

SEXUAL AND REPRODUCTIVE HEALTH IN THE PRACTICE OF THE DUTCH CATHOLIC DEVELOPMENT AGENCY CORDAID¹

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INTRODUCTION

Cordaid is the Dutch Catholic Organization for Relief and Development Aid. It came into being in 1999, through the merger of three Dutch Catholic development agencies: Memisa, Mensen in Nood ('People in Need'), and Bilance (involving the Dutch Lenten Campaign Foundation and Cebemo). This article will analyse Cordaid's approach to the issues of sexual and reproductive health (SRH) that arise in the context of its development work. It will examine the influences on the evolution of Cordaid's SRH policy, in view of the international development discourse and practice, and in view of the developments in Dutch society and the Dutch Catholic community.

The first part of this paper will describe Cordaid's policy on sexual and reproductive health and the values driving this policy. The second part will situate Cordaid's policy and approach to sexual and reproductive health within the wider context of the Dutch Catholic community. The debates that took place in the Dutch Catholic community concerning reproductive health in the 1960s shaped the way the Catholic faithful and Catholic organizations in Holland positioned themselves in regard to this issue. In the third part, Cordaid's approach to SRH will be examined in relation to the United Nations International Conference on Population and Development (ICPD) in Cairo in 1994. For Cordaid, the position taken at the occasion of that conference is still the cornerstone of its sexual and reproductive health policy. The fourth part of the paper will examine the role of the Netherlands in the international development community with regard to sexual and reproductive health, in order to situate the position of Cordaid within the wider Dutch perspective. In the fifth part we will take a closer look at the reality of Cordaid's development work and the way it regards sexual and reproductive health as an integral part of the development agenda. The sixth part examines the reality of Catholic health institutions in African countries, how they deal with sexual and reproductive health issues, and how those Catholic health institutions that partner with Cordaid implement the informed decision making policy Cordaid promotes. The seventh part addresses the challenge to Cordaid of combining the professionalism of a development organization with its Catholic identity. The conclusion will offer a perspective on the future of the policy and position of Cordaid.

*This article is written thanks to the contributions and critical feed-back of Geertje van Mensvoort and Christina de Vries.

1. SEXUAL AND REPRODUCTIVE HEALTH: AN ISSUE OF DIGNITY, COMPASSION, SOLIDARITY AND EMPOWERMENT

Cordaid's policies on sexual and reproductive health are based on the informed decision making principle: people should take responsibility for their sexual and reproductive health decisions. It is up to Cordaid and other agencies (the Church, schools, health institutions) to make sure people are well informed and are empowered to take their responsibility in this respect. Cordaid views its role in light of its mandate to eradicate poverty based on gospel values and the principles of Catholic social teaching. It is not up to Cordaid to prescribe what people should do and it is not its role to act on behalf of other agencies. It aims to help people take decisions in their actual social, economic and religious context, based on the best available information. Knowledge and research underpin these aims. Research has revealed the large gap that exists between the information that is needed to make informed decisions concerning SRH and the information that is offered, especially for youth.² On this basis, the promotion of modern methods of family planning and the use of condoms in the fight against HIV and AIDS are part of Cordaid's informed decision making strategy.

As a professional development organization, Cordaid regards sexual and reproductive health as one of the many issues in fighting poverty. It uses its full knowledge and experience to understand the issue and to see what works to defend human dignity, especially of women. Cordaid has neither the authority nor the responsibility to decide about the choices people make regarding sexual and reproductive health. From the perspective of solidarity and compassion it facilitates people to make their informed decisions and provides the knowledge and experience that is available. Cordaid is part of the broad and diverse Catholic community worldwide and its policies and practices are rooted in the values of Catholic social teaching. As a professional and knowledgeable development organization it seeks an open conversation with the Church and the hierarchy.

For Cordaid, human sexuality and reproduction fundamentally concern human dignity.³ The intimacy of sexuality and the fact that reproduction brings new life into being requires human dignity to be placed at the core. Sexual violence, sexuality as economic exploitation, unequal power relations between women and men are issues of serious concern. There is a strong link between the position of women in society, sexual violence and women becoming infected with HIV.⁴ The fact that women are so often subject to sexual violence and sexual exploitation makes compassion and solidarity key principles in Cordaid's sexual and reproductive health policy. Standing by and supporting women who are in a vulnerable position in terms of their sexual and reproductive health is essential. For Cordaid, sexuality is a contextual issue: it always takes place in a concrete situation of women and men. In developing countries, this concrete reality is often marked by poverty and powerlessness and solutions must be found that are appropriate within that context.

Cordaid's position on SRH differs markedly from that of other Catholic development organizations. There are at least two reasons for this. One relates to the changes that have taken place within the Catholic community in the Netherlands since Vatican II, where there is widespread neglect of the teaching of *Humanae Vitae* on birth control. This is explored in more detail in part two of this paper. A second reason stems from the fact that, historically (since long before Vatican II), Bishops have played no role in the governing bodies of Dutch Catholic development agencies. They are lay-led organizations. These organizations are in conversation with the hierarchy but, unlike what pertains in many other Caritas agencies in Europe. Dutch bishops do not decide on, and are therefore not responsible for, their policies.

2. ATTITUDES TO FAMILY PLANNING IN THE DUTCH CATHOLIC COMMUNITY IN THE 1960'S

In the Netherlands hormonal contraceptives were introduced in 1962 and were rapidly embraced by general practitioners, gynaecologists and women as a safe and non-intrusive method of protection against unwanted pregnancy. As a result, the number of teenage pregnancies and maternal mortality for women above age 40 dropped in the 1970's.⁵ On 21 March 1963, Bishop Bekkers of the diocese of Den Bosch publicly appeared to accept in principle the use of hormonal contraceptives in a famous TV interview, broadcast by the Dutch Catholic broadcasting station KRO:

Much is being said and written nowadays about birth regulation. Science and its discoveries have provided the human race with the possibilities of exerting a controlling influence over procreation. Indeed, regulating the frequency of reproduction has become part of the whole of human responsibilities. It is even fair to say, I think, that birth regulation – which is, incidentally, something quite different from birth control – is becoming an integral part of the total task entrusted to married people.⁶

The impact of this of empowerment to Catholics in the Netherlands can hardly be overestimated: it welcomed the possibility of people taking responsibility for birth; it put responsibility in the hands of married people, not in the hands of the clergy. Consequently, a large part of the Dutch Catholic community chose not to lend their ears to the Vatican's position as taken in *Humanae Vitae*.

The Dutch National Pastoral Council

At the end of the 1960's, the Dutch Catholic Church organized a National Pastoral Council- a gathering of bishops, theologians, priests and laypeople – which met regularly to discuss a broad variety of issues in the aftermath of Vatican II. Marriage and family was one of the items on the agenda. The document which was prepared for the session in December 1968 formulated its position on contraception as follows:

That is why the commission sees no reason to reject one or other method of contraception as against human dignity, as immoral and therefore not allowed, solely on the basis that by this the sexual act would be prevented from leading to conception and pregnancy.⁷

It continued:

The commission is of the opinion that the hierarchy of the Church cannot come to a generalized judgment about a specific method. Although important human values which the church must foster and defend are at stake, they are not such that they are the same in detail for all people, in a manner that would allow generalized statements to be made.⁸

In this statement the Pastoral Council expressed clearly the position of the mainstream of Dutch Catholics: Firstly, the church should foster and defend values around marriage and family, but not take a position on specific methods to regulate procreation. Secondly, whether or not to employ contraceptives in marriage is an issue for married couples alone to decide upon. The Dutch Bishops defended the official position of the Church and abstained when the conclusion was adopted by the general assembly of the Dutch Pastoral Council. The majority and minority positions of Dutch Catholics concerning contraception and the very public debate about it, which developed during the 1960's has hardly changed in the intervening years and is important in order to understand the position of Catholic development agencies in the Netherlands.

3. THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT, 1994

Up until the early 1990's, Dutch Catholic development organizations did not have a coherent and well formulated policy regarding sexual and reproductive health. In preparation for the ICPD in 1994, Dutch Catholic development organization, Cebemo issued a position paper 'Population and Development Controversy: Ethics and Global Culture', which stated:

For Cebemo, the official Church position forms a special point of reference in the formulation of its own point of view. But on the other hand, belonging to the Catholic community does not automatically imply agreement with all the official declarations of the Catholic Church.⁹

This position echoed that taken by the Dutch Pastoral Council in 1969 regarding *Humanae Vitae*: due respect, but not '*Roma locuta, causa finita est*'.

Regarding reproductive health and family planning, the Cebemo paper states: 'Free choice by an individual for the most suitable means of contraception is dictated above all by the possibilities and limitations of a particular social and cultural context, and should be given precedence over any external interference regarding fertility regulation'. Based upon this position, Cebemo rejects all coercive programs on fertility 'whether in the form of punishment or reward'. Accurate information is required in order to allow people to make fully informed decisions.¹⁰ The Cebemo paper regards the issue of population as one aspect of the larger issue of development. Research that highlighted the marginal socio-economic position of women as one of the most important factors in the population debate was seen as an important underpinning for this broader development perspective. The position paper states: '... local social economic circumstances (a "micro" level) are much more relevant to an individual's reproductive behavior than matters which are more removed from daily life such as national population policies or modernization ("macro" level) ...'.¹¹ Therefore, Cebemo rejects vertical, single issue programs on population, although it sees family planning as an important part of integral development programs in view of the continuing unmet need for contraception in some parts of the globe. The paper stresses the need for contraception in order to obviate recourse to abortion in response to unwanted pregnancies.

At the end of the paper, Cebemo clearly defines the position guiding its engagement with the Church and with its partner organizations in developing countries:

The official teaching of the Catholic Church does not permit the use of 'artificial' means of fertility regulation. Nevertheless, Catholic development organizations, working in the field of health, education or on gender issues, have a duty to provide timely, objective and full information on sexuality and contraception to enable individuals to make a free, informed choice.¹²

With that statement, the basis for Cordaid's informed decision making strategy was there. This cornerstone in 1994 was carried over when Cebemo became part of Cordaid in 1999 and remains the basis for Cordaid's policy and practice on sexual and reproductive health.

4. THE APPROACH OF THE DUTCH GOVERNMENT AND DUTCH DEVELOPMENT ORGANIZATIONS TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR)

Internationally, the Netherlands is seen as one of the most liberal societies regarding ethical issues such as euthanasia, abortion, sexual and reproductive rights, and gay rights. This

liberal domestic policy is mirrored in terms of Dutch international policy on development cooperation.¹³

The Netherlands has lobbied the United Nations and the Global Fund to Fight Aids, Tuberculosis and Malaria, for a liberal agenda on SRHR issues.¹⁴ The Netherlands was a strong supporter of the ICPD action plan in 1994, and of other international agreements on this issue. In terms of funding, the Netherlands is one of the most generous donors for SRHR programs relative to its economy.¹⁵ The appointment of a special ambassador for HIV/Aids in 2004 underlined this commitment. In 2010 the remit of this ambassador was broadened to the wider field of SRHR.

Sexual and Reproductive Health and Rights are currently one of the four priority areas of Dutch development cooperation policy.¹⁶ The Advisory Council on International Affairs underlined the need for active SRHR policies by the Dutch government in its advice 'Demographic Changes and Development Cooperation':

In this phase, government policy should as a rule concentrate on reducing the fertility rate through promoting social rights such as SRHR (notably access to family planning), health and education, especially for girls. SRHR (public information and family planning) should be made an explicit part of an integrated health system and be built into education and other development programs.¹⁷

The Cairo plan of action (including abortion) has become the basis for most Dutch NGO activity in the field of sexual and reproductive health and rights. Such comprehensive support for the Cairo agenda makes cooperation between Cordaid and other Dutch NGOs difficult. Some respect Cordaid's position, based on its Catholic identity, and recognise the importance of that position in a world where religion plays a significant role in the life of the large majority of people. In general, however, the position of the Catholic Church is regarded as traditionalist and outdated.

5. SEXUAL AND REPRODUCTIVE HEALTH AS PART OF THE DEVELOPMENT AGENDA

This section examines some of the challenges that arise for Cordaid as a Catholic development agency, as it attempts to address poverty through the promotion of sexual and reproductive health.

5.1. The role of professionalism in development work

For Cordaid as a Catholic development organization, professional knowledge is an important source of its policies and practices, and therefore the dialogue of faith and reason is important. Development is a professionalized field, where organizations are obliged to act as professionally as possible in order to be of best service to people. Professionalism in development is not an end in itself; it has its legitimacy in the challenge to provide true human development to people that suffer from poverty, lack basic social services (health, education, clean water), and whose agency and decision making capacities are limited. In many countries people are denied the full development of their human capacities. Professionalism is also demanded by the limited resources of development organizations. In view of these limited resources, Cordaid has the responsibility to serve people in the best possible way to support them on their road to full human dignity. Professional knowledge informs best practice in policies and programs. Of all the development challenges, sexual and reproductive health is virtually the only issue where there seems to be a conflict between faith and evidence-based professional work. During my ten

years at the helm of the organization, it was the only issue that brought Cordaid into a conversation or conflict with the Church. On almost all other areas of development (microfinance, disaster response, peace building), Cordaid is given space to develop its policies and practices from a professional perspective and based on available evidence, except regarding sexual and reproductive health.

5.2. Fighting poverty as historical and cultural challenge.

The fight against poverty is situated in a specific historical and cultural context. It is important to realize that there is no 'one size fits all' response to poverty. Through its partnerships with local organizations, Cordaid always tries to take account of historical and cultural context in its policies and practices. This requires a capacity to adapt to changing circumstances and the capacity to adapt to the enormous cultural differences in Africa, Asia and Latin America. The ways in which societies understand sexuality and reproduction are very much culturally influenced and they change over time. This notion of change is fundamental for Cordaid's policies and practices. One could even say that 'change' is the essence of the organization: Cordaid tries to bring about change in societies, and overcome poverty and injustice by changing power relations.

5.3. Sexual and reproductive health is an integral part of tackling poverty

Cordaid does not isolate sexuality and sexual and reproductive health from other aspects of development. As poverty reduction is the main goal of Cordaid, the organization tries to identify and understand the various factors that influence the reality of poverty. These include economic, political, ethnic, gender, social and cultural factors. In order to understand poverty, it is important to analyze the interrelated connections between these different factors as the basis for effective policies. Cordaid is always interested in research that helps to better understand the complex reality of development. Sexuality and population are aspects of the poverty discourse that need to be understood in the broader context and cannot be set apart. In its understanding of poverty, Cordaid stresses the role of power and power-relations: poverty is very often the result of unequal power-relations be they ethnic, economic, political, religious or gender based. Therefore, Cordaid analyses the problem of sexual and reproductive health from the perspective of poverty, and therefore from the perspective of power-relations.

5.4. Gender and sexual and reproductive health

For those who look to the causes of and solutions to poverty, attention is increasingly given to the social position women. The World Development Report 2012 *Gender Equality and Development* provides a wealth of research based evidence on the position of women in society.¹⁸ The Report demonstrates that women are bearing the brunt of poverty, world-wide. Therefore, investing in women is seen as one of the key strategies to fight poverty. As recipients of micro-credit, women tend to invest profits in the household, to the benefit of the family. In conflict situations, women can be influential in peace-building.¹⁹ The use of sexual violence and rape as tactics of war has been repeatedly condemned by the UN Security Council in seven separate resolutions (1325, 1820, 1888, 1889, 1960, 2106, 2122). This has brought the issue of sexual violence, gender inequality and sexual and reproductive health into the international debate.

In the last decade, the Vatican has been very critical of gender discourse and has attacked gender theories that regard sexual identity as a sociological and cultural construct. According to the Vatican, the concept of gender denies the natural order of creation of the two sexes.²⁰ The

Vatican attack on the language of gender carries an implied criticism of all those who use gender language to express their commitment to women's wellbeing, and who seek to realize equality for women and defend their dignity. Such a critique does not help to create space for dialogue between the Church and those who want to strengthen the link between the position of women in general and the promotion of sexual and reproductive health.

5.5. The need for clear distinctions in the field of sexual and reproductive health

Debates on sexual and reproductive health are too often muddled by a blurring of lines and a mixing up of issues. For Cordaid, there is a sharp distinction between contraceptives and abortion. Since 1994, the policies of the organization have always emphasised that distinction. Abortion is and can never be part of a contraceptive strategy. Slippery slope reasoning which claims that contraceptive use inevitably leads to abortion is false and distorts the debate. A clear distinction is also required between condoms used as protection against the HIV infection and condoms used as a means of contraception. Even if one uses the same method, the objective is different. Cordaid believes that debates concerning Catholic identity and sexual and reproductive health are not productive unless we apply the rigour of scientific reasoning and are sharp on the use of definitions and terms.

5.6. HIV and AIDS prevention

Since the 1990s, the HIV/AIDS pandemic has given rise to an enormous amount of research on sexual and reproductive health. One of the issues heavily debated concerns HIV prevention: how best to reduce people's vulnerability to this disease. The international community adopted the ABC strategy, which promotes abstinence ('A') from sexual intercourse, encourages couples to be faithful ('B') to one another, and emphasizes the use of condoms ('C') when people engage in sexual intercourse. The Catholic Church promotes abstinence and faithfulness alone, and rejects the use of condoms in prevention strategies. This divergence did not prevent UNAIDS and Caritas Internationalis from signing a memorandum of understanding on a joint commitment to fight HIV/AIDS and to exchange information and experience in January 1999. The enormous and deadly impact of HIV/AIDS made these organizations understand that it was time to join hands instead of fighting over their different strategies.

Especially regarding HIV prevention, meta-research has revealed that comprehensive sexual education of young people is more effective than abstinence-only programmes in influencing sexual behavior: young people are more likely to delay their first sexual intercourse and reduce the number of sexual partners.²¹ Cordaid's informed decision making strategy is based on the evidence that a comprehensive sexual education is the best means of protecting people against sexually transmitted diseases such as HIV/AIDS. The same goes for condom use in HIV prevention. Cordaid has adopted the ABC prevention strategy based on evidence that in the reality of people lives, the use of condoms can reduce infection rates. It is not a new 'belief' that condoms are the solution to HIV and AIDS, but a reflection of the outcome-led policy of the organization.

Here one can see an important difference between the strategy of Cordaid and that of the Catholic Church. The Church operates an input-based strategy, which focuses on the content of the message to be delivered (the 'input'), and it assumes that the right message, when delivered properly, will lead to the desired outcome. Actual outcomes, do not affect the strategy or the content of the message. Cordaid operates an outcome-based strategy, being led by the outcome in the behavior of people: what is effective and what works in the life of people. Research can be conducted into the various possible strategies and methods in order to obtain the best outcome. The problem with the input-based strategy of the Catholic Church is that it neglects

to consider various factors that influence the outcome such as the poverty of women, their unequal power position in relation to men, and cultural traditions regarding sexuality.

6. THE IMPLEMENTATION OF CORDAID'S INFORMED DECISION MAKING POLICY IN AFRICA

Cordaid's health programme is active in more than 15 countries, mainly in Africa. The overall goal of Cordaid's health programme is to improve health for all, and specifically for women and children in fragile contexts. The focus on improving women's health leads Cordaid to promote family planning and informed decision making, HIV prevention and treatment, and to provide access to sexual and reproductive health information and services for youth. In this programme Cordaid collaborates with Catholic organizations, other FBOs, NGOs, civil society organizations, governments and knowledge institutes. Based on discussion with Cordaid's Catholic health partners, it became clear that providing services related to family planning and HIV prevention caused dilemmas for these organizations. This was because their service delivery is influenced by conflicting messages and expectations that derive from various sources, including Church teachings on sexual morality, the Catholic social ethics tradition, government regulations, and the needs and requests of their clients.

6.1. *Cordaid's consultation process with stakeholders*

In 2006, Cordaid initiated a process of reflexion and dialogue with its Catholic partners in health care. The main concern was the firm and inflexible position of the Church regarding the use condoms in HIV prevention and the reality of the pandemic that seemed uncontrollable. The process started with a conference of theologians, bishops, priests and health practitioners in the Netherlands. It was followed by country workshops in Zambia, Malawi and Cameroon. The workshops began with a reflection on the person of Jesus Christ and his compassion and solidarity in his engagement with people and their illnesses. This was followed by consideration of the reality of people in HIV/AIDS affected countries, including their fears and concerns, and their social and gender position. Next came reflection on Catholic social teaching, Church teaching on sexuality and dignity, and the Church's position on condoms. The ethical framework was built upon the distinction, made by Richard Shweder *et al*, between the ethics of autonomy, the ethics of community and the ethics of divinity.²² Three dimensions of existence – individual, relational and religious – influence our perspectives, ethical positions and decision making. This frame was used to understand the dynamics between the different perspectives in ethical discourses and how we could look at the balancing of competing commitments and concerns that people have to accomplish in their ethical decisions. During these workshops the notions of dignity and dignifying surfaced as central emphases in the policies and practices of Cordaid and its partners. In the HIV/Aids pandemic the main challenge is to restore and defend the dignity of people who are discriminated against, who are victims of sexual abuse and who are abandoned by their family and their community. This process of dialogue with partners, theologians and Church leaders reinforced the informed decision making policy of Cordaid and strengthened the relationship between Cordaid and its partners in addressing the dilemmas of organizations and health staff in the field.

6.2. *Evaluation of informed decision making policy*

To better understand the practical implications of its informed decision making policy, and to have more than anecdotal information, Cordaid commissioned a study of its Catholic health services partners in the Democratic Republic of the Congo, Malawi and South Africa in

2009–2010. The study focussed on the following questions: 1) To what extent do faith-based organizations facilitate informed decision making among clients accessing SRH services?; 2) What are the factors that influence the ability of organizations to facilitate informed decision making among clients?²³ For informed decision-making among clients to take place, it is clear that a number of other factors must also be present. The first is whether all the service options are available. None of the partners provided comprehensive SRH services but they complied with the requirement to provide ‘full and accurate information’ on SRH services through making referrals to other providers. Only two organizations openly distributed condoms for HIV prevention, some provided them discreetly, and most relied on referrals.

The second necessary requirement in facilitating informed decision making is that the decision making process is voluntary. On the whole it appeared that partners did their best to ensure that clients made decisions for themselves. However, external factors also influenced the decision making process, especially the influence of family members. As one of the South African focus group participants stated:

It is a Catholic organization, they give bread and tea, and they take care of people. They do that because they are Catholic. But they never talk about religion or how they personally feel. They are who they are and do what they do. They don’t do condoms, but tell you where to get them.

The third factor is that individuals have appropriate information. Partner organizations tried to provide as much information as possible to clients. One of the challenges, however, for some staff was the fact that information without practical examples of goods and services to show to clients potentially limited the effectiveness of their efforts to explain options. Some members of staff were unclear of their organization’s practice (on providing full and accurate information) and therefore avoided discussing goods and services at all. The fourth factor is about good client-provider interaction. It is equally important for the information between the client and the service provider to be two-way. Staff highlighted the need to ensure that they facilitate an environment of openness and honesty between themselves and their clients in order to ensure that they are providing the most appropriate information given the patient’s circumstances. The taboo of discussing sexuality, and the member of staff’s personal views – especially in relation to youths and access to sexual and reproductive services – sometimes hampers this openness.

Overall, the study found that health staff in the health facilities used the key principles of informed decision making but that improvements could be made in the area of policies, better information, referral, communication and theological dialogue. One of the recommendations of the study was for partners to develop a formal policy and referral system for informed decision making to ensure that all members of staff were clear about it. In practice this proved difficult, as it was seen as being too explicit. In a workshop involving key responsible persons for health of several Catholic health facilities in Cameroon it was stated that as health providers they already provide all the necessary information for decision making, but practical referral is done on a case by case basis and is not standard for all clients. A formal referral system was regarded as tantamount to providing the services. However, staff training in informed decision making was seen as an important strategy to improve the health of women.

7. FAITH AND PROFESSIONAL DEVELOPMENT WORK IN SEXUAL AND REPRODUCTIVE HEALTH

Besides being a professional development organization, Cordaid is a Catholic organization. These two aspects of Cordaid’s identity are in constant dialogue in a way that resembles the

faith and reason dialogue. How does Cordaid's Catholic identity influence its sexual and reproductive health policy? In the statutes of the organization, the gospel and the values of Catholic social teaching are explicitly mentioned as the pillars of Cordaid's mission. The notion of human dignity, one of the principles of Catholic social teaching, is central to Cordaid's policies and practices on sexual and reproductive health. Protecting the dignity of women and men is a primary objective of Cordaid's policy. Women and girls, especially, are often subject to sexual violence that is a deep infringement of their dignity. Protecting females against sexual violence, by empowering them and by offering them the knowledge and the means to protect themselves, is an essential part of the policy.

Cordaid's Catholic identity appears also in its solidarity with Catholic health institutions. That solidarity has a long history, going back to the 1930s. One part of that solidarity nowadays is to support these Catholic institutions as they seek to find their way in this difficult area of sexual and reproductive health. So many Catholic health institutions and their staff (medical doctors, nurses, and social workers) struggle with the issue of how to respond to the questions of their clients. Often they feel themselves squeezed between the official Church doctrine and the real life needs of people. It is an act of solidarity to show that Cordaid understands this dilemma. Cordaid's consultation process on its informed decision making strategy created opportunities for organizations and health workers to express their dilemmas and to find common ground.

A Catholic development organization working in sexual and reproductive health cannot distance itself from Pope Paul VI's encyclical *Humanae Vitae*. Its call for true and respectful love, its warnings against political misuse of birth control and a self-centered sexuality are well placed and more than ever relevant today. Tragically, however, *Humanae Vitae* put all these issues in the framework of contraception and presented a ban on contraception as the complete solution for the many issues that are at stake in sexuality. At that point, the Church ceased to be a real partner in the dialogue on sexuality and lost its authority as a respected promoter of true human and God-oriented love. Whereas there is an urgent need for a broad movement for this humanizing of sexuality in an age of making sexuality a commodity, the Church has put itself outside that debate. As a development organization, Cordaid found itself lacking Catholic partners with whom it could engage in a more exploratory conversation on sexuality that reflected people's lives.

Humanae Vitae states: '... the exercise of responsible parenthood requires that husband and wife, keeping a right order of priorities, recognize their own duties toward God, themselves, their families and human society'.²⁴ However, this broad perspective of responsible parenthood was never explored. After the duties to God and natural law were explained, the other actors were of no importance. The sole reference to this broader perspective is in the context of the condemnation of contraception:

... it is never lawful, even for the gravest reasons ... to intend directly something which of very nature contradicts the moral order, and which must therefore be judged unworthy of man, even though the intention is to protect or promote the welfare of an individual, of a family or of society in general.²⁵

It is exactly that broader perspective of man as a social being which *Humanae Vitae* omits to consider, that Cordaid takes into account when it reflects on birth control.

Cordaid took its position in relation to the encyclical based on the acceptance by the Church of the responsibility and the authority of couples to decide on the number and spacing of children, and in its approval of the deliberate choice of couples to use the infertile period to avoid pregnancy. Cordaid shares the encyclical's view on the responsibility of partners for their

family size and the possibility couples have to deliberately avoid pregnancy as a method to realize that responsibility. Cordaid shares the encyclical's objective of promoting a healthy and flourishing family life. Cordaid differs in regarding contraception as an acceptable means, alongside usage of the infertile period, to deliberately avoid pregnancy.

The last substantial issue for Cordaid is the debate in the Church itself. The encyclical refers to this internal debate in paragraph 6. Although there is full respect for the legitimate role of the Pope to take a position in a debate and to guide the Church when there is a diversity of opinions, it has proven to be very counter-productive that after *Humanae Vitae* the debate on this issue came to a halt. Since then any debate on family planning in Catholic theology has been blocked. Those who have engaged in such debate have been put under scrutiny or forced to change their opinion. This has made the Catholic Church an outsider in the global debate on reproductive health. *Humanae Vitae* 21 acknowledges that the teaching as presented in the encyclical is not an easy one and will be challenging for people. The encyclical offers support in pastoral care and refers to the sacrament of Penance recognizing that people may struggle to follow Church teaching. This distinction between the dogmatic and the pastoral side of the teaching of *Humanae Vitae* is important. It acknowledges that the issue of sexuality and family planning has a pastoral dimension besides a dogmatic one.

8. THE WAY FORWARD

Since Cairo 1994, Cordaid has taken an outspoken position on reproductive health. This has placed it in an isolated position within the wider Catholic federations for international development, Caritas Internationalis and CIDSE (*Coopération Internationale pour le Développement et la Solidarité*). Cordaid's position has been broadly supported within the organization by staff members, the board of directors and the board of supervisors. Through its informed decision making strategy, the organization attempted to broaden the dialogue with partners in the field of healthcare in African countries and to connect to the challenges and dilemmas they face on the continent. The most urgent need is to broaden dialogue within the Catholic community worldwide and to end the silencing of the necessary internal debate about sexual and reproductive health within the global Catholic community. With *Humanae Vitae* the Church cut itself off from the important debate on sexuality in society. With this encyclical as the answer to every issue in the domain of sexuality and reproductive health, the conversation never took off. *Humanae Vitae* is perceived (rightly or wrongly) as putting every discourse on sexuality within the framework of marriage and procreation. This has created a tragic obstacle to open and profound dialogue. What the Catholic church has to offer about humanizing sexuality based on its understanding of the sacredness of sexuality, the dignity of human life and the dignity of women, has remained concealed behind the message of *Humanae Vitae*. A new openness is needed from the Catholic Church to contribute to the discourse on sexuality and reproductive health. That dialogue starts with creating space for dialogue. Such an open dialogue is not only important for the Catholic community; it will be welcomed by others in the international development community, who are well aware of the importance of the Catholic Church as the largest faith community in the domain of health, maternal care and sexual and reproductive health. I believe Catholic agencies in the domain of health, education and development, can play an important role as bridge builders in this process, preparing the ground for a more fruitful conversation. Based on their understanding of three main approaches to ethics (of autonomy, of community, and divinity) they could find ways to become partners in the societal debate on sexuality: the commodification of sex, the question of sexuality and power,

of rape, of sexuality and adolescence. To make that process successful, the Church has to grant these organizations the space to operate and make itself an active partner of these Catholic agencies. It requires Catholic agencies to explicitly address these issues that have been concealed for so long, while taking care not to offend the hierarchy in the Church. Perhaps the Bishops' synod meetings on marriage and family will motivate Catholics to consider how, with our different positions and responsibilities, we can promote sexual and reproductive health to the benefit of people and in order to foster their human dignity.

Notes

1 René Grotenhuis was the chief executive officer of Cordaid from 2003–2013. This article reflects Cordaid's policy on sexual and reproductive health during these years. It does not necessarily reflect the current policy of Cordaid.

2 Heather D. Boonstra, 'Young People Need Help in Preventing Pregnancy and HIV; How Will the World Respond?', in *Guttmacher Policy Review*, 10(2007), nr 3 pp. 2–8 <https://www.guttmacher.org/pubs/gpr/10/3/gpr100302.pdf> accessed 1 June 2014.

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