need to provide birth spacing methods (Depovera injections, oral contraceptive pills, condoms) to the local population in order to contribute to the program's objective to improve the health status of the target population".**
"The major part of the local population **MI** intends to serve with its activities is of Muslim faith. Clearly, in the target area women are not empowered to decide when or whether to have sexual intercourse. In addition, the area is facing high incidents of maternal and child mortality as well as malnutrition. The latter makes natural family planning methods almost impossible and thus constitutes an exceptional case as defined in the Bioethics policy [4.2 page 16]. As stated in the policy on page 10: '*In these cases, other contraceptive methods, its application and possible contra indications could be discussed with the couples and provided if the person/couple actively expressed its wishes to use it".*
"**Thus we feel that providing contraceptives to the local community is in line with the Bioethics policy** and further contributes to the program's objective to improve the health status of the target population. …".
"This file note expands upon and refers to file note NTF/CO/2014/004 dated 30.05.2014 under which **MI** intends to provide logistical support to transport contraceptives donated by UNHCR from the UNHCR warehouse to the Public Health Facilities of Myanmar where government health staff would distribute them. After careful consideration and follow up this approach is not deemed suitable as it cannot be assured that the contraceptives reach the targeted beneficiaries and, if so, are provided free of charge. **Therefore, MI will not only facilitate transport of contraceptives provided free of charge by UNHCR under project 2409-31, but also distribute contraceptives on request to women of reproductive age as part of the MI clinical activities as funded by 2409-31 UNHCR and 2408-20 ECHO. MI will educate women receiving contraceptives on their respective effects and on family planning practices that protect life as much as possible**". (Our emphases).

3.3 Concerns raised at open meetings

Mention has already been made of the concern raised and the actions taken by MI at the meeting of the Federal Association of the SOM in October 2013.

At the 2014 Asia Pacific Conference of the Order of Malta held in Hong Kong 16-19 October a concern was raised by a priest and others who subsequently sent a report to HMEH Frà Matthew.

The source of the concern was a report given by the MI Secretary General that included mention of the delivery of contraceptives (condoms and the pill) to different groups as part of MI projects involving birth spacing. It appeared to the priest in his written concern that the MI Secretary General gave the impression "of being entirely familiar with the teaching of the Church on the impermissibility of these contraceptive methods and made a point of emphasizing how necessary it was for the field agents to use them. The teaching of the Church was treated as a matter of impractical theory, ill-suited to the realities of life in the difficult situations of developing world field-work".

4. Objectionable current positions of MI on ethical issues

"... to the extent that such [charitable] activities are promoted by the Hierarchy itself, or are explicitly supported by the authority of the Church's pastors, there is a need to ensure that they are managed in conformity with the demands of the Church's teaching and the intentions of the faithful ..."[3]

Note: *This section is concerned with identifiable* ***current*** *positions of MI. These are identified by reference to extended quotations from current documents in* ***Appendix 1: Notes on MI documents*** *(see pages 28-35). These documents are referred to by blue capital letters in brackets, e.g.*[A]. *The identification of a position as objectionable is followed by an explanation of why it is objectionable.*

4.1. **Contraceptives are provided for birth spacing in circumstances in which couples cannot practice Natural Family Planning (NFP).** (See [A], [Bii, p.13@4.2], [Bii, p.16@5], [C]). Apart from the situations in which MI considers NFP impractical for the women it is serving (see, for example, **3.2** above), it is also the case that MI still does not have any materials for teaching of NFP or staff trained to teach it, so contraceptives will presumably be provided for many more than those for whom NFP is deemed impractical. 3.2 above provides evidence of a programme in which MI saw (in September 2014) a "strong need" to provide contraceptives and was active in transporting and distributing them.
The perception by MI of when contraceptives are required ranges from situations in which women are thought to have no choice about when they have intercourse to situations in which because of malnutrition NFP is considered to be inapplicable.
The belief that it is inapplicable seems to assume a somewhat outdated understanding of **NFP practice** as essentially consisting in the 'rhythm method' in which a woman tries to predict the time of her ovulation based on the length of past cycles. But with the 'mucus method' (or ovulation method)[4] or the symptom-thermal method regularity of cycles ceases to be important. The presence and consistency of cervical mucus will indicate when a woman is about to ovulate. This is a highly accurate method of determining when ovulation will take place. Customarily a severely malnourished woman will not ovulate and the absence of cervical mucus will be an indication of the fact. If it happens that she is about to ovulate her cervical crypts will produce mucus that can be detected so that intercourse can subsequently be avoided. In either case contraceptives could not be deemed necessary for birth spacing.
It is currently stated policy that MI will not use contraceptives which have an abortifacient effect or will not fund projects which make use of them. (See [A], [Bii,p.16@5]). We have been informed[5] that MI supplies Levonorgestrel to rape victims on request and intramuscular (IM) Depo-Provera for birth spacing where NFP is deemed inappropriate. Their principal mode of action is the suppression of ovulation. However, both have another mode of action which is to change the lining of the womb to prevent implantation

[3] Pope Benedict XVI, *On the Service of Charity*, Apostolic Letter issued 'motu proprio', 11 November 2012.
[4] Devised by John and Evelyn Billings in the 1970s. For one discussion see J L Bigelow, et al. 'Mucus observation in the fertile window: a better predictor of conception than timing of intercourse', *Human Reproduction*, Vol.19, No.4 (2004):889-892.
[5] In an email to the Chairman of the Commission from the Secretary General dated 19 October 2015

of an embryo, i.e., they could have an abortifacient as well as a contraceptive mode of action.[6]

Why this position is objectionable.

"Sexuality is ordered to the conjugal love of man and woman."[7] The moral norm is that the exercise of sexual capacity is to be confined to marriage. And the norm for its exercise in marriage is "that it is necessary that *each marital act* remain oriented in itself to the procreation of human life. This doctrine, often expounded by the Church's Magisterium, is based on the indissoluble connection – established by God and not rightly severable by human volition – between the two inherent meanings of marital intercourse: unitive and procreative."[8]

It is clear that MI is engaged in issuing contraceptives not only to married couples but also to others. But to do so is not only to be complicit in immoral sexual activity among the married (contraception) but to encourage among the unmarried contracepted intercourse, the habit of which leaves them badly disposed for what is required in marriage.

4.2. **Condom distribution to prevent transmission of Sexually Transmitted Infections (STIs) is in principle acceptable.**[9] (See [Bii, p.14@4.3])

Why this position is objectionable.

There are five reasons:

- Distribution of condoms fosters immoral behaviour (see 4.1 above for what is normative). "Reliance on condom use can foster a false sense of security and reinforce a willingness to engage in sexual activity that is immoral and unhealthy and that poses a continuing risk of HIV infection."[10] To be noted is the following statement of Cardinal Ratzinger made in his capacity as Prefect of the Congregation for the Doctrine of the Faith: "The problem of educational programs in specifically Catholic schools and institutions requires particular attention. These facilities are called to provide their own contribution for the prevention of AIDS, ***in full fidelity to the moral doctrine of the Church***, without at the same time engaging in compromises which may even give the impression of trying to condone practices which are immoral, for example, technical instructions in the use of prophylactic devices."[11] Distribution of condoms is not an expression of true charity.
- Distribution of condoms makes MI complicit in non-marital sexual activity.

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[6] For Levonorgestrol see https://www.nlm.nih.gov/medlineplus/druginfo/meds/a610021.html and for Depo-Provera see https://www.dailymed.nlm.nih.gov/dailymed/druginfo/cfm?setid=199cf13e-0859-4a73-9b45-e700d0cd1049#section-2.1 See under 'Full Prescribing Information' section 2.1 and section 12.1 in particular on the efficacy of Depo-Provera in thinning the endometrium.

[7] *Catechism of the Catholic Church,* 2360.

[8] Pope Paul VI, *Encyclical Letter Humanae Vitae, §§.*11-12. (New translation by John Finnis published by the Catholic Truth Society, London, 2008.)

[9] For examples of what this has meant in practice see the two MI projects in Shan State, Myanmar, both of which involved the distribution of condoms, and both of which were approved by the Secretary General, the second on October 30th, 2014. See Appendix 3, pp.37-40.

[10] Catholic Relief Services document. *Protecting Life: CRS Abstinence and Fidelity Programs* (p.44). The phenomenon is known as 'risk compensation' – the increased risk-taking behaviour resulting from a false sense of security induced by condom promotion. For a discussion of the phenomenon see Hanley and Irala , *Op.cit.* footnote 12, pp.5-6, 73, 92-97, citing higher infection rates with greater condom use in Africa.

[11] Cardinal Joseph Ratzinger, Letter to Archbishop Pio Laghi [Apostolic Nuncio to the USA at the time], 29 May 1988. *Origins* 7 July 1988, vol.18, no.8, pp.117-18.

- It will often be the case that users of condoms will have a contraceptive as well as prophylactic purpose in mind, in which case MI is complicit in the evil of contraception.
- It is scandalous that a Catholic relief organization should be acting contrary to the Church's teaching.
- To prevent transmission of HIV and other STIs it is both more truly charitable and more effective to promote abstinence and fidelity programmes.[12]

It must be acknowledged that there has been debate about the justifiability of supplying condoms in the case of sero-discordant married couples. About this it may be observed:

(a) Among categories of persons to whom MI anticipates distributing condoms are sero-discordant couples. This raises the question of whether, for this limited group the distribution of condoms might be justified in order to prevent cross-infection. Some have argued that it might be if (i) in using a condom the couple intended a marital act and (ii) in particular there is no contraceptive intent. Condition (ii), might well be satisfied, i.e. the couple might not be acting with the precise intention of preventing conception. Condition (i) however, cannot be satisfied, since the Church's moral tradition classifies 'intercourse with a condom' as 'unnatural vice', i.e. the type of sexual act which is intrinsically incapable of being procreative. Since marital acts must be of a procreative kind, 'intercourse with a condom' cannot be intended as a marital act. That is the predominant view of theologians faithful to the Magisterium.[13]

(b) Since condom use does not guarantee protection from infection, an infected spouse, being under a grave obligation not to infect an uninfected spouse with a potentially deadly virus, should abstain from sexual intercourse.[14]

The Secretary General [C @p.2] sees it as an obligation of MI to inform people of all evidence-based risk reduction methods in HIV prevention. He regards CAFOD's policy as sound in this respect and quotes a CAFOD document invoking a comment by Pope Benedict XVI in *Light of the World* that was thought to support such a policy. The statement caused some considerable confusion. The Pope had written that in a prostitute's use of a condom "there can be nonetheless, in reducing the risk of infection, a first step in a movement toward a different way, a more humane way, of living sexuality".[15] This observation was indeed taken at the time by many parties to imply a limited endorsement of supplying condoms. The ensuing controversy prompted the Congregation for the Doctrine of the Faith (CDF) to issue a statement clarifying the Pope's comment which said:

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[12] For an extended exposition of this claim see Matthew Hanley and Jokin de Irala, *Affirming Love, Avoiding AIDS. What Africa Can Teach the West* (Philadelphia: The National Catholic Bioethics Center, 2010).

[13] Notable among those theologians are Archbishop Anthony Fisher OP and Bishop Jean Laffitte; see Anthony Fisher OP, 'HIV and condoms within marriage', *Communio* 36 (Summer 2009), pp.329-59, and Jean Laffitte, 'La solicitude de l'Église pour les malades du sida. Sida, exercise de la sexualité, usage du préservatif dans et hors du marriage. La situation de l'Afrique subsaharienne', *Studia Moralia* 49:1 (2011), pp.19-33. The position was earlier argued for by Luke Gormally, 'Marriage and the Prophylactic Use of Condoms', *National Catholic Bioethics Quarterly* 5/4 (Winter 2005), pp. 735-49.

[14] For an emphatic statement of this obligation see the article by Bishop Jean Laffitte cited in the previous footnote.

[15] *Light of the World: The Pope, the Church, and the Signs of the Times – A conversation with Peter Seewald* (2010), pp.117-119

> "... it must be noted that the situation created by the spread of AIDS in many areas of the world has made the problem of prostitution even more serious. Those who know themselves to be infected with HIV and who therefore run the risk of infecting others, apart from committing a sin against the sixth commandment are also committing a sin against the fifth commandment – because they are consciously putting the lives of others at risk through behaviour which has repercussions on public health. In this situation the Holy Father clearly affirms that the provision of condoms does not constitute 'the real or moral solution' to the problem of AIDS and also that 'the sheer fixation on the condom implies a banalization of sexuality' in that it refuses to address the mistaken human behaviour which is the root cause of the spread of the virus. In this context, however, it cannot be denied that anyone who uses a condom in order to diminish the risk posed to another person is intending to reduce the evil connected with his or her immoral activity. In this sense the Holy Father points out that the use of a condom 'with the intention of reducing the risk of infection, can be a first step in a movement towards a different way, a more human way, of living sexuality'. This affirmation is clearly compatible with the Holy Father's previous statement that this is 'not really the way to deal with the evil of HIV infection'."

The Note concludes:

> "in the battle against AIDS, the Catholic faithful and the agencies of the Catholic Church should be close to those affected, should care for the sick **and should encourage all people to live abstinence before and fidelity within marriage.**"[16]

Regrettably the public has generally been more familiar with an opportunistic construal of the Pope's statement in the book than with the clarification issued by the CDF.

4.3. **MI should take a morally neutral stance in the provision of information about the methods of preventing the transmission of HIV.** This appears to be the implication of the Secretary General's commendation of the approach of CAFOD at [C @p.2].

Why this position is objectionable.

If certain methods of preventing HIV transmission are morally objectionable then to tell people how to adopt them is objectionable. It is self-deceiving to describe as 'morally neutral' the provision of information designed to help people act in a morally objectionable fashion.

If one instructs people in how to act in a particular way which is wrong precisely with a view to them choosing to act in that way then one is guilty of what the Church's moral tradition calls *formal cooperation* in wrongdoing which is always wrong. (See the National Catholic Bioethics Center [USA] statement on 'The Principle of Cooperation in Evil' in Appendix 2.)

4.4. **There are situations in which MI has to "strike a balance" between the Church's teaching and what it perceives to be its "moral and medical responsibility towards the people we serve".**

Why this position is objectionable.

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[16] Congregation for the Doctrine of the Faith, *Note on the banalization of sexuality. Regarding certain interpretations of 'Light of the World'*. 22 December 2010.

Briefly: to quote Cardinal Ratzinger (in 4.2 above, pp. 21/22, reference 11), Catholic charitable organizations are required to act "in full fidelity to the moral doctrine of the Church" and not to engage in compromises. Besides, true medical responsibility would constitute moral responsibility. There can be no opposition between them.

4.5. **MI is said not to be able to endorse the promotion of condoms but it provides information and education of a kind which is intended to be conducive to the use of condoms in preventing transmission of HIV.** (See [C@p.3])

MI is clear that there are situations in which it thinks it is justifiable to distribute condoms (see **4.2** above). As observed in the previous section **4.3**, education in the use of condoms involves formal co-operation in wrongdoing. It is interesting that the Secretary General refers to CAFOD as a model. CAFOD's strategy is to arrange for partners to distribute condoms. That also involves formal co-operation in wrongdoing. *At present we lack accurate information on the precise character of agreements MI has with partners in respect of condom distribution. (See [A] @ 7)*
The MI documentation we have seen on evaluating the suitability of partners makes no mention of ethical criteria for judging suitability. It is a striking fact that though MI has for decades been involved in collaborative partnerships with other agencies its 'Principles of Partnership' referred to in the documentation we have seen [*Guidelines for Governing Malteser International* – page 14] is still a work in progress.

MI in some of its partnerships may be involved in legitimate forms of material co-operation in the wrongdoing of partners[17] but in regard to AIDS prevention and 'reproductive health' it holds policy positions which commit it to actions which are themselves wrong.

[17] Again see the NCBC Statement on 'The Principle of Cooperation in Evil' (Appendix 2).

5. What explains MI's erroneous ethical positions?

MI did seek advice from ecclesiastical authority when some of its practices were called into question. The ecclesiastical authority from whom MI sought advice was its Spiritual Adviser, Bishop Marc Stenger of Troyes. They also sought advice of other theologians in formulating its current policy. As far as can be discerned there are the following crucial elements in the advice received which are liable to result in misunderstandings and consequently activities contrary to the Church's moral teaching:

5.1 There is an over-riding requirement that human life is to be preserved when in danger. (See [Bi] @ final paragraph quoted.)

This is not Catholic teaching. Respect for human dignity imposes the absolute negative requirement that one does not intentionally kill the innocent. But respect for human dignity also requires that one never violates the moral law when acting to preserve a human life since the moral law is in place to protect human dignity. To encourage others to act immorally is to encourage them to violate their own dignity.

5.2 It is appropriate to engage in 'contextual ethics' (situation ethics) in face of concrete situations and to do so can lead one to depart from "purely theoretical rules" (i.e. binding moral norms). (See [Bi])

A situation ethic, i.e. one that discounts observance of absolute (i.e. exceptionless) moral norms, has long been condemned by the Magisterium of the Church. The norms are absolute and exceptionless because they protect the dignity of the human person.

5.3 One may choose the lesser evil. (See [Bi] @ final paragraph quoted.)
The Catholic moral tradition does not permit 'choosing' the lesser evil.[18] *One is never allowed to choose moral evil. "This theory [of the lesser evil] is, however, susceptible to proportionalistic misinterpretation (cf. John Paul II, Encyclical Letter* Veritatis Splendor, *nn.75-77). An action which is objectively evil, even if a lesser evil, can never be licitly willed."*[19] *The so-called principle of the lesser evil might be better described as the principle of counselling against the greater evil: it applies to situations in which a*

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[18] It is instructive to consider what St Thomas Aquinas makes of this 'principle' in, for example, *Summa theologiae* 2a 2ae q,110, a.3 ['Whether every lie is a sin?'], obj.4 & reply:

> Obj.4. Further, one ought to choose the lesser evil in order to avoid the greater: even so a physician cuts off a limb lest the whole body perish. Yet less harm is done by raising a false opinion in a person's mind than by someone slaying or being slain. Therefore a man may lawfully lie, to save another from committing murder, or another from being killed.
>
> Reply: A lie is sinful not only because it injures one's neighbour, but also on account of its inordinateness, as stated above in this article. Now it is not allowed to make use of anything inordinate in order to ward off injury or defects from another; as neither is it lawful to steal in order to give an alms, except perhaps in case of necessity when all things are common. Therefore it is not lawful to tell a lie in order to deliver another from any danger whatever. Nevertheless it is lawful to hide the truth prudently by keeping it back, as Augustine says (*Contra Mend.* 10).

This exemplifies the principle that we are not permitted to choose moral evil in order to avoid or prevent physical evil.

[19] Congregation for the Doctrine of the Faith, *Note on the banalization of sexuality. Regarding certain interpretations of 'Light of the World'*. 22 December 2010.

person is determined upon an evil course of action but has two options, one less evil than the other; one seeks to persuade him against acting in the more evil way knowing that if one succeeds in that respect he is nonetheless going to behave in an evil fashion, albeit making a less evil choice than he might otherwise have done.

6. Summary of the Commission's critique.

MI's current policy in respect of 'reproductive health' and of HIV and AIDS prevention is **inconsistent** with the Church's teaching in holding the following:

- 6.1 that it is acceptable to provide contraceptives for birth spacing;
- 6.2 that it is acceptable to distribute condoms to prevent transmission of STIs;
- 6.3 that MI should educate people in the use of contraceptives for birth spacing and in the use of condoms as an option in preventing the transmission of STIs; and
- 6.4 that, in certain situations, MI has to depart from the Church's teaching when it perceives its "medical and moral responsibility" to be at odds with that teaching.

The Commissioners should emphasise that the Board and Management of MI have been led to adopt these positions on the basis of theological advice from their Spiritual Adviser and from other theologians (see 5, p.25).

Appendix 1: Notes on MI documents

In what follows bold identifies the document from which texts are quoted, quotations are in roman text and comments are in italics.

[A] Formal endorsement of the policy: *Bioethics – Basic principles on Birth Spacing and Reproductive Health* (issued and signed 17 July 2015).
p.2

2. NFP will always be the recommendation for healthy couples when dealing with birth spacing.
But MI as yet has no materials on NFP but, we were assured, is working on producing them. There was little evidence of progress in this work when the Commission visited the Cologne HQ of MI in August 2015.

3. When NFP is not possible due to reasons of health (i.e. irregular menstrual cycles due to undernourishment), the health problem (in this case the undernourishment) will be approached first.
See the comments at 4.1 in the main text on the inadequate understanding of NFP methods illustrated by this statement.

4. Provision of contraceptives will never be undertaken systematically to broad target groups, but only in exceptional cases, on a strictly individual basis and under medical and ethical supervision.
No rationale is provided for the exceptions and ongoing practice (see 3.2 in the main text) is that contraceptives are provided on a more extensive basis than this clause proposes.

5. Contraceptives that can avoid [*i.e. prevent*] the implantation of an embryo in the uterus (such as IUDs) or that have an abortifacient effect on the implanted embryo will not be used in MI implemented and/or financed projects.
See the information recorded at section 4.1 about the contraceptives that MI considers that it is acceptable to distribute; both have as one of their modes of action prevention of implantation of the embryo, i.e. they are abortifacient.

7. The root causes of situations of injustice related to reproductive health (for example prostitution as a consequence of poverty) will be assessed, analysed and, where options for action are available, MI will intervene. Otherwise, the support of third parties, i.e. partner organizations, will be taken into consideration.
What kind of interventions by partner organizations are envisaged which would not be open to MI? Possible issue of co-operation in wrongdoing here.

[B] *Bioethics – Basic Principles on Birth Spacing and Reproductive Health* [July 2015 draft revision.
Note that this is a revision of a December 2014 document. It would appear that MI had no code of ethics in respect of birth spacing and reproductive health before developing this document in 2014, despite the fact they had been involved in these activities since 2004.

[Bi] Bishop Marc Stenger's Preface

"The leadership of MI undertook a reflection during the seminar of 22-23 January 2014 on the ethical decisions to be made with regard to the 'reproductive health' missions undertaken by MI teams in various parts of the world. The results of the reflection pursued within our seminar, composed of people having a long working experience with deprived populations, confirm that decision-making cannot rely only on theoretical premises. Instead teams should develop ethical reflection contextually in the light of the Church's moral teaching and they should conduct a thorough analysis of the concrete in order to achieve prudential decision-making." [20]
This seems to categorise the Church's teaching on the norms of sexual relationships as purely 'theoretical' when they are in fact 'practical norms'. Instead of 'theoretical' norms the Bishop seems to recommend a context dependent application of theory and therefore one modifying theory in the light of the concrete situations that MI teams confront.

"The MI teams who are on the ground are sometimes contractually involved in programmes 'for the prevention and treatment of sexually transmitted diseases', or birth spacing for reasons of family or social balance. The choice of means employed by these programmes, such as the systematic distribution of condoms, could leave those on the ground in a compromised situation with regards to the ethical principles of the Catholic Church which guide the Order of Malta's undertakings."
There is no principled rejection here of either provision of contraceptives (for birth spacing) or of provision of condoms (for HIV prevention) but merely the acknowledgment that those implementing programmes are very likely to find themselves at odds with the Church's moral teaching.

"It is our vocation as Christians to provide relief for people in need and protect the transcendent dignity of the human being. Therefore those in the field who implement MI concrete actions must therefore ensure with an enlightened conscience that this 'good' prevails in their work on the ground.

"... in order to permit the development of a free and responsible judgment in this regard [*i.e. birth spacing and 'reproductive health'*] it is necessary to educate couples and form their consciences with regard to the nature and requirements of responsible procreation. Where life is in danger, staff members of MI have the task of finding the best way to try and save it. In some cases they could be forced to choose the 'lesser evil', that is to say, to allow a moral evil to persist with the sole aim of preventing a greater evil such as, for example, the spreading of an illness or the death of innocent people. In all things it is their duty to seek to make people aware of the value of life and of the moral requirements which this value implies.
Note the following:

[20] The second and third sentences are somewhat different from the text in *Bioethics – Basic principles on Birth Spacing and Reproductive Health* supplied to us by the Secretary General of MI. They are a correction of the wording in that text which Bishop Marc Stenger provided in an email to the Chairman of the Commission on November 16th 2015.

(1) This was written in the light of the January 2014 seminar but as of August 2015 MI had no materials for teaching NFP.

(2) The Catholic moral tradition does not permit 'choosing' the lesser evil. One is never allowed to 'choose' moral evil. The so-called principle of the lesser evil might be better described as the principle of counselling against the greater evil: it applies to situations in which a person is determined on an evil course of action but has two options, one less evil than the other; one seeks to persuade him against acting in the more evil way knowing that if one succeeds in that respect he is nonetheless going to behave in an evil fashion, albeit a less evil choice than it might otherwise have been.

(3) Bishop Stenger does in fact go on to speak of 'allowing' rather than 'choosing' but it seems clear from the context that what is being referred to is the distribution of condoms to prevent transmission of HIV – which is a case of choosing rather than 'allowing'.

(4) Bishop Stenger seems to regard a requirement to preserve life as an over-riding moral principle, i.e. one that over-rides other moral principles. It isn't. Respect for human dignity does indeed require that one should not intentionally kill the innocent (not that one should preserve life at all costs) but it also requires that one observe the moral norms governing human sexuality, breaches of which are also serious offences against human dignity.

[Bii]Text of the Policy
p.9

"Building our work on the principles and guidelines of the Catholic Church and consequently of the Sovereign Order of Malta, MI finds itself exposed to situations where a balance needs to be struck between the values-oriented identity of the organization, the needs in the field and the trends and policies of the international community. As a Catholic organization dealing with birth spacing and reproductive health and its relevant components, MI needs an approach with an ethical perspective and a humanitarian point of view. One which, in other words: places human dignity at the centre of our work and uses a multi-dimensional analysis to take into account the human being and the human environment in all their complexity. The foundations of MI's work in this field arise from our mandate, humanitarian principles, the charism of the Order of Malta, the compendium of the social doctrine of the Church, encyclical letters from the Holy See [*Humanae Vitae* and *Deus Caritas Est* are referred to in a footnote] and the policy of the Caritas family. Empirical evidence needs to be taken into account when dealing with this issue, as well as the values perspective of our Catholic identity."
Note the following:

(1) A 'humanitarian point of view' seems to be something other than what is offered by 'an ethical perspective'. Among the humanitarian principles there is a strong emphasis on the importance of neutrality, particularly in relation to religious belief. This may well have influenced MI policy on birth spacing and HIV prevention.

(2) *The 'Catholic identity' of MI is specified in terms of a 'values perspective' rather than a normative framework. When people talk about 'values perspectives' they tend to be elastic about norms. What MI needs is a clear normative framework consistent with the Church's teaching.*

(3) *No clear specification of foundations is achieved by referring to the mix of documents mentioned here.*

(4) *What could be identified as the policy of the 'Caritas family'?*

p.12 @ 4.1:
"Responsible love will be promoted by encouraging faithful and stable partnerships/marriage, delaying of the initiation of sexual relations and the rejection of sporadic sexual partners. This information will be provided to both young men and women."
Two comments:

(1) *Should MI be in the business of encouraging faithful partnerships other than marriage? The reference should be to "faithful and stable marriage" and abstinence before marriage.*

(2) *A behaviour change programme cannot be properly described in terms of 'providing information', even if that is a vital part of it. If it has not done so, MI should familiarise itself with behaviour change programmes such as 'Youth Alive'.*

"Information and education for adolescence will be endorsed as one of the core focal points of our program. Theology of the Body workshops could be useful for teaching self-respect and respect for others by providing an organic and spiritual approach of the individual in relationships."

This is aspirational talk; where is the evidence for serious follow-up?

p.13 @ 4.2:
"Further contextual elements can make NFP difficult (for example for undernourished women due to irregular menstrual cycles). In these cases, the first thing to do will be to approach the cause of this disturbance (in this particular case the undernourishment) and to recommend that both man and woman abstain from sexual intercourse until they are in good health. **If staff members of MI have good reason to think that this recommendation will not be followed, other contraceptive methods, their indications and possible contra indications could be discussed with the couple and provided if the person/couple clearly express their wish to use them.** (see section 'Corporate Stance' below, first paragraph.) Our emphasis.
Note the wording "other contraceptive methods" suggesting that NFP is regarded as a 'contraceptive method'! It is clear from this paragraph that MI's code takes it as acceptable to provide contraceptives where NFP is regarded as not practicable. MI's views on the applicability of NFP seem to betray ignorance of more recent developments in NFP.

p.14 @ 4.3: STIs
"If staff members of MI consider that there exists an imminent risk of the transmission of sexually transmitted infections (STIs), preventative devices such as condoms could be provided to patients in the understanding that this can be a life-saving – or at least harm-minimizing – measure (especially in the case of HIV sero-discordant couples or sex workers). However it should be remembered that this is only a short-term solution that does not address the real cause of the pandemic. Wherever possible such a decision will be made after assessment and medical examination."

So condom distribution for prevention of STI transmission remains in principle acceptable – as "life-saving, or at least harm-minimizing". As there does not seem to be evidence that MI is geared to addressing "the real causes of the epidemic" one has to presume that condom distribution is its only response.

p.16. 5. Corporate Stance
"MI is not obliged to make use of all the contraceptive methods recommended by donors, national health agencies or partners. Some contraceptives (like intrauterine devices – IUDs – or some pharmaceutical contraceptives) are considered abortifacients, as they can potentially prevent the implantation of an embryo in the endometrium or lead to a miscarriage. This kind of contraceptive will not be used in MI projects as it is considered that life begins at conception and every life deserves to be protected and respected."

What is unfortunate about the Corporate Stance of MI is that there is no principled objection to contraception but only to contraceptives that are abortifacient. It turns out (see section 4.1 of the main text) that the two types of contraceptives that MI approves for distribution are potentially abortifacient, as that is one of their modes of action.

[C] Ingo Radtke's document of 29.07.2015: *The historic and the current situation in MI projects concerning reproductive health – a report for the MI Board of Directors.*
p.1
"MI is one of the very few Catholic humanitarian organisations globally implementing projects concerning reproductive health (including sexual violence), HIV/AIDS, and related topics. MI responds to these priorities both through direct implementation and through partner agencies in the respective countries. Specifically, the related projects include information and education on birth spacing methods – and if natural family planning is not an option for the couple due to medical or social reasons, distribution of birth spacing methods on request[21] – as well as prevention, treatment, care and support for people living with HIV/AIDS. A strong emphasis on behavioural change is fundamental to all projects and programs. This approach requires the constant balancing of Catholic social teaching and our moral and medical responsibility towards the people we serve".
"MI is well aware of the fact that the global response to AIDS has been very much concentrated on risk reduction, it is especially driven by the pharmaceutical industry. Therefore, MI was always in a constant balancing act between our own policy (which is before all technical measures very much promoting behavioural change), national and international guidelines and the requirements set by donors as well as by the beneficiaries".

[21] For an example of MI's active involvement in the distribution of contraceptives see section **3.2** in main text.

Here we see again:

(1) Commitment to distribution of contraceptives when, it is said, NFP is not an option (MI has had no materials for teaching NFP so presumably distribution of contraceptives has been the practice. We noted that a Natural Family Planning programme is to be developed).

(2) The emphasis on what MI perceives as the need to strike a 'balance' between the Church's teaching and what they regard as their "moral and medical responsibility towards the people we serve". The phrasing here is striking, since it seems to contrast MI's 'moral responsibility' with the demands of the Church's teaching.

We should investigate a possible issue of co-operation in wrongdoing: what precisely does MI do when it leaves to partner organizations the implementation of projects, in part or entirely, concerned with RH and HIV prevention?

p.2

"MI sees this as an obligation of informing people comprehensively about both the value, as well as the potential side effects of those decisions: i.e. of different evidence-based HIV prevention methods – leaving couples themselves free to make their own choice. According to CAFOD, '... information should cover all risk reduction options and not just one or a selected few'.

[*At this point the main text carries a reference to the following footnote*: CAFOD's strategy in this regard draws support from the reflections of many theologians and Church leaders over the years and, most recently the comments by Pope Benedict that "there can be nonetheless, in the intention of reducing the risk of infection, a first step in a movement toward a different way, a more human way, of living sexuality". See, *Light of the World: The Pope, the Church, and the Signs of the Times – A Conversation with Peter Seewald* (2010), pp.117-119, (cited in CAFOD: Towards a Comprehensive Approach to HIV Prevention. A tool for mapping a comprehensive approach to HIV prevention, 2011)[22]]

Furthermore, '... information should be factually correct and evidence-based, not moralistic or judgmental, or driven by commercial interests. Incomplete or inaccurate information is unacceptable."

(1) It is well known that CAFOD's sources for theological advice are moral theologians who are critical of Magisterial teaching.

(2) The aspiration to provide "complete information" is likely to be motivated by the humanitarian principle of neutrality.

p.3

C. Policy Development since 2004

"The policy stated very clearly that 'as the relief organization of the Order of Malta, MI cannot endorse the promotion of condoms; however the organization provides relevant information and education so that individuals can make responsible and informed decisions to protect themselves against HIV transmission'. Collaboration was established

[22] One of us [LG] recently asked a friend, a long-standing member of the South Asia desk at CAFOD, for access to this document. She said that it did not appear to be available; that CAFOD had a policy of transparency about its work and all documentation relevant to its work in HIV prevention is to be found on its website.

by the former MI Health Coordinator with the Caritas family and CAFOD ... to develop this policy in line with Catholic teaching. The policy was widely disseminated by the former chief medical officer and health coordinator, and implemented in the respective project locations over the following years. It remains valid in this form to the present day."

CAFOD's published policy (2015)[23] is to provide accurate information about condom use, which they consider an effective HIV prevention strategy, but to refrain from the purchase or distribution of condoms. As will be evident from Appendix 3, MI has undertaken distribution of condoms as well as providing information about their use.

[23] See *CAFOD's global HIV strategy and guidelines* available at www.cafod.org.uk/Campaign/More-issues/HIV-and-AIDS

Appendix 2: Principles of Cooperation in evil and of scandal.

THE PRINCIPLE OF COOPERATION IN EVIL

Cooperation in evil is any specific assistance knowingly and freely given to the morally evil act of another person or institution. A cooperator is the person or institution that provides this assistance and a "principal agent" is the person or institution whose immoral act is assisted by the "cooperator." The principle of cooperation in evil has been developed in the Catholic moral tradition as a guide to assist with the identification of different types of cooperation and the conditions under which cooperation may or may not be tolerated. It is important to note that cooperation in evil does not depend on recognition by the principal agent that his or her act is morally evil. The principle of cooperation presumes an objective moral order in which someone may cooperate in the evil of another even though the principal agent does not believe he or she is doing evil.

Cooperation is formal if the cooperator intends the evil act of the principal agent. Formal cooperation is explicit if the cooperator directly intends the evil act. It is implicit if the cooperator intends a good end but accomplishes it by intending the principal agent's act as a means to that end. The assistance given in implicit formal cooperation may be limited to a specific component of the principal agent's act, or it may also establish the very conditions by which the principal agent's act is possible. Formal cooperation in evil is never morally permissible. A health care example of explicit formal cooperation is the Catholic hospital that has arranged for direct sterilizations to be performed at the facility of a non-Catholic partner, and issues a written policy that establishes the criteria by which candidates for sterilization are to be evaluated and accepted for the procedure. In this instance the Catholic hospital is explicitly approving of its assistance in the immoral procedure. A hospital commits implicit formal cooperation by negotiating and approving an agreement with a non-Catholic partner (e.g., a Joint Operating Agreement) which establishes the conditions that make direct sterilizations possible at the facilities of the non-Catholic partner.

Cooperation is material if the cooperator does not intend the principal agent's act. The act of the cooperator in material cooperation is itself good or morally indifferent but is used by the principal agent for an immoral purpose. Material cooperation can be either immediate or mediate. Immediate material cooperation contributes to the essential circumstances, and mediate material to the non-essential circumstances, of the principal agent's act. Mediate material cooperation can be either proximate through a direct causal influence, or remote through an indirect causal influence, upon the act of the principal agent. Immediate material cooperation by an institution in an intrinsically evil act such as contraception is never morally permissible. Mediate material cooperation can be morally tolerated if through the cooperation there is a great good to be preserved or a grave evil to be avoided. The anesthesiologist who provides the anesthesia during an immoral surgery due to circumstances out of his or her control, and who does not intend the evil of the procedure, engages in immediate material cooperation. The nurse who provides preoperative care to a patient about to undergo an immoral procedure, but does not intend the evil engages in proximate mediate material cooperation. The hospital employee who prepares surgical kits, some of which may be used in immoral procedures, but does not intend the immoral procedures engages in remote mediate material cooperation.

Cooperation in the immoral act of another which may be justified under the principle of cooperation nevertheless may not be allowable if it causes insurmountable theological scandal. For example, a collaborative arrangement between Catholic and non-Catholic health care institutions may involve the Catholic institution in justified mediate material cooperation, but might be refused because it causes insurmountable scandal.

The *Catechism of the Catholic Church* defines scandal as "an attitude or behavior which leads another to do evil," and states that "anyone who uses the power at his disposal in such a way that it leads others to do wrong becomes guilty of scandal and responsible for the evil that he has directly or indirectly encouraged."[24] The Catholic moral tradition (and implicitly the *Catechism*) distinguishes between "active" and "passive" scandal. Scandal is active if either it is directly intended, or is not directly intended but is indirectly caused by the nature of the act in question, e.g., by publicly sinning, or by doing something which has the appearance of evil. Passive scandal is caused accidentally and proceeds from weakness or ignorance on the part of the one scandalized. Passive scandal can sometimes be avoided by a proper explanation. Cooperation that might be morally licit may nevertheless need to be avoided because of scandal that cannot be overcome.

The *Catechism* also mentions the "scandal of the Pharisees."[25] St. Thomas Aquinas explains that this sort of scandal proceeds from malice and is taken by those who wish to hinder spiritual goods by "stirring up scandal."[26] Because it arises from malice, there is no obligation to remedy a pharisaic scandal in the same way that passive scandal due to ignorance ought to be resolved. Interestingly, St. Thomas places responsibility on the part of the scandalized to respond to any explanation of the circumstances, because he concludes that if after the matter has been clarified the scandal persists, "it [the scandal] would seem to be due to malice, and then it would no longer be right to omit that spiritual good in order to avoid such-like scandal."[27]

Although they are sometimes related in concrete circumstances, cooperation in evil and scandal are essentially distinct. Cooperation in evil does not, but scandal does, cause the evil of another.

The National Catholic Bioethics Center, USA.

[24] *Catechism of the Catholic Church*, nn. 2284, 2287.
[25] Ibid., n. 2285.
[26] St. Thomas Aquinas, *Summa Theologiae,* II-II, q. 43, a. 7, c.
[27] Ibid. In his reply to the fourth objection, Aquinas explains that the obligation to resume the provision of spiritual goods in the face of scandal also applies to those who have a duty to relieve the wants of others in temporal matters.

Appendix 3. Two recently approved projects (December 2013, October 2014)

3A

Malteser International

Project approval

1. Project application

Continent: 2 Asia **Region:** 230 Southeast Asia

Country: Myanmar **Project category:** 1 Standard project

1.1 General situation

Wa Special Region II and Shan Special Region IV are considered as HIV hot spots in terms of their geographical situation and socio economic structures. The two main towns, Phang Kham and Mong Lar, are located next to the Chinese border along the road linking Thailand with Myanmar and China. For the past years, the cross border trade and industry have resulted in a massive increase of the sex business. It caters also to long distance truck drivers and migrant populations that quickly spread sexually transmitted infections (STI) and HIV/AIDS accross the region. This is further exacerbated by the weak local health system that scarcely addresses issues of HIV and STI.

1.2 Project description

The project is a continuation of the 2013 project cycle. In order to reduce the HIV transmission especially among the population at risk and to alleviate the burden of the disease for the people living with HIV/AIDS (PLHIV) and their families, Malteser International, who is so far the only humanitarian organisation with access to the area, follows a two pronged approach consisting of prevention on the one hand and a comprehensive package of support for people living with HIV/AIDS including patients on antiretroviral therapy (ART) on the other. The prevention component includes awareness raising and health education activities for high risk groups (such as female sex workers and their clients). Furthermore, training of sex worker-peer educators, voluntary confidential counseling and testing as well as condom distribution.The Package of Support for people living with HIV/AIDS includes ART, hospitalization, nutrition support, home based care, counseling, condom distribution as well as TB detection, referral and family DOTS for HIV/TB coinfected patients. During the project period, efforts to transfer PLHIV, to identify partners for the condom distribution and to investigate the possible link with Global Fund at the end of the project will be intensified (see email by Ch.Ruhmich annexed). For the project rationale please refer to the attached email by Marc Stenger.

Project title: Prevention and Treatment of HIV/AIDS in Wa Special Region II and Shan Special Region IV Shan State - Myanmar

Specific objective:
1. Prevention of the transmission of HIV
2. Provision of a comprehensive Continuum of Care for people living with HIV

Location(s): Pang Kham Township (Wa Special Region II), Mong Lar Township (Shan Special Region IV)

Project period: 01.01.2014 to 31.12.2014

Months: 12

Catchment population: 72.000

Target Group: 72.000

Direct Beneficiaries: 690

Contracting partner(s):
n/a

Sector	
Relief, reconstruction and rehabilitation	0%
Health & nutrition	0%
Water, sanitation and hygiene	0%
Disaster risk reduction	0%
Livelihood and social programmes	0%
Total %	0%

Donor	EUR
36 UNOPS	259.259,26
34 WFP	12.747,41
blank	0,00
blank	0,00
blank	0,00
Estimated project volume	272.006,67

Malteser International

2. Project approval

Project title: Prevention and Treatment of HIV/AIDS in Wa Special Region II and Shan Special Region IV Shan State - Myanmar

Step 1:	Proposed Regional Department	13.12.13, M Paech, 23.12.13 date, name, signature
Step 2:	Checked Programme Director	16-12-13 date, name, signature
Step 3:	Checked Finance and Administration	17.12.13 date, name, signature
Step 4:	Approved Secretary General	19.12.13 date, name, signature

3B

Malteser International

Project approval

1. Project application

Continent: 2 Asia **Region:** 230 Southeast Asia

Country: Myanmar **Project category:** 1 Standard project

1.1 General situation

Myanmar is confronted with one of the most severe HIV/AIDS epidemics in Asia.The HIV prevalence rate for the adult population was 0.45% in 2014 among general population age 15+.Prevalence is higher in Key Affected Populations like female sex workers (FSW 7.1%).Shan State is recognized as one of the places with the highest incidence rate of HIV infections.The below stated project areas are considered as HIV hot spots in terms of their geographical situation & socio economic structures (cross border trade; sex business; migrant population) & further exacerbated by the weak local health system that scarcely addresses issues of HIV & sexually transmitted infections.

1.2 Project description

The project is a continuation of the 2011, 2012, 2013 and 2014 project cycle funded by Global Fund. In order to reduce the HIV transmission especially among the population at risk and to alleviate the burden of the disease for the people living with HIV/AIDS (PLHIV) and their families, Malteser International follows a holistic approach in line with it's Bioethics policy (as presented at the AMA 2014) consisting of prevention on the one hand and a comprehensive package of support for people living with HIV/AIDS including patients on antiretroviral therapy (ART) on the other. The prevention component includes awareness raising and health education activities for high risk groups (such as female sex workers and their clients). Furthermore, training of sex worker-peer educators, voluntary confidential counseling and testing as well as condom distribution.The Package of Support for people living with HIV/AIDS includes ART, hospitalization, nutrition support, home based care, counseling, condom distribution as well as TB detection, referral and family DOTS for HIV/TB coinfected patients. Furthermore the public health system is strengthened through trainings of local health staff, advocacy meetings with local health authorities, upgrading of hospital lab facilities etc. These activities are complemented by the World Food Progam for nutrition support.

Project title: Prevention and Treatment of HIV/AIDS in Shan State - Myanmar

Specific objective:
1. Prevention of the transmission of HIV
2. Provision of a comprehensive Continuum of Care for people living with HIV

Location(s):
Wa Special Region II, Northern Shan State, Myanmar
Shan Special Region IV, Eastern Shan State, Myanmar
Kyainge Tong, Eastern Shan State, Myanmar & Tachileik, Eastern Shan State, Myanmar

Project period: 01.01.2015 to 31.12.2016 **Catchment population:**

Target Group:

Months: 24 **Direct Beneficiaries:** 6.100

Contracting partner(s):
n/a

Sector	
Relief, reconstruction and rehabilitation	0%
Health & nutrition	100%
Water, sanitation and hygiene	0%
Disaster risk reduction	0%
Livelihood and social programmes	0%
Total %	**100%**

Donor	EUR
66 Global Fund	1.192.117,69
34 WFP	19.303,85
blank	0,00
blank	0,00
blank	0,00
Estimated project volume	**1.211.421,54**

Malteser International

2. Project approval

Project title: Prevention and Treatment of HIV/AIDS in Shan State - Myanmar

Step 1:	Proposed Regional Department	28.10.14 M. PAECH, Paech 28.10.14 C. LASSER, (Lasser) date, name, signature
Step 2:	Checked Programme Director	28.10.14 date, name, signature
Step 3:	Checked Finance and Administration	30.10.14 date, name, signature
Step 4:	Approved Secretary General	30.10.14 date, name, signature

Appendix 4: List of Interviewees

HE Count Thierry de Beaumont- Beynac	President MI
Richard Freiherr von Steeb	Vice-President MI
Prince Karl zu Löwenstein	President MI Europe
M. Nicholas de Cock de Rameyen	Past-President MI
Ingo Radtke	Secretary General MI
Sid Johann Peruvemba	Vice-Secretary General MI
Dr Marie Theres Benner	Senior Health Adviser MI
HE Albrecht Freiherr von Boeselager	Grand Chancellor (Past Grand Hospitaller)
HE Bishop Jean Laffitte	Prelate SOM

Appendix 5: MI Board of Directors and Organization Charts

Sovereign Order of Malta

H.E. Dominique, Prince and Count de La Rochefoucald Montbel, Grand Hospitaller 2014-
H.E. Albrecht Freiherr von Boeselager, Grand Hospitaller 2006-2014

Board of Directors 2015

H.E. Count Thierry de Beaumont-Beynac, President (2012-), (Vice-President (2006-12)
Richard Freiherr von Steeb, Vice-President (2006-)
Charles-Louis de Laguiche, Treasurer (2006-)
Michele Burke Bowe, Board Member (2012-)
Charles de Rohan, Board Member (2014-)
Karl, Prince zu Löwenstein, President, MI Europe (2012-)
James F. O'Connor, President MI Americas (2012-)
H.E. Michael Khoo Ah Lip, Delegate, Asia/Pacific region (2009-)

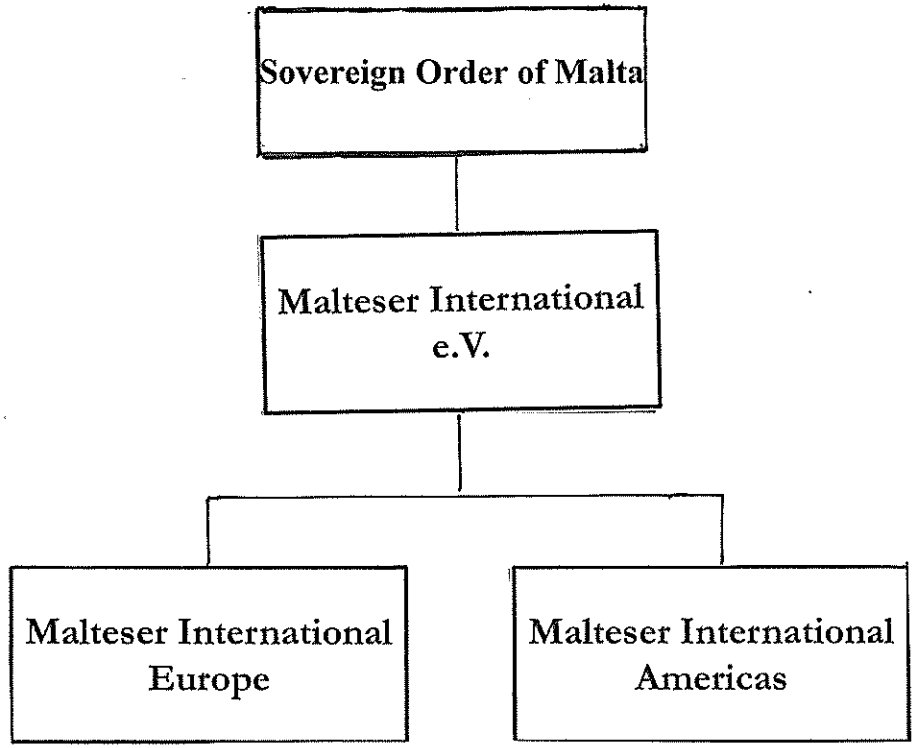
Bishop Marc Stenger, Spiritual Adviser (Chaplain) (2012-)

Previous Directors from 2006

Nicolas de Cock de Rameyen, President 2006-2010, Board member, 2010-2011
Johannes Freiherr Heerman von Zuydwyck, President 2010-2012
Theodor Wallau, Vice-President 2006-2011
Geoffrey Gamble, Vice-President 2007-2011

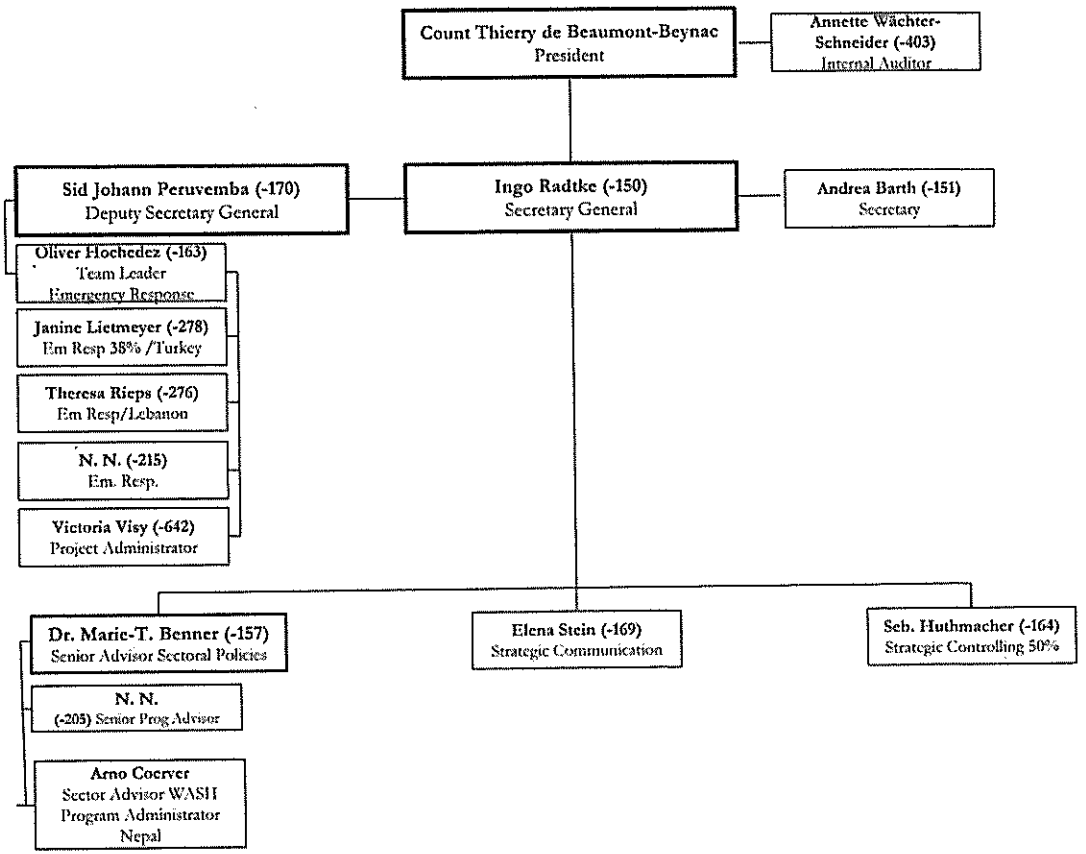
Malteser International
Order of Malta Worldwide Relief

Organizational structure Malteser International



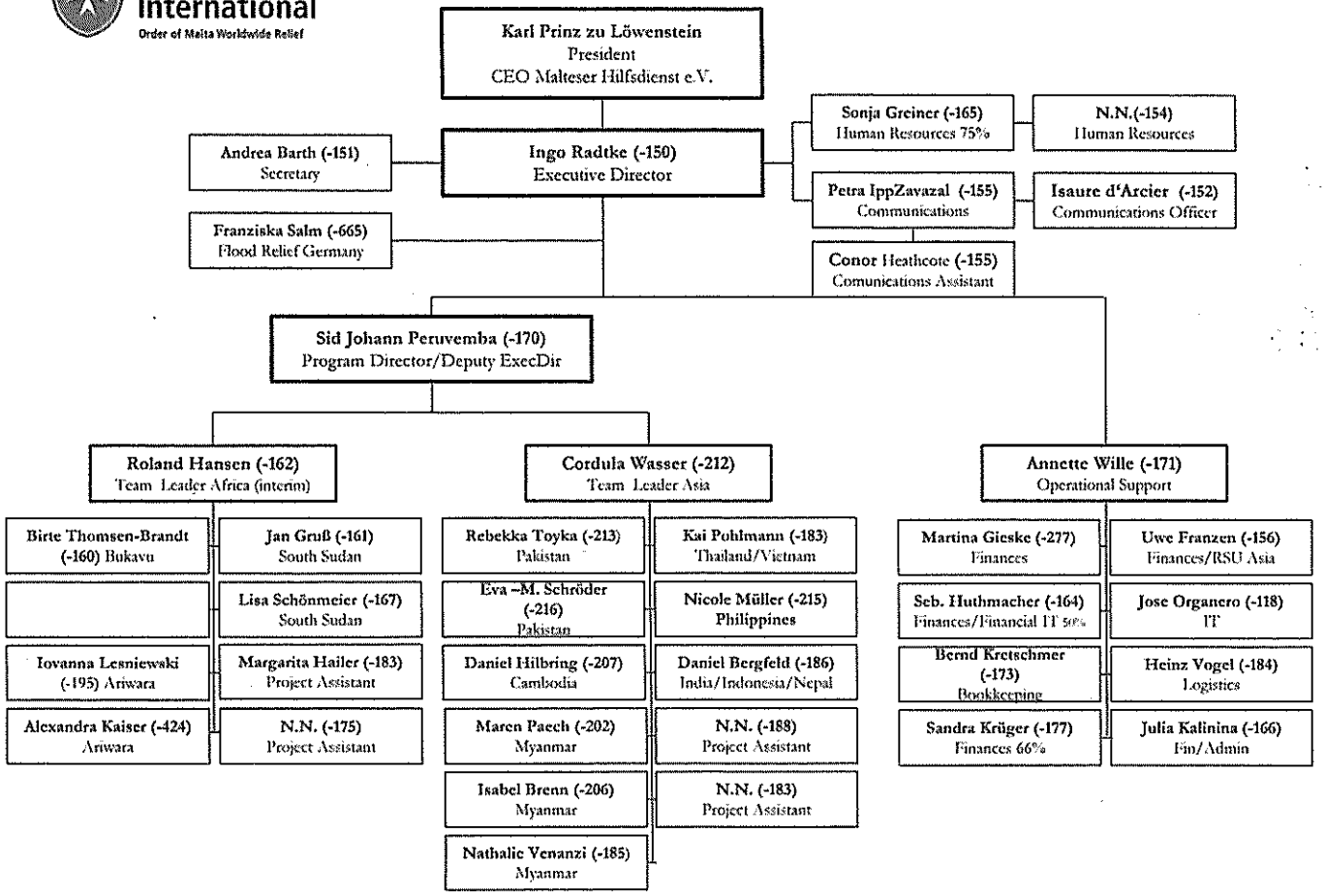
Malteser International
Order of Malta Worldwide Relief

Organizational structure General Secretariat Malteser International e.V.



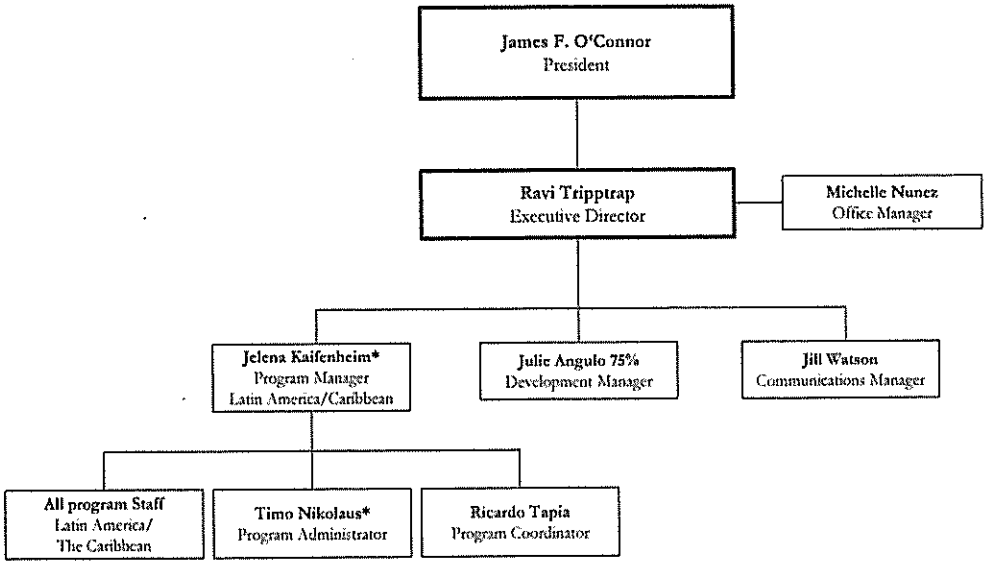
Malteser International
Order of Malta Worldwide Relief

Organizational structure Regional Headquarters Malteser International Europe



Malteser International
Order of Malta Worldwide Relief

Organizational structure Regional Headquarters Malteser International Americas



* based in Cologne

As of June 1st, 2015