This volume is a reflection on the Society of the Divine Word's (SVD) participation in God's mission to heal. Following an introduction is a collection of thoughts and stories of some members of the SVD who are trained in a health- or healthcare-related profession or academic discipline. They live the SVD's mission *ad extra* and *ad intra,* either primarily or in conjunction with other apostolates, through clinical practice, pastoral counseling in clinical settings and health-related research and teaching. They are missionaries as healthcare professionals, counsellors, researchers and teachers who highlight the holistic, collective and collaborative nature of health and healing in the SVD's mission. Following their reflections and stories is a reflection on disability by an SVD in formation and two articles authored by theologians who discuss the role of disability, health, healthcare and care giving in the mission of the Church and evangelization. Afterwards is a biographical sketch of the life and mission of Veronika Rácková, SSpS, a medical doctor who was murdered as she provided care to a patient. A document of the World Council of Churches (2005) concludes this volume. The goal of this publication is to encourage discussions in SVD provinces and regions on how to participate in God's mission to heal and to motivate particularly younger members of the SVD to discern a missionary vocation through professional training in clinical practice, health-related research and teaching.

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SVD Health Professionals Participating in God's Mission to Heal
Edited by Alexander Rödlach, SVD

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INTRODUCTION

Alexander Rödlach, SVD
USC - Chicago Province

The mission of the Society of the Divine Word (SVD) does not include an explicit focus on healthcare, unlike other religious orders and missionary congregations within the Catholic Church, such as the Camillians (MI) whose primary ministry is care for the sick and the dying, or the Medical Mission Sisters (MMS) whose overarching goal is to provide the poor with better access to healthcare. The SVD is first and foremost a missionary congregation and adjusts its mission focus, specific apostolates and ministries to the needs and priorities of the local church and the people it serves. Such needs at times are related to health and healthcare, and should motivate SVD provinces and regions to engage in health - and healthcare-related apostolates and to encourage its members to pursue health professional training and practice, engage in health- and healthcare-related research and commit to teaching in the area of health and healthcare.

I am an anthropologist with a research interest in the relationship of culture, religion and health, which has been a strong emphasis of the Anthropos Institute since its beginning (Rödlach, 2022). The sub-field of anthropology that systematically studies health, illness, healing and care giving is called medical anthropology (Wiley and Allen, 2009). More recently, I have become interested in the SVD's

involvement with health and in healthcare. This prompted me to reach out to all SVD provinces and regions and solicit names and contact information of confreres who, in one way or another, participate in an apostolate related to health and health care. I contacted them and asked them to write how they view the relationship of their vocation as religious missionaries to their calling to serve through and in healthcare, and how the two are aligned in their apostolates. Some of them preferred to speak with me personally; I subsequently transcribed our conversation.

This volume is a collection of their reflections and stories, listed in alphabetical order by the author's last name. These confreres are trained in a healthcare profession or an academic discipline related to healthcare. They live our mission *ad extra* (for and with the people we are sent to) and *ad intra* (for and with our confreres) either primarily or in conjunction with other apostolates, through clinical practice, pastoral counseling in clinical settings, research and teaching that draws from their professional knowledge, skills and expertise. Some of them are priests, others are brothers. Two are in temporary vows; one is a bishop. They are not identified in this volume as priest, brother, bishop or seminarian, although their specific status in the SVD becomes evident in their reflections and stories. Their texts indicate that it does not really matter if they are ordained members of the SVD or not, or if they are in temporary or perpetual vows. What matters is that they have been responding to God's call to be witnesses of God's love and care through training, practice, research and teaching in one or more health profession or healthcare-related academic discipline.

The terms "health professional," "healthcare professional" and "healthcare-related discipline" are used in a very general and broad sense in this volume, simply referring to those who are (1) trained in a specific health profession, such as medicine, nursing, physiotherapy and clinical

psychology, (2) engaged in health- or healthcare-related research and teaching, such as neuroscience, or (3) trained in providing pastoral care and clinical counseling in a clinical or care giving context. Using a narrower definition of these terms does not seem appropriate, considering that the health-related apostolates of the SVD do not fit clear and narrow definitions and applications. Further, SVDs respond to their vocation as religious missionaries through and within healthcare in unique ways that defy clear-cut characterizations which evolve and change over time. The distinctive ways through which the authors of the reflections and stories respond to God's call is also revealed in their choice of writing style. Some reflections and stories are more autobiographical, highlighting key events that are significant for understanding their vocation to be missionaries as health professionals. Others are more reflective, emphasizing personal experiences and their meanings to help the reader to understands the author's calling. Again, others are more theological, drawing from the Sacred Scriptures to interpret their vocation. However, all reflections and stories clearly show that the authors feel called to participate in God's mission to heal as SVD missionaries.

These reflections and stories highlight one particular way for us as a community to be "faithful co-workers and missionaries of the Divine Word" (Society of the Divine Word, 2012a:8) in order "to bring the good news to all nations and proclaim the Father's liberating and unifying love" by making "the goodness and kindness of God visible in our life and service" (Society of the Divine Word, 2012a:6). This is undertaken "where the Gospel has not been preached at all or only insufficiently and where the local church is not viable on its own," always "showing special predilection for the poor" (Society of the Divine Word, 2012a:7). The particular way described by the authors is through research, teaching and professional practice in healthcare. As said earlier, unlike other religious orders, the SVD has no explicit focus on healthcare in its spirituality and mission.

We are first and foremost missionaries. Our Constitutions clearly state that missionary work is the end and aim of our society (Society of the Divine Word, 2012a:6). It is up to provinces, regions, missions, communities and individual SVDs to discern the most appropriate way to respond to the call to be in mission. Therefore, we (1) "insert ourselves into the actual situation of those among whom we work" (Society of the Divine Word, 2012a:7), (2) become familiar with the social, cultural and other realities that influence and frame the lives of people among whom they live and work, (3) subsequently identify their joys, concerns, and needs as the focus of our engagement with them and (4) finally support confreres who already have the necessary knowledge, skills, expertise and passion to address those needs, or we facilitate the training of those who feel called to gain relevant knowledge, pertinent skills and expertise. For some provinces, regions, communities and confreres, this discernment process leads to an engagement with and in healthcare.

Such discernment pays close attention to what the SVD Constitutions state about the communication apostolate, which also applies to our missionary work in general, namely that "it is principally the needs of the people we serve that determine the means and content" (Society of the Divine Word, 2012a:11) of our apostolates. These needs are then compared and contrasted by provinces, regions and communities with the passions, skills and expertise of individual confreres in order to determine a specific response to them. At the same time, the Constitutions encourage us to "foster a sense of personal initiative and responsibility in carrying out our missionary task" (Society of the Divine Word, 2012a:13). Provinces and communities encourage individual members to reflect on and pray over their participation in the SVD's mission, being "open to the signs of the times … [and] the demands of the apostolate" so that the community is "ready to strike out in new directions" (Society of the Divine Word, 2012a:13). The first resolution

of the 2003 provincial chapter of the India Mumbai Province explicitly encourages "confreres to develop new and creative ministries in response to the individual charisms received from the Spirit and, at the same time, to take steps to make every apostolate in the province a community venture" (Society of the Divine Word, 2022). This resolution and similar statements from other provinces situate individual initiatives within the shared mission of the SVD. Individual confrere's initiatives, responding to their communities' discernment process, can include a commitment to be in mission through healthcare-related research, teaching and practice.

In practical terms, such discernment is often done during regional and provincial assemblies and chapters, resulting in specific resolutions and more general mission statements that guide the communities' mission. These resolutions and statements are then presented to and confirmed by the General Council. It would be worthwhile to do a careful review of documents generated during assemblies and chapters but, for the purpose of this volume, a quick review of mission statements that were formulated between 2002 and 2006 is sufficient (Society of the Divine Word, 2022[1]). The Ural Region (Russia, Belarus and Ukraine) included in its mission statement, approved at its regional assembly in 2003, that "only Jesus Christ can heal the deep wounds of human beings today." The congregation's leadership team recently reminded us (Kleden and Leadership Team, 2022) that we live in a deeply wounded world and are called to listen and respond to its cry, invited to rethink our missionary praxis and encouraged to creatively seek new forms of evangelization. In general, collaboration with others is essential to healing a wounded world. The "wounds" obviously do not only refer to physical and emo-

[1] Not all provinces and regions' mission statement were represented in the SVD Curia online database of mission statements, which explains why not all zones are equally represented in this brief overview of statements related to health, healing and healthcare.

tional wounds of individuals, communities, nations and humanity as a whole. We are also called to attend to the many and varied social, political and ecological wounds that are associated with human suffering. However, among these many "wounds" are also physical and emotional wounds and the resulting scars that people carry with them, often for many years or even for the rest of their lives. These cannot be ignored as we seek new forms of evangelization, follow God in listening to and hearing the cry of the poor (Job 34:28) and participate in God's mission to heal. Our confreres in Hungary underscored in their mission statement, approved during the 2002 province chapter, that our social engagement, attending to these wounds, makes our missionary work more authentic.

Those among us who are trained or feel called to be trained to recognize, alleviate, soothe and cure physical and emotional wounds and scars, help provinces and communities to be witnesses to God's concern for human suffering by addressing such pain through health-related research, teaching, clinical care and pastoral counselling in clinical settings. Confreres who feel called to be missionaries through health-related professional engagement remind us that "the Word was made flesh and dwelt among us" (John 1:14) and that an important part of our missionary work is to show God's love by caring for the wounded and scarred flesh of those whose life we share, addressing their physical pain, emotional anguish, spiritual suffering and social isolation. Several provinces and regions explicitly included some sort of health apostolate in their mission statements, approved at their SVD chapters and assemblies. A quick review of such mission statements (Society of the Divine Word, 2022) is evidence that provinces and regions across the globe recognize that the health and healing apostolate is an integral part of our missionary work.

The following paragraphs are by no means a complete review of such statements but intended to offer a sample of

official documents from provinces and regions that highlight the relevance of health and healing of body, mind and spirit in our missionary work. Further, the purpose here is not to evaluate the actual apostolates of provinces, regions and communities. We are aware that formulating a mission statement is just a first step in initiating an apostolate. Mission statements and resolutions are essentially statements of intentions that articulate our fundamental purpose, outlining why we exist (Ganu, 2013). Ideally, such statements use concise and clear language to define goals and objectives, include measurable statements of observable behavior and are linked to planning, implementation and evaluation efforts that help to determine to what degree the stated purpose and vision have been achieved (Bart, 2002; Bryson 2004; Gurley et al. 2014; Kantabutra and Avery 2010). Our goal here is not to assess and evaluate to what degree these apostolates have been implemented nor how effective they really are.

In its 2003 mission statement the Angola Province committed itself to three areas of rebuilding the social fabric of the country which was ravaged during a prolonged civil war and years of economic uncertainty and hardship. One of these areas is healthcare. Similarly, the Madagascar Region recognized in its 2003 mission statement the promotion of the health apostolate as an important focus of its missionary work. Also, the Mozambique Region approved in the same year a mission statement that highlighted health as an important field of activity for its missionary service. The Congo Province recognized in its mission statement (approved in 2004) the struggle against HIV/AIDS as one of the areas in which local SVD communities should be involved. The Kenya Province also emphasized in its 2006 mission statement the importance of counseling, especially among persons living with and affected by HIV and AIDS.

Like provinces and regions in Africa, our confreres in Asia also emphasize the importance of healthcare for missionary

work. The Timor and Timor L'Este Province included in its mission statement (2003) the importance of providing care for those living with HIV and AIDS and those struggling with various addictions. The India East Province approved (2003) its commitment to establish an SVD Social Service Center to serve, among others, individuals living with HIV and AIDS, people struggling with alcohol addiction, physically and mentally challenged persons, leprosy patients and people affected by industrial pollution. The India Mumbai Province approved in its 2003 provincial chapter the resolution to recognize HIV/AIDS ministries as a priority. The Korea Region committed itself in its 2004 mission statement to meet the psycho-spiritual needs of migrant workers. The Vietnam Province pledged in its 2002 mission statement to engage in prophetic dialogue with persons infected with HIV and living with AIDS and to serve and ease their pain. The 2006 mission statement of the Papua New Guinea Province is particularly explicit in its focus on health. The province states that "Jesus was a healer" and, therefore, we too are "committed to improving the physical and mental well-being of the people" and to "support all … confreres directly involved in health ministries." The PNG Province is also committed to collaborate with all involved in health ministries, particularly the Holy Spirit Missionary Sisters, in order to raise awareness about HIV and AIDS and care for those living with HIV and AIDS along with their families.

Similar commitments to recognize health as an important area of our missionary work come from provinces and regions in other SVD zones. For example, our confreres in Germany pledged in their mission statement (2004) to reach out to the elderly, sick and handicapped. The Polish Province, which includes Ukraine, expressed in its 2003 mission statement its commitment to serve and work among those struggling with addiction. Our confreres in Slovakia emphasize in their mission statement (2003) special apostolates to the sick, particularly among the

marginalized Roma community. The Ural Region (Russia, Belarus and Ukraine) identified the need to work with drug dependents and people infected with HIV (2003). These and other statements have inspired communities and individual members to attend to the physical and emotional wounds and scars of the people they are sent to and live with, cooperating with Christ in his mission to heal.

The reflections and stories of some of our confreres further exemplify the relevance, significance and importance of a health and healing ministry in our missionary work. Through their training, research and teaching and by providing care as physicians, nurses, clinical psychologists, pastoral counselors, neuro-scientists, physiotherapists, dentists and hospital chaplains they live our mission. Other SVDs, whose stories are not included here, also participate in the healing ministry through additional health-related professions and academic disciplines. As there are many such professions and disciplines, the Holy Spirit may still call some members of our Society to be trained in and practice professions and academic disciplines that are not yet represented in the SVD's global missionary efforts.

Each of the confreres who authored a reflection and story in this volume or shared his thoughts with me during an interview, has had a unique pathway into the healing ministry of the SVD. Some were already practicing health professionals before they joined the Society. Others were encouraged by the leadership of their provinces to pursue health professional training in order to serve in such an apostolate of their provinces. Again, others felt drawn to healthcare during their ministry in parishes and institutions – our mission *ad extra* – or in our SVD communities – our mission *ad intra* – as they heard and responded to "the cry of the poor" (Psalm 34:2) and were trained in a specific health profession or healthcare-related academic field. These varying pathways illustrate the complex and social nature of a vocation, influenced by a person's life trajectory

and experiences, formative experiences during family upbringing exposure and to values in communities and other social networks. We don't experience a vocation in a vacuum or in isolation but hear God's call when we do well in certain classes at school that are aligned with a specific health profession, show specific academic capabilities, are touched by human suffering, encounter individuals struggling with their health and are part of a province that needs some one to address health-related needs either *ad intra* or *ad extra*. Due to the complexity and social nature of a calling no one vocation story is identical to another. This is true also for how vocations are lived. The calling to participate in God's mission to heal may lead some to full-time or part-time clinical work, research and teaching or it may simply influence how members informally care for others in our SVD community and for people whose lives they share. At times, such calling may be responded to immediately or put on a back burner for some time until it moves to the foreground either temporarily or leading to a long-time engagement. However, in all instances, the health professional or academic training and practice defines who they are. Fowler (1999), discussing Faith Community Nursing, suggests that nursing integrates clinical practice with a vocation: "Its identity is vocational, its intent is ministry, its instrument is nursing, and its involvement is covenantal" (1999:187). Applied to an SVD's participation in God's mission to heal, the "vocational" aspect is a call to a health apostolate for which one has gifts and talents, and in which a brother or priest finds purpose and meaning, resulting in a specific religious and missionary identity. The "ministry" aspect is the call to be part of Christ's healing mission. The "instrument" aspect is one's training in a specific health profession or discipline. The "covenant" aspect is rooted in the understanding that as a member the SVD one's health- and healthcare-related work is part of the collective and collaborative mission of the SVD. These four components of a calling help to better understand the vocation of our confreres who participate in the healing ministry and its importance for our mission.

As we read the reflections and stories of our confreres, we can remember others in the SVD who also have a unique calling to participate in the healing ministry. We may also remember some who considered a vocation as a health professional but were not able to pursue training and practice because of their own shortcomings and limitations, poor leadership in their provinces, regions and communities, or social, political and economic circumstances. We may also remember some who are trained and practiced as health professionals but became frustrated or burnt out during their ministry. Others might not have felt sufficiently supported by other SVDs and drifted away from their communities and our mission. Still others might have struggled to integrate their vocation as religious missionaries with a calling to serve through health professional practice, research and teaching. Such problematic developments are not necessarily indicators of individual or collective failure. God can call us through difficult and painful experiences to discern a change in vocation. After years in one ministry God may guide us to identify a new ministry that, for some, could even mean the decision to leave the SVD. We respect such individual vocational pathways and as a community accompany confreres during their discernment processes. At the same time, we recognize that the shortcomings, failures and sins of individual SVDs and even entire communities may be responsible that a confrere's discernment results in outcomes that seem inappropriate.

As we read the reflections and stories of SVDs, we see not only unique pathways but also recognize shared patterns in calling and mission. The texts show how important our communities are for confreres discerning a call to collaborate with God in his mission to heal. Some were encouraged by confreres and the leadership of communities to engage in volunteer service that helped shape their vocation. Others were led to discern a health-related ministry as they reflected on illness and disability during service events:

Overseas Training Program (OTP), Cross-Cultural Training Program (CTP) and Clinical Pastoral Education (CPE). This is evidence of how important it is to provide formal and informal learning opportunities during and after formation. Such would include engagement with others in reflection, ample opportunities in communities to share experiences and receive practical advice and support. Confreres involved with healthcare not only work together with other confreres, but also partner with governmental and non-governmental organizations with a healthcare emphasis, collaborate with members of other orders, particularly the Holy Spirit Missionary Sisters, and maintain contact with lay people engaged in healthcare. Reflections and stories, included in this work, confirm that although we are called as individuals, our mission is always a collective and collaborative mission.

The reflections and stories highlight that our mission is not only to care for the spiritual well-being of those we are sent to serve, but also their physical and emotional health. Confreres engaged in a health-related field remind us through their clinical practice, pastoral counseling in clinical settings, academic research and teaching that the human body is God's gift; caring for the wounded human body, mind and spirit is as important as caring for souls. The reflections and stories are examples of an integral and holistic understanding of health and healing (Tomljenovic, 2014; Westberg, 1999). We are called to be witnesses of God's love and care and the coming of his Kingdom to the whole human being. We "are not saved as souls but as wholes" (Wright, 2008:200). Or, as one of the reflections states, Jesus' mission was holistic and ours should be too! As individuals, our holistic mission will always be incomplete. However, as a community, we complement each other's contribution, which then becomes a truly holistic mission. Some use their health professional expertise to contribute to our holistic mission by caring for the wounded human body while others care for the scarred spirit and

mind of those entrusted in their care. Some are part of Christ's healing mission by researching physical, mental and other ailments that afflict humanity; others do so by improving healthcare services, or by teaching others knowledge and skills that can benefit those struggling with their health.

The reflections and stories also emphasize our mission's care for the physical and emotional health of those who fall between the gaps in healthcare: those who struggle to find the healthcare services they need to address illness and disability, those who are unable to afford clinical interventions, treatments and therapies, those who have no one to advocate for them with healthcare providers and healthcare systems. Thus, SVDs in the health professional field live the "preferential option for the poor" (Groody and Gutiérrez, 2013) which is at the core of our mission. Professional training, research, teaching and practice of some allows us to respond to the "cry of the poor" (Job 34:28) who are sick, disabled, aged and in need of physical and emotional care. The poor are individuals and communities in whose lives we immerse ourselves. They are also our confreres who struggle with their health because of age, addictions and other health issues. Without SVD health professionals we lack the knowledge, skills and expertise to respond appropriately to their cry. In such cases our integral and holistic mission remains incomplete.

The reflections and stories also illustrate the experience of some confreres that our initial formation might be insufficient for our mission. We need to be competent in the foundations of philosophy and theology but that might be different for those who are priests and those who are brothers. However, we require in our ministry specific skills and training to address the needs of the world and the cry of the poor. For some who feel called to be missionaries of the flesh (John 1:14) *ad intra* or *ad extra*, this means that one must be engaged in research, teaching and clinical practice in healthcare-related fields.

The reflections and stories are also evidence that our confreres are missionaries through their professional knowledge, skills and expertise. For some, clinical and professional practice is integrated in and part of other ministries. For others, being a healthcare professional is the primary avenue to living their mission. Their research, teaching and clinical practice deepen their relationship with God and with those they accompany. They are able to reach some who may neither visit a church nor speak with a priest or a brother and have never had the opportunity to recognize God's love and care for them. In other words, SVDs in healthcare preach the Gospel by providing clinical care as professionals and transforming healthcare as researchers and teachers. Such preaching through professional engagement can bring people closer to God, like Naaman, who was healed following Elisha's advice and then professed: "I now know that there is no God in all of the earth, except in Israel" (2 Kings 4:15). Preaching through professional practice can also lead people to recognize God. Consider the lame man who was cured by Peter and John and then began "praising God" (Acts 3:8). Such preaching can guide people to the experience of God's love and care, such as the residents of Lydda who witnessed the healing of Aeneas through Peter (Acts 9:35). The religious and missionary vocation is a call to serve; healthcare is not abstract and theoretical. Our confreres generally consider their health- and healthcare-related ministry a realization of their religious and missionary vocation as SVDs.

To sum up, the reflections and stories of our confreres who participate in God's mission to heal underscore that our mission is an integral and holistic mission that might require some of us to be involved with health-related research, teaching, clinical practice and pastoral counselling in clinical settings. They highlight that this mission "to heal every disease and every affliction" (Matthew 10:1) is a collective and collaborative mission. The Gospel is not only preached through homilies and catechesis but also through

our professional practice. Clearly, the stories and reflections offered in this work argue that professional engagement with health and healing can reach some persons who otherwise may not be able to hear the Gospel and encounter the Lord.

Following the reflections and stories of our confreres is a reflection written by Brian Junkes, SVD. He shares his experience of disability and his work with individuals with disabilities in parish settings. His reflection reminds us that Christ's healing mission is not only to individuals with acute or chronic illnesses but also to people with physical, emotional, intellectual and other impairments. This text sets the stage for the theological reflection of Roger Schroeder, SVD, who is on the faculty at the Catholic Theological Union in the United States. He discusses our mission to accompany individuals with disabilities and makes a strong and convincing argument that our mission should not only focus on individuals living with impairments but also on recognizing and addressing systemic issues that create social and organizational structures that exclude and marginalize. In other words, our mission needs to focus also on the societal arrangements that create disability through social situations that marginalize individuals with impairments. The following text is written by Therese Lysaught, PhD, a theologian at Loyola University Chicago, United States and a member of the Pontifical Academy for Life in Rome, Italy. After summarizing the Church's commitment to caring for the sick throughout history, which has been re-affirmed in a variety of more recent magisterial documents, Therese Lysaught emphasizes that we not only meet, encounter and care for a person made in God's image when we show God's love to the sick, wounded and scarred. We also join the live of the Trinity as the Christ in us meets and relates with the Christ who is present in those who suffer, which echoes and reflects the relationship of Father, Son and Spirit.

These theological reflections are followed by a biographical sketch of Veronica Rácková, SSpS, written by Krystyna Szweda, SSpS who works at the Historical Congregational Archive of the SSpS Generalate in Rome. This text summarizes the life and mission of Veronica Rácková, SSpS who was a religious missionary and physician participating in God's mission to heal in South Sudan. Her clinic's ambulance was shot at when she brought one of her patients to the hospital, resulting in her death. She heard and responded to the cry of the poor and died giving witness of God's love and care, illustrating the ultimate extent of *martyria*, the everyday witness of Christian life. She is a powerful intercessor for those of us committed collaborators with Christ in his mission to heal. We also believe that the blood of the martyrs is the seed for the Church.

A document of the World Council of Churches (2005) is included at the end of this volume. The document is titled *The Healing Mission of the Church*. While there are more recent publications on this theme, this document is particularly valuable for us to reflect on our mission and its relationship to healing. The first section on the context of health and disease at the beginning of the 21st century is obviously outdated. Major events and developments during the last fifteen years have significantly changed the global realities and contexts of health, illness and healthcare. However, the general patterns highlighted in this document have not changed and are still relevant today. For example, poverty continues to be the major driver of illness (Warden, 1998), varying perceptions of disease etiologies as well as diverse approaches to diagnose and treat illnesses persist across the globe (Foster, 1976) and cultural perspectives on health as balance and illness as imbalance remain common throughout the world (Foster, 1984), to mention just a few. The document's sections on health and healing in the biblical tradition, Christian history and theology are helpful to reflect on as we look at health, illness and healthcare in our world and our mission. The document also offers a

corrective to Western allopathic medicine from a biblical perspective, which is evident in many of the reflections and stories of our confreres. While the document lacks an in-depth reflection of how to further the healing ministry and healing mission of the Church as healthcare professionals, it does present broad patterns that shape health and illness globally and provides a brief outline of a history and theology of the Church's mission to heal that can guide conversations in SVD communities on our participation in this mission.

It is my hope that this volume is helpful particularly for our young or new confreres as they discern their vocation, identifying together with their communities specific apostolates to which they are called to as part of their province or region's mission. Perhaps their individual and collective discernment will lead them to consider a health- or healthcare-related profession or academic discipline.

I

REFLECTIONS AND STORIES

1

MEDICAL MINISTRY WITH THE POOR AND THE MARGINALIZED

Ruel Bancoro, SVD

AUS - Australia Province

I had been a practicing physician (general practitioner) in the Philippines when I entered the congregation of Divine Word Missionaries in 2013. Before studying medicine and becoming a medical doctor, I had worked in the United States as a registered nurse for more than twelve years. That healthcare experience serves as the background of my vocation to religious life. Since I was young, I have been committed to serve the public and this influenced my decisions to first become a nurse and later a physician. Ultimately, it motivated me to begin my formation in a religious community. As a nurse and physician, I felt that something important was missing in my clinical work; I recognized over time that religious life and missionary service could fill the gap.

Even before I joined the SVD, I realized that lay medical professionals who practice their profession can also be on a meaningful and fulfilling journey of faith with a deeply spiritual prayer life. Indeed, many of my colleagues in medicine live a virtuous Christian life without belonging to religious congregations. However, in my case, this was not

sufficient. I felt the calling to live my faith and practice medicine as a member of a religious community that would enable me to be a missionary to the poorest of the poor as a medical practitioner. As I studied philosophy and did my postulancy and novitiate, it became clear to me that I was able to practice medicine along with living a religious missionary life. Religious life and medicine inform and reinforce each other, very much like the Benedictine *ora et labora.* Religious life provides the spiritual and value framework that inform the practice of medicine. Medicine provides grounding in the experience of human suffering that informs how religious life is lived.

During formation as a religious brother in Cebu City, which is part of the Philippines South Province, I was encouraged to participate in as many medical apostolates as I was able to. During the first year after the novitiate and while studying theology, I was assigned to be the school physician at one of the campuses of San Carlos University in the city. While I enjoyed my medical work with the students, I enjoyed even more the other apostolates that I was allowed to do: ministries among the urban poor and marginalized. With the support and encouragement of confreres like Heinz Kulüke, SVD and Paul Bongcaras, SVD, two of the most prominent figures in the medical outreach ministry of the province, I was given the opportunity to organize regular free clinics for street dwellers and the homeless, the urban poor and informal settlers, as well as those living at dump sites and in dilapidated housing projects. This medical service, which is aligned with the commitment of the SVD to Justice and Peace and the Integrity of Creation (JPIC), provided free consultations, basic medications and supplements and other services to the poorest of the poor. In that ministry I was also able to be an advocate for patients who needed to go to government hospitals for further medical evaluation and treatment. In the Philippines it can be very challenging to receive medical care at government hospitals; such institutions have very limited funding for the poor

who are unable to pay for the services they need. If services are available, the poor often do not know how to access the free services or how to deal with the layers of bureaucracies that complicate medical care and are not welcoming to the poor. While I was frequently criticized by my colleagues in the medical profession for trying to help the poor to be respected by the hospital staff and to receive the appropriate care they deserve, I was also able to develop a large network of friends among health volunteers at the clinic who enthusiastically assisted me and the poor. They helped by keeping records and monitoring the conditions of the patients in their neighborhoods between their visits to the clinics.

Ruel Bancoro, SVD during a health assessment in Kenya.

In 2018, I volunteered to join the Kenya Tanzania Province to immerse myself in the HIV/AIDS ministry. I went through a local certification program to be a HIV/AIDS counselor. In addition to my ministry with persons living with HIV and AIDS (PLHIV/AIDS), I was assigned to help out in several parochial clinics run by the SVD to serve the urban poor. I was even able to join small mobile clinics, organized with the help of local health volunteers, to provide medical care in the different slums in Nairobi, the capital of Kenya, including the infamous and dangerous Kibera slum.

In addition to serving as an urban missionary and physician, I provided medical care in the rural missions of the SVD in Tanzania. There I provided clinical services for the Maasai, the largest indigenous group in the country. It was there that I was able to help treat cases that I had never

experienced before, such as lion bites. In our parish, in the remote Simanjiro plains, we collaborate with Flying Doctors, a non-profit organization from the Netherlands that offers air ambulance services for medical emergencies. With volunteer medical students, we were able to reach the Maasai in remote areas and so provide them with basic medical care, vaccinations and pre-natal care. That time in Africa was very enriching for me as an SVD seminarian and medical practitioner.

Returning to Cebu, Philippines, in 2020, I found myself at the frontline of medical care because of the COVID-19 pandemic. Access to needed medical care became more difficult, particularly for the poor, largely because the government had reallocated funding for hospitals to provide basic food for its citizens. Our elderly confreres, who had been organizing regular medical clinics for poor communities, were not allowed to continue their usual ministry, because of the high risks to their own health if they contracted COVID-19 due to their age. I was, therefore, asked to extend my medical services and take over their work in the areas that needed urgent help. This required extended partnerships with hospitals and other medical organizations.

Ruel Bancoro, SVD in Tanzania with Maasai and representatives of the Flying Doctors.

The COVID-19 pandemic not only required us to provide care to the poor but also to care for our local religious communities and their friends. I was able to collaborate with the local government in setting up our retreat center as the place where our SVD confreres, employees and

lay partners could isolate and remain quarantined. I was assigned to monitor the conditions of those who showed symptoms and to supply symptomatic medications and supplements as needed. I took on the additional role of being the designated driver in the community for those who tested positive for COVID-19 and so accompanied them to and from the hospitals or testing centers. Further, I was tasked to develop a COVID-19 protocol for confreres and employees which included mandatory antigen testing, monitoring the condition of those who tested positive and preparing them for their return to the community when they were no longer infectious or a risk to others.

Ruel Bancoro, SVD administering the COVID-19 vaccine to a patient at a clinic in the Philippines.

Being a medical doctor and a religious in temporary vows in the SVD, I became more and more aware of the challenges that lie ahead for our SVD communities. Obviously, a program to address pandemic preparedness should be a priority. Even confreres without any medical background can be trained in this area. I also see challenges in the area of elder care, especially nowadays when holistic aging care is the expected norm. As I have worked in many nursing and elder care facilities, I am aware that a good balance between appropriate, timely and dignified medical care for the elderly is paramount. I also see the challenges in the care for chronically sick or elderly confreres, even extending palliative and hospice care for their dignified deaths. As these medical care services can be financially burdensome,

sound provincial policies are needed to identify and allocate resources to target this special area of care.

Even though I am still in formation and have not yet taken final vows, I feel that I have already lived the vocation that I embrace for my future. The years of formation prepared me well to provide medical care for poor and marginalized patients and to take care of our confreres and those who work with us. Advocating for the poor had been an honor for me in the increasingly secularized society in the Philippines where the medical profession seems to have lost its humanitarian mission of serving the sick and the suffering. Some physicians and health professionals seem more focused on themselves and less committed to addressing the health concerns of the poor. I hope that I can help my colleagues in medicine to rediscover and commit themselves to the main goal of medicine: to address the suffering and pain of those around us even if they cannot pay services provided. My vocation as a religious missionary and as a physician was strengthened during the time of my formation. I am grateful to God to be called to live the Gospel's call for radical love and service to the poor.

2

RESPONDING TO GOD IN AND THROUGH MENTAL HEALTH MINISTRY

Sam Cunningham, SVD

USC - Chicago Province

In 2021, when celebrating 40 years of priesthood, I was asked by one of the students at Divine Word College in Epworth, Iowa: "How, as a clinical psychologist, did you decide to become a priest?" Stunned for a moment, as I collected my thoughts, I responded: "Actually, it is the other way around. I am a priest who decided to study psychology." The student proceeded to interrogate me: "So why did you spend so much time studying?" I responded, "You are right. It was a long time studying. I studied for two years for an M.A. in Marriage and Family Therapy, four years for a Doctorate in Clinical Psychology and one more year to complete the requirements for licensure by doing a Post-Doctoral Residency in Forensics. I did this study because, as I worked primarily with Spanish-speaking immigrants and their children as my assignment to our SVD ministry and mission, I found I needed more tools for my ministry. Listening to the needs in the community I was confronted with individuals and families who had mental health concerns and had nowhere to find help because of costs, language and cultural barriers."

I am a clinical psychologist today because my formation as a Christian and a Divine Word Missionary led me to respond to the needs of people living on the margins in need of healing. In many cultures, the mentally ill are isolated and abandoned. They are like Bruno in the song from the movie "Encanto," titled "No One Ever Talks About Bruno." Until they somehow disrupt the lives of those around them, they are often not seen and, if not living on the street or in prison, they are hidden by their families like an embarrassment. As part of my course work for a M.Div. and M.A. in Mission Theology at the Catholic Theological Union in Chicago, I studied the Gospel of Luke. The text of Jesus' pastoral plan in Luke 4:18-19 resonated in my being. "The Spirit of the Lord is upon me because he has anointed me to bring glad tidings to the poor. He has sent me to proclaim liberty to captives and recover of sight to the blind, to let the oppressed go free." My SVD formation has taught me that Jesus' plan for ministry is our plan for ministry, and I learned over time that my vocational response is to be realized by responding to those in need of mental health services.

This response was not something that happened suddenly or immediately. I am a late bloomer who needed time to understand how God calls me to live as an SVD missionary priest-psychologist. My formation for ministry began on a farm in Central Illinois as part of a Catholic family who participated in its local parish church and school. The first time I heard about missionaries, priests, brothers and sisters who went to different lands, was at St. Patrick's School when our Franciscan pastor came to our class and talked about his work in China. He spoke some Chinese words and that impressed me. My world was widened. I realized there were languages other than just the English we spoke at home, the German my grandmother would speak or the French I heard when we vacationed in Canada. The world was bigger than Minonk, Illinois! I wanted to experience the world of other peoples by being a missionary, just like my Franciscan pastor.

That dream became a continual thought for my future. My 8th-grade teacher, Sister Mary Catherine Stier, OSF one day talked to us about a strange picture of Mary that she had hung in our classroom. She informed my class that it was an image of Our Lady of Guadalupe, who appeared to Juan Diego. Sister Mary Catherine instructed us that Our Lady appeared to an indigenous man to show the man and his people that Mary loved them. Our Lady also spoke to the Spanish who had conquered the indigenous and told them that Mary saw the indigenous as her children and that the Spanish should stop mal-treating her children. The appearance of Mary led to many indigenous becoming Christians. Our teacher went on to explain that Mary only appears to the poor. We as Catholics must be concerned for the poor. Hearing this became a call to me to want to work with the poor who are often mistreated.

Sam Cunningham, SVD holding the image of Our Lady of Guadalupe (OLG), a gift from his 8th grade teacher who both taught him about OLG and introduced him to the SVDs.

My mother, who worked at the bank where Sister Mary Catherine, OSF did her banking, informed Sister that I was interested in being a missionary priest. Mom told her I had checked out several communities but did not find them interesting. Soon after that conversation at the bank, Sister pulled me aside and asked about my interest in becoming a missionary. I told her that I was interested

in learning other languages and wanted to work in different countries where people had been mistreated like the indigenous of Mexico to whom Mary had appeared. She told me about the Divine Word Missionaries. One of her relatives was an SVD working in Taiwan. She gave me a card to send to Techny, Illinois, for more information. I did so and two weeks later Ken Reed, SVD visited my family and me. Five months later I began my studies with the SVDs at Divine Word Seminary High School.

My high school and college education is important in my life. Studying with the SVDs brought me into contact with diverse classmates that were very different from the Anglo-German community of my Central Illinois rural home. This was in a time of civil unrest, during the civil rights movement of Martin Luther King, Jr., the Farm Workers Movement of Cesar Chavez and the peace movement protesting the Vietnam War. As these movements were going on outside of the seminary, I was meeting people who were directly involved in them. My teachers and professors were filling in the gaps intellectually, by helping me understand what was happening in the news. Edwin Cabey, SVD, and Gary Riebe, SVD, two of my professors, opened my mind to liberation theology and why this particular brand of theology had something to say for the world of those living on the margins of global societies. At the urging of Gary Riebe, SVD I went to Mexico to study Spanish and Latin American Literature, which broadened my college degree in English Literature.

I was enthralled and began going with Gary Riebe, SVD, and other seminarians who were Chicano (of Mexican descent but born in the United States) to Rock Island and Moline to reach out to Spanish-speaking immigrants. This introduction to the Hispanic ministry would begin a courtship with the cultures, languages and peoples of Spanish-speaking countries, both in Latin America and the United States. I was very captivated intellectually and emotionally and

wanted to learn more about the people I felt called to live with and minister to in Bolivia, Paraguay, Argentina, Brazil, Mexico and Puerto Rico. In the United States, I would come into contact with immigrants from all across the North, Central and South Americas. On December 12, 1981, the feast of Our Lady of Guadalupe, I was ordained to the priesthood, which was a celebration of my past, present and future ministry. Sister Mary Catherine, who had introduced me to Our Lady of Guadalupe, was a witness and presented me with the picture she had used to teach me about the Patroness of the Americas. The picture hung in every classroom she had taught in for 50 years. It was her ordination gift. It was a gift of joy.

Like every intimate relationship, my relationship with the cultures and peoples of Latin America made me conscious of the lights and shadows in myself and others—the people I was coming to love. Learning languages was difficult for me, and I would always be aware of my shortcomings and my prejudices. I had to continually let go of my ethnocentrism. It was hurtful to hear and observe the xenophobia and racism expressed by people from my own culture. I found myself at times caught in the middle. At the same time the cultures and people that I was falling in love with also had shortcomings. I didn't have to seek them out because as a priest I would hear in the confessional and in my office about the wounds of addictions, domestic violence, sexual abuse, trauma, marital woes and the difficulties of intergenerational living often complicated by being influenced by more than one culture. As I visited with families, I often witnessed that there was another group of individuals living in families who did not come to my office because they were hidden away from sight. They were the people suffering from schizophrenia, dementia, bi-polar disorder, delusions, anxiety, depression, autism and other conditions that I would later learn were neuro-cognitive disorders. It was overwhelming. I was not prepared by my formation and education to respond to these needs in ways that would

follow the pastoral plan of Luke 4:18-19. How could I help in healing? I needed additional tools that my theological education did not offer.

Looking for insight into how I could better respond to the needs of the people with whom I was working, I regularly attended workshops and seminars, while at the same time reading everything I could find about culture and mental health. By chance, while I was in Paraguay and teaching pastoral theology at the National Seminary, I met Henry Smith, SJ, a social psychologist from Northern Ireland, who received his Ph.D. from the University of Southern California. He spent six months of the year in Belfast working on Catholic-Protestant relations and six months of the year in Paraguay working with professionals in the country as they sought to develop a Christian ethic for business and politics, which was well needed after 35 years of dictatorship in the country. He became a mentor as he enlisted my aid to help him with his workshops in Paraguay. The first one was a seminar for the Secretary of Education in Asuncion. I learned from Henry Smith, SJ about psychology, which gave me an intellectual orientation for working with institutions, organizations, groups, and families. He gave me new insights into the group process, which I found to be invaluable for healing the hurt found in multigenerational families. When he found out that I was returning to the United States, he encouraged me to pursue M.A. studies in Marriage and Family Therapy.

I took his counsel and enrolled in the master's program at what is today Adler University in Chicago. It was a two-year program during which I learned marriage and family therapy processes. My practicum site was in the Puerto Rican neighborhood of Humboldt Park in Chicago. Much of my therapy hours were spent with families dealing with domestic violence and the trauma of losing loved ones to drugs and gang violence. Using control through violence became an issue that both perpetrators and victims sought to shed. Many came to me because I was not only a therapist who

spoke Spanish, but also a priest, a figure that was trusted in the community. The work entailed helping perpetrators learn new ways of relating without using the control tactics of violence. Victims sought ways to leave the violent cycle of hell they found themselves living. I felt totally connected to my missionary priest vocation.

Helping with the integration of missionary priesthood and working as a therapist, I was asked to do formation at the SVD Theologate in Chicago. There I was able to work with Roger Arnold, SVD who as a priest, clinical psychologist and moral theologian became a trusted mentor and friend. "Rog" became a person to bounce off my ideas and concerns. He was invaluable because, as I finished my M.A. studies and was looking for a place to practice my newly forming skills, an opportunity came out of the blue. Arturo Hurtado from Latino Family Services called to offer me a job at his agency working with Spanish- and English-speaking sex offenders, who were mandated to therapy by the courts. I was reluctant to accept the job because, like most people, I had a very negative image of sex offenders. I was afraid of them.

Arturo, who had been the first Mexican SVD before he left the order to marry his wife Elsa and study social work, made it clear that he really needed someone with my background to help him. Roger counseled me with the insight: "If you want to stop the victimization of children, women, and men, someone has to work with the perpetrators." He said those words and looked directly into my eyes. I won't say the word that wanted to escape from my lips. I felt trapped and yet I knew that I had to respond with "yes."

The "yes" has led to a ministry of over 20 years that has involved treating over more than 600 men who are registered as sex offenders. Each one of them has been mandated by the court system to participate in almost three years of therapy to, hopefully, prevent their re-offending. I

have learned a lot during this time. First of all, even though they received an offensive label and diagnosis, I share with them the same dignity as a human person because we have been created by God. Secondly, there is really only a thin line between them and me. The thin line is a decision. If I am going, to be honest with myself, I accept that I am a sexual person with thoughts and fantasies. The difference is in the conscious decision not to victimize. I have learned that God has given us the gift of sexuality, which is our relationship magnet. Sexuality attracts us to or repels us from others and God. We can either use that gift to create equal and just relationships with others, with God and nature, or to create exploitive and unjust relationships that victimize others, God and creation as a whole. Saying "okay" to the invitation to work as a therapist with men marginalized as sex offenders has become a gift to me and my vocation as an SVD missionary priest. It has taken me into a deeper relationship with God and others.

The therapy program itself requires the therapist and the client to reinforce cognitive frameworks for making decisions that do not lead to the violence of victimization. It is social justice work that is at the heart of Catholic social teaching. Again, it is following the pastoral plan of Jesus spelled out in Luke, "freeing the oppressed and setting the captives free." Wanting to learn more and be more effective, I enrolled and was accepted into the Doctor of Clinical Psychology Program at Adler University. It was an intensive four-year program with practice at different sites, such as psycho-educational testing with middle school children in a Christian Brothers middle school in a gang-ridden Hispanic neighborhood and psycho-educational work in prisons and halfway houses. The programs were all built upon the work I had been doing with sex offenders. I was able to secure a competitive spot in the internship offered by the clinic at Adler where I continued my work with prisoners and sex offenders. At the same time, in late evenings, I wrote a doctoral dissertation titled "The Effectiveness of Workshops

Sam Cunningham, SVD during supervision sessions with Aprilia Untarto, SSpS, one of the spiritual directors at Divine Word College in Iowa.

on Domestic Violence for Priests and Pastoral Ministers in Order to More Consciously Respond in Ministry."

My internship year required me to supervise other M.A. and Psy.D. students involved in clinical work. Again, my work with students revolved around creating a just relationship with them so that they in turn related justly with their clients. I thoroughly enjoyed it. Even though I was doing psychological therapy I was still doing the work of a priest. I was calling others, like my students, to respond in the just ways of the Gospel and reach out to people on the margins of society, who are the poor, the imprisoned, and the even more marginalized who are classified as sex offenders. The post-doctoral residency at the same clinic helped me to build up those skills and qualify to sit for and pass the state licensure exam.

As a licensed clinical psychologist, I have been able to influence the work of other providers, such as psychiatrists and other therapists, to diagnose and psychologically treat patients in mental hospitals and community clinics. Before I came to Divine Word College in Iowa, I was employed at Catholic Charities in Indianapolis, Indiana, treating clients who were referred for therapy by priests, pastoral ministers, educators, and the legal system because of mental illness and learning disabilities. Further, my doctoral degree in psychology and license as a clinical psychologist has

enabled me to help people traumatized because of crime, to qualify for legal immigration status by documenting their trauma through testing and diagnosis. I am still very much involved in immigration ministry both as a priest and psychologist.

Five years ago, I was asked by my provincial, Tom Ascheman, SVD, my classmate, to move to Divine Word College, Iowa, to teach psychology, accompany the formation program, reach out to immigrants in the area, live with the SVD community and serve at the college. I enjoy my work here. As Assistant Professor of Psychology in the Interdisciplinary Program I teach the following classes: Diversity in Sexuality, Cross-cultural Psychology, Abnormal Psychology for Pastoral Ministry and Developmental Psychology for Ministers. Because of my theology and pastoral experience degrees, I have developed other courses such as the History of Christianity in Latin America, Just Relationships, A Look at Catholic Social Teaching and the United States: Evolution of A Country of Immigrants. However, the classroom has not taken me away from clinical practice as the only bilingual clinical psychologist in north-eastern Iowa. I see clients each week referred to me by parishes. I have also been able to continue, through the use of the internet, my work with sex offenders at Latino Family Services.

Sam Cunningham, SVD advising Berson Bien-Aime, a Divine Word College student from Haiti.

Working as a mental health professional has not detracted from my ministry and mission as a

Divine Word Missionary priest. It is just the opposite! My role as a psychologist has enriched it and qualified me to help my confreres to accompany the people we are called to serve with professional skills, bringing glad tidings to the poor and freeing the oppressed.

Sam Cunningham, SVD during one of his classes at Divine Word College in Iowa.

3

SHARING GOD'S LOVE AND CARE IN OUR COMMUNITIES THROUGH NURSING

Michael Decker, SVD

USC - Chicago Province

I currently work at Divine Word College in Epworth, Iowa, which is part of the Chicago Province. Since January 2018 I have been providing nursing care for the entire Divine Word College community. The college community is currently (April, 2022) comprised of 97 students from 17 different countries: 32 SVD seminarians, 48 religious sisters from various congregations (one is an SSpS), 13 diocesan or religious order priests and three are lay students. In addition, the college community includes 28 SVDs as well as 55 staff, employees and faculty members.

Michael Decker, SVD

In 1985 when I was doing ministry in a parish in St. Martinville, Louisiana, among the African American community, I was asked by my superiors in the United States Southern Province to study nursing so that

I could provide care for the retired members of the province. I agreed to their request and studied gerontology at St. Mary of the Woods College in Terre Haute, Indiana, from January to May 1986. I was with a group of women religious studying gerontology so that they could care for the needs of aging members in their communities. I was there so that I could do the same for my SVD community. For me this was the beginning of my healthcare training that led me to nursing. In August 1986, I prepared for studies in nursing by taking prerequisite courses for admission to the School of Nursing at the University of Southern Mississippi in Long Beach, Mississippi. I took courses in psychology, chemistry, anatomy, physiology and microbiology-all required before I could be admitted to the university's nursing school.

After being officially admitted to the nursing program, I had classes from Monday to Thursday. On Fridays I had clinicals at various hospitals from 7:00 AM to 3:00 PM. Some of the clinicals were in medical surgery, orthopedics and mental health, as well as with mothers and their newborn babies, military veterans, people struggling with drug addictions, substance abuse, alcohol abuse and other demographic groups. Thus, I had many opportunities to learn how to practice nursing with people, of various cultural and religious backgrounds, struggling with diverse health issues. Then, after work on Friday afternoons in the hospital, a group of nursing students, including myself, took the opportunity to share our clinical experiences with the nursing college supervisor to learn more by reflecting on and discussing our experiences in the hospital setting. In May 1990, I graduated from the University of Southern Mississippi with a Bachelor of Science in Nursing degree.

During my training, I was also responsible for the healthcare of the SVD community at Bay St. Louis, Mississippi, where I was a member. This helped me to immediately use my nursing training and skills to benefit the SVD community. This responsibility continued on after

my graduation in May 1990 until 1992 when I left for my first assignment at Christ the King Seminary in Manila, Philippines. Upon my arrival there I found out that the province had recently completed the construction of a building for all retired members of the three SVD provinces in the Philippines. Villa Christo Rey could house up to 32 retired SVDs. During the first years, it was home for 18 to 22 retired SVD members. I was the SVD nurse in charge of the everyday operations of the retirement facility. I had 5 nurses on staff, as well as 10 to 12 male nursing assistants, 3 cooks, one maintenance man and a receptionist. I lived with the SVD retirees, responsible for their care 24 hours a day, seven days a week. The nurses were on duty from 7:00 AM until 7:00 PM. The male nursing assistants were there also during the nights.

I was the nurse in charge at Villa Christo Rey from 1992 to 1995. Reflecting on the time there, I recognize that it was a meaningful, important and formative cross-cultural experience since I worked with a local staff and lived with and served SVD retirees from Germany, The Netherlands, the United States as well as several from the Philippines. Most of the residents in the community had lived and served in the Philippines for 40 or more years. I learned much from them and the Filipinas and Filipinos about cultural similarities and differences, intercultural living and how to be a missionary in the Philippines. The care provided in Villa Christo Rey included basic nursing care, such as daily bathing and grooming of residents unable to do it for themselves. We also administered the daily medication prescribed by the doctor to the retired missionaries. We helped residents move about the building and adjacent gardens, sometimes assisting them to move about with a cane, walker or wheelchair.

A meaningful event happened after the Easter Vigil in 1993. We had just finished our Easter Vigil service with the retired members of the community when I received a call informing

me that one of the priests had collapsed after he had celebrated the Easter Vigil at a nearby parish. Upon arriving at the parish, I observed that the confrere could not move his legs and concluded that he most probably had suffered a stroke and needed to be brought to the local hospital for tests. This was done immediately. After his discharge from the hospital, he returned home to Villa Christo Rey for our observation and care. He required daily physical therapy in the retirement house and a few times a week at the hospital under the supervision of physical therapists. On the day after his arrival from the hospital, he needed three people to assist him to move from his bed to the wheelchair. After a few weeks of therapy, he was able to move from his bed into the wheelchair with the assistance of only a single person. Then, after a few more weeks, he was able to move around with a cane with one person assisting him. It was rewarding to see the progress he made in a short time. Such experiences strengthened my vocation to be a missionary as a nurse, to give witness of God's love to my confreres through the nursing care I might be able to provide.

I recognize the value and importance of working together with others. At our SVD retirement facility we worked with our employees. Furthermore, we were assisted and supported by the SSpS sisters in charge of Lourdes Hospital in Manila where we often brought aging confreres when they needed extensive nursing and medical care that we could not provide at the SVD retirement facility. The SSpS sisters and the nurses at the hospital always provided very good care to the SVD priests and brothers. Our missionary service is most effective when done in collaboration with others!

I also want to highlight the importance of education in our mission and ministry. During my time at Villa Christo Rey, I would organize ongoing education events in nursing care, such as teaching how to do cardiopulmonary resuscitation (CPR) and the Heimlich Maneuver for someone who might

be choking. The nurses would also provide training in other nursing skills that would improve the care we provide as a team to our aging confreres. We learned from each other.

In 1995, I returned to the Southern Province of the United States to continue providing nursing care for the SVD community, particularly the retired members in the St. Augustine's retirement facility at Bay St. Louis, Mississippi. I did this missionary service from 1995 until 2003, living and working in the community in order to care for 18 SVDs, which included six to ten retirees who needed daily nursing care. The services I provided included bathing them, administering their daily medication, accompanying them to their medical appointments and to ensure their ongoing care as prescribed by their physicians.

In 2003, I was transferred to the Chicago Province. My assignment was to care for the students at Divine Word College in Epworth, Iowa. Many Students came to the United States from Vietnam, but the group also included students from South Sudan in East Africa and Haiti. Much of my ministry to them was providing basic health education and nursing care, such as educating students about good eating habits, monitoring their blood pressure, and giving them simple advice about how to stay healthy. Providing nursing care for the community was, however, at times very challenging. Some students from South Sudan had never in their lifetime visited a doctor, dentist, optometrist or ophthalmologist until they arrived at Divine Word College. Sometimes they required major healthcare interventions. I remember one Sudanese student who needed dental treatment that was estimated to cost over $15,000. Some of his teeth had to be extracted, other teeth needed root canal surgery, and he also required upper and lower dentures. Fortunately, with the assistance of benefactors, we were able to find a local dentist who would do the treatment for free. Another dentist would do basic dental treatment free 4 to 5 times a year for 25 to 30 students. Some

students required the service of physicians familiar with tropical medicine, as they had been exposed to pathogens that are uncommon in the United States and that most physicians would be unable to recognize, diagnose and treat. Doctors trained in tropical medicines were clearly needed.

In 2008, I transferred to another formation house in the province, our theologate in Chicago, where I served students and formators until 2017. My responsibilities included to provide basic nursing care, to educate students on what they need to do to remain healthy, and to teach basic nursing skills that would be helpful when they participate in the CPE training in hospitals throughout the United States, while doing their CTP, or engaged in mission assignments somewhere in the SVD world.

Since 2018 I have been back at Divine Word College in Epworth, Iowa, and immediately realized that things were different compared to my earlier (2003-2008) assignment there when some students required extensive and specialized medical or dental care. This time, with a much larger number of students, general nursing care for the students takes much of my time. For example, the vaccination records for all students need to be kept up to date - e.g., for measles, mumps and rubella (MMR) tetanus, diphtheria, tuberculosis and COVID-19. Some students have high blood pressure and are diabetic. Others require visiting specialists due to hepatitis, gynecological issues (yes, also female students are in my care!) and auditory problems, to name a few. In addition, nursing care includes tending to skin injuries, treating allergies and administering medication for fever and body pain. Students playing soccer and volleyball sometimes have injuries to their hands, fingers, ankles and backs that need to be addressed. Thus, being present at all sporting activities to provide on-site and immediate care is essential. We know that applying ice to injuries, to decrease swelling, is important for a quick

recovery. Occasionally, sport injuries might require a visit to the doctor for evaluation, such as an x-ray to see if any body part is broken. Physical therapy is recommended if students have injured a part of their body that needs healing and strengthening.

Michael Decker, SVD prepared to provide nursing care in case the Divine Word College students get injured playing soccer.

During the past couple of years, responding to COVID-19 has been the most time-consuming part of my ministry for the Divine Word College community. First, it has been important to educate the entire community about the need to wear a mask, keep social distancing and hand sanitize frequently to reduce the spread of COVID-19. In addition, I educated everyone about the signs and symptoms of a COVID-19 infection: fever, coughing and body aches, to name a few. If any student or SVD community member would exhibit such symptoms they would be isolated, have food brought to them for 14 days and be given Tylenol to reduce some of the symptoms. They

Michael Decker, SVD checking the blood pressure of a Divine Word College student.

Michael Decker, SVD coordinating the blood donation clinic in the gym at Divine Word College in Iowa.

would also have a specific bathroom assigned to them so that they can separate themselves from others who are free from symptoms. If employees show symptoms, we asked them to stay at home for 14 days. During the summer of 2020, all Divine Word College members were frequently tested for COVID-19 by a rapid nasal test at a local facility, where the results were known and shared with us within 15 minutes. Also, the state of Iowa provided a polymerase chain reaction (PCR) saliva test with results known within 48 hours. Later in 2021, everyone was able to do both of these tests by themselves in the community. All of these services were important for

(1) monitoring who was infected with COVID-19,
(2) isolating those who are infected and
(3) reducing the spread of the virus.

In early 2021, everyone at Divine Word College had the opportunity to receive the first shot of the vaccine and later a second and third shot. A fourth shot become available for persons 65 years and older and others with underlying health issues. We are grateful for the availability of the vaccine but recognize that most people around the globe are unable to get even the first shot of the vaccine. This reminds us of the unjust and unequal distribution of life-giving healthcare and public healthcare services.

To sum up, practicing nursing care for elderly confreres and those in formation, as well as providing basic nursing

education to students, has been a meaningful ministry for me. Caring for others, including nursing and clinical care, is a way to show others how much God loves them and cares for them through persons caring for each other in our communities. Providing good healthcare for students is important because it shows them that we are called not only to preach the Gospel but also to care for the bodies and minds of those whom we serve. It also prepares them for their future ministry as healers among those they will serve as Divine Word Missionaries.

4

BEING AN INSTRUMENT OF GOD'S CARE THROUGH NURSING, LIFE COACHING AND PRIESTLY MINISTRY

Josef Denkmayr, SVD

ECP - Europe Central Province

I was born in 1963 and have been a member of the SVD since 1991. I was almost 30 years old when I joined the SVD, having resisted for many years the call to religious life. Eventually, I gave in to the repeatedly returning thoughts of becoming a priest and missionary. Already in my childhood I felt this calling within me. However, it always seemed to be the "second choice" in some way. The desire to be close to people who are suffering and to help alleviate their pains and aches as a nurse took first place. Maybe it was because in my family I had several role-models in the healthcare field. Some of my nine siblings were already trained and working in this field as a medical doctor, a midwife and a nurse. I wanted to follow in the footsteps of one of my siblings who is a nurse, even though, at that time, it was rather rare that a young man would become a nurse. Nursing, more at that time than today, has been considered a typically female profession. It was, therefore, not surprising, that during the three years of my nursing education, which I completed with the diploma in health and nursing, I was

largely in the company of women. This further explains why my original calling to become a priest, my "second choice," moved further into the background and was considered less and less by me as an option.

However, I had done my nursing education in a hospital run by a religious order. Therefore, for students at this school, faith and religion were always an integral part of our commitment to provide care for the sick. Further, the nursing education at this particular school was holistic and the patient was seen and treated as a whole human being who has various physical, emotional, social and spiritual needs. We were trained to not only identify and diagnose the symptoms of the body but also to pay attention to patients' psycho-social and spiritual needs and to figure out how to address them.

After graduating from nursing school, I worked for some years at a cardiology ward for men. The patients were often men in their most productive years who were professionally very successful. However, cardiac arrest forced them to suddenly interrupt their professional career, being admitted to a hospital, often teetering on a knife's edge, and only saved by the skin of their teeth. At that time, I liked to be on night-duty. Not much was going on during the night and we always had plenty of time to talk with our patients. I remember many and long conversations. Men, who generally don't discuss weaknesses, failures and suffering, would not hide their vulnerability. They had to admit to themselves that they could not carry on anymore in the old rut. They shared with me how their married life and relationships in the family had been strained, and now, on top of all of these struggles, they themselves had become seriously ill and incapacitated. Some even broke into tears. As for myself, I discovered that I could listen with empathy and so create an atmosphere in which patients could open up. Sometimes, it seemed to me that these conversations where like "confessions" with a priest. I loved my work as a nurse, and I have

never regretted to have taken the path to becoming a health professional. Every day, I went happily to the hospital to render my service. However, after same years in my profession, the earlier "second choice" of becoming a priest was more intensely and more frequently coming to my mind. The Lord didn't give up bugging me! However, I was not ready to pursue this option–at least not yet. But as the thought of joining a religious order was much on my mind, I enrolled at a public university as a non-traditional student in the Department of Theology while still continuing to work as a nurse. I was not yet ready to give up my vocation as a nurse; taking some theology courses seemed at that time an acceptable compromise. Even though I had not joined a religious community, I was at least engaging intellectually with theology.

For a long time, there had been another desire in my heart. I wanted to go to Africa. I do not know what event triggered this desire. Then, I read about a possibility offered by the Divine Word Missionaries to young and older persons. They offered a "Temporary Missionary" program that enabled those interested to experience life as a missionary. They, in fact, invited volunteers to work with them at one of their "mission-stations." I was intrigued by this program because it made it possible for me to go to Africa. Also, the idea of being a missionary for some time calmed my conscience. I could pursue being a missionary for a year without joining a religious missionary order! The opportunity of having a one-year sabbatical, a "time - out" from my professional practice, would further suit me in my search for an answer to the question whether I should remain a nurse or become a priest. During the time of preparation for my commitment, I acquainted myself with the religious order whose offer I had accepted. Learning about the SVD and speaking with members of the order motivated me to cancel my plan to work as a volunteer in a clinic in Kenya for a year. I decided to join the Divine Word Missionaries! However, I was not yet ready to give up nursing; I needed to

further discern if I could become a missionary priest while still remaining a nurse. I also completed an additional training as a life- and social coach that helped me to further reflect on how to integrate both of my callings: the vocation to the priesthood and the vocation to nursing. After many years of reflecting and searching, I finally entered the Society of the Divine Word in 1991, together with five other candidates.

One Saturday morning, during one of the regular classes for novices, I had an experience that helped me reflect on how to integrate my two vocations. In the adjoining room, one of the confreres was giving his confreres a haircut. All of a sudden, we novices heard a loud and emotional cry for help. One of the confreres had collapsed on the barber's chair and the one giving the haircut yelled in despair: "He is dying!" and "It is a heart attack." Then, as fast as I could, I ran into the room and, using my nursing skills, started with re-animation and heart-massage. That's what I had learned as a nurse. Around me stood some confreres, rather perplexed and scared, and perhaps even a bit impressed with what this novice did. I told them to call the ambulance and administer the anointing of the sick! It felt strange that I, a "young" novice, would give orders to elderly confreres. They were my mentors in the community as I was learning what it means to be a religious, a missionary and a priest. However, the roles changed when my nursing expertise was relevant. I was now their mentor, telling them what needed to be done to address this health emergency. When the ambulance arrived, the heartbeat and respiration of the confrere who had collapsed, had returned. "Well done!" remarked the emergency physician. I was greatly relieved. Unfortunately, the confrere who had suffered the heart attack died some days later, in the intensive care unit, after he had suffered a second heart attack.

This experience of the usefulness of my nursing knowledge and expertise motivated me, after having taken vows, to ask

Josef Denkmayr, SVD responding to the request of the infant's parents in Ghana to bless the child.

my superiors to be granted permission to volunteer as a nurse in a nearby hospital on two weekends a month. My formator welcomed the idea even though this meant that I could not stay in the community house during the time when I volunteered; instead, I had to stay in an apartment provided by the hospital. This was an unusual arrangement for SVDs in temporary vows. The dean of the faculty and some of the professors also expressed some reservations, being concerned that the absence from the community might negatively affect my studies of philosophy and theology. However, after a collective reflection and discernment process, permission was graciously granted, and I was able to be a volunteer at the hospital. In hindsight, I consider this a wise decision as it enabled me to stay connected and up to date with nursing and not weaken my vocation as a nurse. I already sensed at that time that my nursing vocation may one day again be important in case of emergencies, such as the one I just described.

The dream I had when I was young to live one time in Africa, became a reality after I took final vows and was ordained. I was appointed to serve in Ghana. During the six years I spent there, I recognized in a special way the connection between priestly ministry and professional service to the sick. "Father, please, pray for my sick child," was a common request of parents who brought their sick child to me. Sometimes the prayer had to wait because I had to clarify some questions beforehand: What symptoms have you observed? Since when? What treatment have you tried

since then? As a nurse I considered it important to first ask such health-related questions and only then find time for a prayer, asking God for healing. I was convinced that the God of life and healing was present as I diagnosed symptoms and determined if a clinical intervention was immediately necessary. God was also present during the prayer that followed when we started the often very long journey to a hospital or nearby clinic, sometimes driving for more than one hour over fifty miles on bumpy and dusty bush tracks. Two German Holy Spirit Sisters ran a small clinic in the area of my parish, located in a distant village. This clinic was often our first destination. The clinic had no electricity or running water. Once in a while, I visited the two sisters, celebrated the Eucharist with them, and lent a hand to the clinical work they were just doing. Later, all of a sudden, one of them died and the other one fell seriously ill and had to return to Europe for treatment. So, I took over the clinic for three months. Fortunately, there were very competent Ghanaian nurses at hand and I became a student again, learning from them. They passed on to me their experience and knowledge in tropical medicine and how to provide care in a context of scarcity without a medical doctor nearby. Nursing care and providing care in general is not done by a single person but rather by a team whose combined experience, knowledge and wisdom enable all involved to do their level best for their patients.

Josef Denkmayr, SVD visiting an elderly parishioner in his parish in Ghana.

One night, a ten-year old boy was brought to the clinic. His right arm showed an enormous swelling, which the Ghanaian nurses and I diagnosed as the result of a snakebite! We first tried to use the "black stone," also known as snake stone, to draw the snake's venom out of the boy's bloodstream. This traditional treatment is applied on the site of the bite, after making a small incision to the skin. Later we administered an antitoxin serum. However, nothing helped. Later the parents admitted that the snakebite had occurred several days before they came to the clinic. They did not come to see us because they wanted to treat the boy with native herbs, mostly because they had no money to go to a hospital or a clinic. I can still see the young boy in front of me and feel the pain of not having been able to help. It also taught me how important it is for us to understand local ways of treating illnesses and how poverty is a barrier to receiving necessary care. If we want to be effective in treating patients, we need to also address such barriers. In other instances, however, I was able to successfully alleviate symptoms and even cure patients, sometimes with very simple means. A disinfectant ointment, pills for malaria and antibiotics were always in my travelling bag when I visited remote villages, in addition to holy water, a rosary, the bible and whatever I needed for celebrating Mass. After all, promoting both health and salvation are what God calls me to do. It was very rewarding for me to experience in Ghana the synergy created by both of my vocations that helped me to be a witness to God's love and care. Nursing and pastoral care not only complement each other but together help me to be a much more effective instrument of God's care than through one of the two vocations alone.

In my experience the integration of both vocations was also a blessing in the SVD community. At the mission station in Ghana, I lived together with an Indian confrere. Sometimes we became patients ourselves and suffered from malaria or typhoid fever, were vomiting, had diarrhea, experienced

bouts of fever and suffered from other physical afflictions. When one of us was sick, the other one would sit by the bedside of his confrere, nursing him back to health. We administered intravenous drips for each other. And we bathed the confrere, washed his bed sheets, cleaned the room from vomit, feces and other effects of sickness. This created a strong bond between us; it welded us together as a religious community. It opened our eyes to see what it means to be a true confrere. For our parishioners it was an example of Christian care modeled after Christ's care for us. Unfortunately, after several years of struggling with frequent illnesses, I was forced to return home to Austria. I said farewell with a heavy heart.

At the moment, I am engaged in pastoral and parochial work in my home country. Naturally, at the beginning, I missed the joy and liveliness of church services in Ghana. On the other hand, I felt that people welcomed me and were grateful for having me as their pastor. Here in Austria, malaria and snake bites are not a problem. However, people approach me because of other kinds of worries and concerns. Some experience tensions in their married life or with their families. Others struggle with depression or insomnia, and still others face doubts about their faith. They often do not ask for prayers but want to talk with a trusted person about themselves and matters concerning their lives and emotions. Skills I learned during the training as a life and social coach are very helpful during such conversations. Not only people from the parish benefit from such skills but some of my confreres as well. One wing of St. Gabriel, the building in which the SVD community lives, is an assisted living and nursing facility for our aging and elderly confreres. Together with Theresa Schinnerl, SSpS and assisted by several employees, I am responsible for their medical care. A medical doctor visits the confreres once a week. Again, my nursing expertise is helpful in the community. Some time ago, a confrere had suffered a heart attack. The other residents felt helpless and were unable to help.

Fortunately, I was around and able to resuscitate him. Some in the community felt also helpless when a confrere developed manic-depressive symptoms. One time, I recall, he was nowhere to be found and confreres were desperately looking for him everywhere. Later, one confrere found him locked in his room. Sometimes, he exploded in fits of rage and abusive language and no one knew how to handle him. To observe such behavior of a confrere, who has been a religious, priest and missionary for many decades, has been particularly painful for us. One would not expect such behavior in a religious house. It contradicts what we stand for and are, but it still happens as we are frail human beings who can be affected by all kinds of illnesses. In this particular case, thanks to my nursing training and experience, I could diagnose the irrational behavior and other symptoms as signs of a mental illness. As a nurse I had also learned the skills to de-escalate such situations, to motivate the patient to cooperate with us and to effectively communicate with him. Later, I had to arrange for him a compulsory hospitalization in a psychiatric ward of a hospital. Well, that was a singular, dramatic and actually atypical case. Most of my experiences in the community are not like that. Usually, confreres share during confidential conversations their

Josef Denkmayr, SVD and Theresia Schinnerl, SSpS sharing a moment of joy with Michael Grundtner, SVD who has lived in the elder care wing of St. Gabriel in Austria, until his passing in 2022.

hurt and how it has been negatively affecting them emotionally and even physically. They felt more at ease to express such concerns as well as physical pain and ailments to someone who is both a confrere and a health professional, who can understand their concerns as religious missionaries and who can help them with clinical knowledge and expertise.

Josef Denkmayr, SVD and Theresia Schinnerl, SSpS discussing the x-ray image of one of the elderly SVDs who lives in the elder care wing of St. Gabriel in Austria.

In much of today's Europe, including Austria, it has become common and necessary for an increasing number of elderly persons to leave their familiar surroundings. They are then expected to find a new "home" in unfamiliar circumstances and locations. I am convinced that it is invaluable for our elderly and ailing confreres to remain in a place they are familiar with and in a community that can take care of them. I have helped to create the necessary infrastructures and organization so that our elderly confreres can stay with us as long as possible. My training in nursing and my experiences as a nurse, a pastor and a life and social coach have been very helpful in this regard.

On a poster, advertising for religious vocations, I once read the following: If you want to touch and move the hearts of people, then you either need to become a surgeon or a priest. I did not become a surgeon; instead, I became a nurse and a priest. I feel that I was able to touch the heart of people because of both vocations. And in the same vein, I believe that it is just as important to allow my heart to be touched by others. It is not

about either being a surgeon or a priest or, as in my case, being either a nurse or a priest! I feel that God guided me to learn and experience an integral and holistic understanding of the human person through the combined experiences of nursing, theology and coaching. The physical, emotional, social and spiritual needs of people need to be recognized and addressed together. Also, these needs and concerns can only very seldom be understood through a single discipline, profession or approach. We need to look at needs, worries and concerns from various angles and by paying attention to the many variables that are involved. Healing can happen particularly when one adopts a holistic view of a person and approaches human suffering by providing pastoral care as well as care informed by health professional knowledge and skills.

To complete the training as a life and social coach, I had to write an extensive paper. I chose the following theme: "The Bible as a Guide for Life and Social Coaching." On the basis of some biblical healing narratives, I reflected on the attitude of Jesus towards people struggling with physical, emotional and other ailments and his approach to healing them. Jesus healed rarely "without further ado." Mostly, he refers to the life condition of the person, to problems that are covered up, to unsaid suffering and, once in a while, also to guilt and sin. In short, stress and strain, abandonment and needs, everything that puts us down, paralyses and drains life is taken seriously by Jesus. Jesus addresses human suffering by directing people to see and ultimately address their problems themselves. When the two disciples were on the way to Emmaus, they ask the stranger who had joined them on the road: "Are you the only one, who does not know what happened?" They do not recognize that the stranger walking with them was Jesus. Jesus asked, "What happened?" as if he knew nothing, as if this was not one of his concerns. This is the time when the two disciples begin to share with him their disappointment but also their hopes, which had come so suddenly to an end with the death of

Jesus. As they shared this with Jesus, their hearts started warming up and, almost unnoticed, healing is happening. Jesus models how his followers can join his health mission. Sometimes, we need to listen. Sometimes we need to speak. Sometimes we pay attention to peoples' pain and sorrows. Sometimes we share our own suffering. Sometimes it concerns primarily bodily pain and discomfort. Sometimes the focus is worries of the soul and the spirit. Sometimes we are spiritual directors. Sometimes we are nurses. Sometimes we are life coaches. But all the time we are guided by Jesus, inspired by the Spirit, truly promoting health of body, mind and spirit. All the time, health and salvation are our concern.

Throughout my years as an SVD, my training and experiences in the areas of nursing, theology and life coaching have helped me greatly to be an instrument of God's care and love. Sometimes, however, I have felt helpless and was just a witness to human pain and suffering, praying for those affected by it and believing that God loves them and will send someone else to facilitate healing. Experiencing limitations and incapacity has made me humble but also strengthened my faith in God who works through individuals and communities. We do our best but ultimately it is the Lord who heals. We are, as our Constitutions state, just collaborators of the Divine Word.

5

PROVIDING HOLISTIC CARE MODELED ON JESUS' HEALING MISSION

Inna Reddy Edara, SVD

SIN - China Province

The Bible contains numerous healing stories. God heals and the prophets heal in the Old Testament. Jesus heals and his disciples heal in the New Testament. Jesus defined his mission in terms of liberation and healing: "The Spirit of the Lord is upon me, because he has anointed me to bring glad tidings to the poor. He has sent me to proclaim liberty to captives and recovery of sight to the blind, to let the oppressed go free …" (Luke 4:18). The majority of the healing narratives of Jesus address issues that transcend physical aspects and point to restoring the whole person, thus, making wholeness the basis for the healing ministry in the Church. Further, healing has a central place in the Church and her mission.

The mission of the Church is the continuation of Jesus' ministry, and it is the task given by God to the people of God to accomplish it in the world. According to St. Paul's letter to the Corinthians (1 Corinthians 12), we are given spiritual gifts through the Holy Spirit, and healing is one of them. Every Christian is called to participate in the church's

mission, though not every Christian is a full-time missionary. The mission consists in being sent out (DeYoung, 2021) because, after all, the first thing Jesus notes about his mission is that he was sent to proclaim a message of good news to the poor (Luke 4:18). Scholars who talk about "sending" imply the sending of the Son by the Father and the sending of the Holy Spirit by the Father and the Son together, which is known as the essential mission (Köstenberger and O'Brien, 2001:265). The Church, all the faithful people, and particularly the missionaries partake in this essential mission. In our discernment journey we call it a "calling" or "vocation." Responding to this calling and being in mission suggests the intentionality and movement (Schnabel, 2008:27-28) of the person being invited to live a certain way of life.

I am firmly convinced that I have a calling from God to live a professed religious and missionary life. I understand that calling and mission are dynamic developmental processes (Kirkpatrick, 2017), during which I felt that I have a calling originating from God (Treadgold, 1999) and believe that becoming a missionary was what I was called for to do with my life (Weiss et al., 2003). Since the time I responded to this calling, I believe that I have been engaging in some sort of mission work by providing various types of services to the needy, including social, educational, psychological and spiritual services.

Notably, as I trace back my journey to a healing mission, I find a set of chronological incidents leading to its development. I grew up in a traditional Catholic family in a small agricultural village in India. My parents had nine children; I am the 8th child. Growing up in the village setting and Catholic surroundings, I always dreamt of being a missionary priest. I entered the seminary of the Society of Divine Word right after graduating from high school.

During my early formation years, I had some practical experiences of doing healing mission work, such as through my missionary exposure in tribal areas of India during my studies of philosophy and the novitiate and while doing fieldwork among street children during my studies of theology in India. I volunteered to help the Missionaries of Charity sisters in their selfless ministry of caring for physically and mentally challenged people during my later formation in Taiwan where I did voluntary work at one of the Catholic hospitals during my regency.

While continuing my theological training at the Department of Theology at the pontifical Fu Jen Catholic University in Taipei, I was very much involved in my free time with caring for people affected by HIV and AIDS as well as their families. During my CPE course at Cardinal Tien Memorial Hospital, I was deeply touched by the pain and suffering of the patients. I experienced that healing entailed acceptance of and positive engagement with their illness for some of them.

Inna Reddy Edara, SVD with students in Taiwan during an adventurous educational program that helps them to confront their fears.

When I was providing sacramental and pastoral services to the people in one of the parishes in Southern Taiwan, where most parishioners are of indigenous descent, I had again occasional opportunities to engage in healing ministries, focusing mainly on marriage and family issues.

Due to these first-hand experiences and realizing the need for more professionals

with relevant training, I decided to pursue a healing profession and applied for permission to study for an advanced degree in pastoral counseling, a program that integrates psychology and spirituality, at Loyola University Maryland in the United States. First, I obtained a Master of Science (M.S.) degree and worked in formation ministry and a university setting. Later, I got a Ph.D. and have been working at Fu Jen Catholic University as a professor, administrator, researcher, mentor and mental health counselor.

When we minister as missionaries and priests, we encounter many who need care and healing. During my missionary and pastoral life, I have been involved in various apostolates like caring for people with HIV/AIDS, homeless, prisoners, parishioners, seminarians, students, university faculty and staff and others. I will share three concrete experiences of my healing ministry, each in the respective areas of pastoral apostolate, formation work and academic ministry.

First, let me share a story of a man, who was infected with HIV and suffering from AIDS (Mitchell and Linsk, 2004), whom I accompanied during my pastoral apostolate. Let us call him Gao. He was introduced to me by a staff member at one of the Catholic organizations, Lourdes Home, that supported and cared for the people living with HIV and AIDS and their families. When I first visited Gao in his home, he was scantily dressed, his face had a depressed expression, and his body seemed to be very weak. He was living with his wife and their two elementary school-age sons. The whole family was very welcoming toward me. Gao was informed of my visit by Lourdes Home's staff. He was happy to have someone visit him, feeling ostracized by many due to negative stereotypes about people infected with HIV (Earnshaw et al., 2012). As I accompanied Gao, I empathized with his pain, sadness and worries. I listened to his story of dealing with the infection, the numerous medical treatment he had to do, the financial problems he faced because of medical

expenses, the lack of support systems, the issues faced by his family and the emotional stress and existential crisis he struggled with.

In addition to dealing with the infection, Gao had to face two other important issues. One was a marital problem, for his wife questioned his faithfulness to their marriage, and the other was his relationship with his two sons. I believe my visits with him and my presence in his home through empathic listening and practical guidance helped him to cope with the infection and emotional trauma. My conversations with his wife in Gao's presence were able to educate her about the various stages of an HIV infection. My playtime with their two sons was able to normalize their family atmosphere. I visited them regularly for many months and connected them with Lourdes Home and other agencies for further ongoing help.

Inna Reddy Edara, SVD with students and faculty at Fu Jen University in Taipeh, Taiwan during a celebration.

God is where charity is. Christian tradition has seen the presence and action of God in the working of practical charity (Nicolson, 1996). Sensitive care givers have progressively developed a rich collection of experience in answering people's needs at various levels, as Jesus did (Vitillo, 1994).

As I was serving people living with HIV and AIDS and their families, I felt my healing mission to listen to and address their needs is effective when God's presence is discovered in this encounter, and when the people I served could feel and say that "in my pain, fear and alienation, I have felt in your presence a God of strength, love and solidarity" (United States Conference of Catholic Bishops, 1987).

Second, during my ministry as a formation coordinator and spiritual director, I saw the significance of accompanying candidates who want to join the SVD, and helping some of them heal from their psychological and spiritual struggles. Various scandals of the clergy around the world reminded us of the great importance of training young people to become mature, committed and responsible leaders of the church. Not just the scandals of clergy around the world have highlighted the need for a holistic education and psychosexual and developmental assessment, but also some concrete examples of cases among the candidates for priesthood and religious life in various congregations and dioceses in Taiwan, which convinced me of the importance and necessity for holistic formation that emphasizes and fosters healing.

During my formation and counseling ministry with candidates and professed members of the SVD and other congregations, I came into contact with a candidate who suffered from schizophrenia and paranoia. The violent behavior associated with this mental illness not only compromised his vocation but also traumatized the entire community. Helping another candidate, who was diagnosed struggling with major depression, almost 24 hours and 7 days a week initially led to burn out, but over time it helped me be more compassionate and have a healing presence in his life. My regular sessions with another candidate who acknowledged a homosexual orientation and potential tendencies for active sexual behavior challenged me to recognize the importance and significance of professional guidance and

healing ministry. One candidate with probably narcissistic personality traits took much of my time as I tried to help him understand that he is not exceptional and, therefore, exempt from doing what anyone else has to do, but must learn to fit into the community's way of life. Another one with anger issues significantly disrupted the community's harmonious living. Again, another candidate, who went from one to another religious order to find a suitable community to live his vocation, did so because he himself was confused; he didn't know who he truly was and what he exactly wanted. I also accompanied a religious sister who strictly adhered to the congregational rules of having regular spiritual direction and counseling but had a hard time looking deeply into issues affecting her emotional well-being and lacked the courage and motivation to deal with them. There was another sister who was strongly convinced she had a calling but struggled with the vows of obedience and chastity, more than what is considered acceptable.

Being almost always available to a candidate, who was probably struggling with episodes of depression and schizophrenia, was the most challenging experience for me. Let us call him Zig. Zig was eventually diagnosed with and treated for a schizo affective disorder, which is marked by a combination of schizophrenia symptoms and depressive moods (American Psychiatric Association, 2013). In general, people with a depressive mood lose interest or pleasure in everyday activities, have problems concentrating and making decisions, feel empty and hopeless, think life is void of worth and meaning and have thoughts of ending their life. Schizophrenia is a mental disorder characterized by a wide range of unusual behaviors, including delusions, which are false beliefs, and hallucinations, which are false perceptions (American Psychiatric Association, 2013). People with schizophrenia are unable to distinguish between reality and imaginative events. They feel and think that their unusual experiences are real, whereas others assume that these individuals are lost in their own world.

Zig's unusual behaviors started with him skipping classes and falling behind on assignments. He was not involved in the group dynamics and only passively participated in community interactions, gradually retreating to isolation. Zig's behaviors interrupted community life, and the other members of his community were not only unable to understand him but also criticized him as being non-communicative and irresponsible. Some of his close friends, who were not part of the community, tried to help him but in the wrong way, such as asking him to get over it or take time to relax or pray more ardently. As his counselor, I spent many hours with him. Much of the time, he just repeated his distorted beliefs and often sat with me in silence, not knowing what to say or do. I had to always make sure he was safe, for he was delusional and hallucinating. He would bump into the wall, thinking there was an open space. He would completely isolate himself from others, for he thought they were plotting to hurt him. He was scrupulous about liturgical and spiritual matters, to an extent that he repeatedly wanted to do confession and often doubted if Christ was really present in the Holy Communion.

Inna Reddy Edara, SVD during the graduation commencement in Taiwan for master's students.

I accompanied Zig, listened to him with empathy, used therapeutic skills to help him deal with his mental health issues, found valuable resources that he could use, debriefed the community members on his health, made psychiatric appointments and accompanied him to clinical consultations. While caring for Zig, I also tried to empower him. I helped him set small and reasonable goals and progress toward

them slowly. Since the schizo-affective person is extremely sensitive to stress – in fact, Zig's illness was triggered primarily by stress resulting from being a student who needs to regularly attend class and submit assignments by specific deadlines (Corcoran et al., 2003) – I tried to create a stress - free environment to help him heal while also making sure that he followed the treatment protocol and stayed safe. I educated the other community members about this disease and how they could best support him in his healing process.

In my counseling work with university students, I have been helping and guiding students to deal with their everyday problems concerning anxiety related to academic success, daily life, emotional problems, issues with dating and intimacy, psychological conditions and future career plans. I also have dealt with random cases of pornography addiction, prolonged and complicated grief, childhood incest and so on.

Here, I present a student's personal experience of the loss of her mother and the subsequent complicated grief. Let us call her Lea. Lea was born out of wedlock. She remembered seeing her biological father just once when she was very young. When Lea's mother eventually married another man, she was sent to live with her maternal grandmother. After graduating from high school, Lea moved in and lived with her mother, stepfather and stepbrothers in a house that was bought by her mother but was registered in her stepfather's name.

Lea's suppressed issues surfaced when her mother got sick. One day when her mother was seriously ill, Lea brought her to the near by hospital for treatment where she was treated successfully. Lea's mother died after a month due to unknown reasons. Her stepfather blamed her for taking her mother to a hospital that, in his view, does not provide good care. Consequently, Lea blamed herself for the death of her mother and constantly felt guilty. Being frequently accused

by her stepfather of being responsible for the death of her mother, she began feeling even deeper guilt and started thinking that she was the cause for her mom's death. She said she felt lonely, tired, depressed and hopeless.

Grief is a normal and a universal emotional response to a significant loss (Worden, 1991), and it is inescapable even when its existence and impact are denied. Lea was going through grief at her mother's death. In fact, it was a delayed grief due to the lack of a mourning environment. When she was provided the comfortable environment for the "emotional expression" of her grief (Marrone, 1999) in therapy sessions, she was able to cry spontaneously, accept her emotions and begin her mourning process.

One of the important determinants of grief involves social and relational support. Another important aspect of coping with loss and coming to terms with it is a "shared reminiscence" (Rosenblatt and Elde, 1990), which includes creating an environment where family members grieve together. Such an environment was completely absent in Lea's life. She not only lacked the social support matrix but was also blamed for her mother's death. Through "cognitive restructuring" (Marrone, 1999) within the sessions, Lea was able to see that she had done all that she could do for her mother, and she was in no way responsible for her death. With mental reframing of her distorted cognition, Lea was set on a path for a healthy grieving and healing process.

Lea had a very difficult and detached relationship with her mother. When there were occasions to be together, Lea was almost always in an argument with her mother. Once her mother died, Lea realized it was too late to reconcile. In the therapy sessions, Lea was able to work through "psychological reintegration" (Worden, 1991) by exploring her childhood experiences and her relationship with her deceased mother. As the therapy continued, Lea also appeared to have been moving toward some sort of "psycho-spiritual

transformation" (Marrone, 1999). In other words, in the midst of dealing with a prolonged and complicated grief in a therapeutic relationship, Lea worked through her loss and grief, began to walk on a healing path, and gained an ability to re-ascribe positive meaning to her life.

During all these experiences as a health professional and a priest during my engagement with people entrusted to my care, I was guided by an understanding that our mission is primarily the mission of God (*Missio Dei*). God entrusts his mission to the Church (Peters, 1972). Therefore, the mission has to be seen as a movement from God to the world, and the Church should be viewed as an instrument of carrying out that mission (Bosch, 1991). The prologue of the SVD Constitutions states that Jesus' life is our life, his mission our mission" (Society of the Divine Word, 2012a). Further, the mission of God and, therefore, also our mission is holistic. The New Testament includes references to a holistic mission, starting with Jesus' incarnation. During his public ministry, Jesus reached out to those under the subjugation of sin and proclaimed freedom to them. Jesus dealt with various spiritual and physical needs of his audience, thus giving a guide map for the holistic mission of the Church. The Church has followed Jesus' example by preaching, ministering, feeding, clothing, housing, educating and healing people.

Inna Reddy Edara, SVD with Taiwanese students during group dynamics that promote team building.

Our concern for people's physical needs relieves human suffering and facilitates a powerful psychological healing process. In this sense, the holistic approach to mission must consider that an individual is a unity of body, mind and spirit. Rowden (1989:32) said that "holistic mission brings ministry to the whole of human need–not just one aspect singled out for special attention because of its perceived priority, but the full range. Holistic mission, then, is concerned with wholes-the whole of God's mission to the whole world, the whole of the church's God-given task, the whole of human need."

As I reflect on my experiences of the healing mission, I become convinced that the roots of our holistic mission are found in the biblical offices of prophet, priest, sage and king. Each of these offices brings a unique identity, calling, giftedness and role. From these offices, the fundamental marks of a minister emerge, guiding them in both their self-concept as well as their day-to-day responsibilities before God. Finding pastoral identity and healing mission in the biblical setting seems logical. There is the need for a priest to mediate God's compassion, a prophet to intervene God's Word, a sage to mediate God's wisdom, a king to mediate God's rule. The biblical offices provide a solid framework to measure the healing mission. Though minister's gifts, temperament and training will cause them to gravitate toward one identity more than the others, as is evidenced in my personal trajectory in pastoral ministry and healing mission, yet, by maintaining all these areas of responsibility, church leaders function properly as "pastors" or shepherds, thereby identifying themselves closely with the Lord Jesus, who called himself "the good shepherd" (see John 10:11, 14) or "Jesus, the divine physician" (McTavish, 2018).

I could say, based on my experience, that maintaining a sort of balance among various areas of pastoral mission is a tremendous challenge. In today's world, as I have experi-

enced, pastors and missionaries are presented with a bewildering and unstable bundle of images depicting the essence of ministry: preacher, teacher, administrator, therapist, change agent, care giver, manager and so on. Such a bundle of images and roles challenges the healing minister to maintain a coherent and cohesive pastoral identity.

Henri Nouwen's book on the "wounded healer" (1979:4ff) was often referred to during my spiritual, religious and counseling studies. I contend that the health professions are called to recognize the sufferings of their time in their hearts and make that recognition the starting point of their healing service. Wounded healers share in the sufferings of Christ, and they share with suffering people the comfort of Christ (2 Corinthians 1:4). For Nouwen, those engaged in health professions must be willing to go beyond their professional role and leave themselves open as fellow human beings with the same wounds and suffering –in the image of Christ. In other words, in the process of engaging in the healing ministry, we heal ourselves from our own wounds and others through our professional service. Therefore, being a wounded healer and health professional starts with a deepening self-awareness of one's struggles and receiving compassionate support from God and others. Feeling one's sadness, anger, anxiety and inadequacy, one can deeply empathize with other people's emotions and help them articulate their experiences and walk on the healing path.

As I continue to grow and mature in different areas of my life, I am convinced that, no matter what role you play or which ministry you are engaged in, there is a spiritual dimension operating in all the actual situations of the people. In a gist, priestly ministry, counseling, therapy, teaching and educating are primarily the mission of God, leading us and helping others to live a holistic and integrated life.

To sum up, our mission must be holistic, which must consider that an individual is a unity of body, mind, spirit and soul. Taking care of one part must integrate other parts as well. Our understanding and practice of holistic mission must bring service and healing to the whole of human need. Then only, our belief in and the praxis of holistic mission is said to embrace God's mission to the whole of humanity in fully meeting all human needs.

6

MISSION AT THE FRONTIER OF HUMAN SUFFERING AS A NEUROSCIENTIST, TEACHER AND PRIEST

Jean Ngeyeye Ikanga, SVD

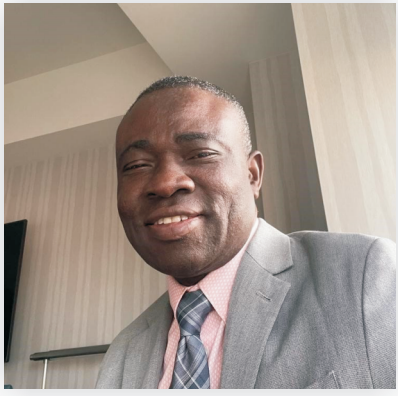
CNG - Congo Province

Alexander Rödlach (Alex):
Jean, can you briefly outline where you are coming from and where you did your formation and training as a clinical psychologist with a specialization in neuropsychology?

Jean Ngeyeye Ikanga (Jean):
I am from the Democratic Republic of Congo (DRC). I entered the SVD novitiate in 1992. After completing studies in philosophy in Kinshasa, I went to Nairobi where I studied English and then did my theological studies. While studying theology I became very interested in the bible. After my ordination in 2003, I was assigned to work in the DRC. I was so interested in the bible that the provincial at that time sent me to Rome to visit universities which offered programs in biblical studies. I was to identify a program I was interested in. When I came back to the DRC, I was still very interested in biblical studies, but in the meantime someone else had started biblical studies and the province could not send two SVDs for the same area of advanced studies. My superior encouraged me to identify a different area. I

reflected on it until something touched and moved me as I went about my regular parish ministry.

When I visited a parish on a Sunday to celebrate Mass with the local community, a mother approached me with her young daughter. She asked me to pray over the child because she believed that her daughter was possessed by demons. When I requested more information about the daughter, I discovered that this young child had been raped and since then afraid to be close to men. Every time she saw a man, she became anxious and fearful. I consulted a psychologist who diagnosed her condition as post-traumatic stress disorder (PTSD) due to the sexual abuse she had to endure. This is just one of many encounters I had in my ministry as a priest. In each case, I heard stories of suffering and struggled to understand the cause of people's emotional, mental and spiritual distress. I felt called to learn more so that I could better serve and support them. I knew that it was important for me to know the causes of distress that the people I met experienced. Only then could I offer the pastoral care they needed. At that time, I also remembered that, when I was young, I had felt drawn to study something related to medicine. It was then that I began to understand how both my calling as an SVD and interest in healthcare could come together. When the provincial asked me again to let him know what studies I was interested in, I suggested that I study clinical psychology. He supported my decision.



Jean Ngeyeye Ikanga, SVD

We then tried to identify a school to apply for admission to a program in psychology. A friend of the provincial told me that he knew a Jesuit who was the president of a university

in the United States. He thought that he might be able to assist me. Fortunately, this Jesuit supported me during the application process, and I was admitted to Regis University in Denver, Colorado, where I went and completed an undergraduate degree in psychology and neuroscience. As an undergraduate student, I became fascinated with neuroscience - the study of the brain in order to understand how it functions. I was intrigued by this academic and professional field because I believed that it could help me to better understand much of the causes of the suffering I had encountered during my pastoral ministry. I was admitted to a doctoral program in clinical psychology with a specialization in neuropsychology. This is a field that does not exist in much of Africa and the Congo, so I believed that I could bring something valuable to my country to help alleviate the suffering of its people. Later I was also trained as a physician assistant at University of Detroit Mercy in Detroit, Michigan. During my studies I did an internship and received a postdoctoral fellowship in neuropsychology at the prestigious Emory University in Atlanta, Georgia. One of the professors, Dr. Anthony Stringer, an African-American faculty member, encouraged and supported me. He realized that I could be the first in the DRC to practice neuropsychology. He also worked with me to design a test to assess cognitive functions. I have been using that test since I returned to the DRC in 2017.

Currently I am at the Catholic University of the Congo's Department of Psychiatry where I am teaching and training students in psychiatry and neurology. I am also working with the elderly population, particularly those who suffer from Alzheimer disease. This is the focus of my present research, clinical practice and pastoral ministry. Alzheimer disease in the DRC is often associated with witchcraft. People believe that elderly persons forget things and get lost because of witchcraft. My research is to understand how the disease affects the brain through brain imaging and an analysis of the proteins that cause Alzheimer disease as well as the disease's genetic causes.

I compare my work with the ministry of our confrere Frank Roelants, SVD. He saw the growing number of street children in Kinshasa, DRC, who were abandoned and rejected by their families and relatives. He felt called to do something to address the needs of these children. I saw the suffering of elderly who were abandoned and rejected too, because many think that they are either witches or targets of witches. Through my research, I want to show them and their relatives that this is not the case but that they are suffering from a physical disease. I tell families that their mother is suffering from a disease and remind them that we need to respect and love them because even in their suffering they still are the image of God. This is where my mission as an SVD and my work as a scientist converge and embrace each other, particularly when I visit parishes to celebrate Mass, mainly in Kinshasa. At the end of Sunday Masses, I tell the people that I am looking for people who have memory problems. Then, I visit them and their families, do all the testing and offer useful information about the Alzheimer disease. There is still a long way to go before people understand that this disease has nothing to do with witchcraft. I hope and pray that in the future those who suffer from Alzheimer will be accepted by society.

Meanwhile, the Congolese Bishops' Conference has given me a new responsibility: to start a School of Medicine at the Catholic University of the Congo in Kinshasa. This has been taking a lot of energy and time, but I hope that, as the time goes on, I will again have time to dedicate myself to helping people in Kinshasa and other parts of the DRC as a neuropsychologist and SVD. I have already visited Cameroon and hope to continue my work there too. I intend to go to Nairobi, Kenya, to undertake additional research. Gratefully, I have also received a grant from the University of California at Berkeley to do additional research there. Finally, I am hoping to start a project in Cote d'Ivoire, to see if I can include Muslim French speaking countries in my work.

Alex:
When you spoke about explaining to people who understand Alzheimer disease as related to witchcraft and sorcery, I can imagine that being a scientist and a priest can create interesting dynamics. Is this correct and can you say something about this?

Jean:
This question often comes up when I attend international conferences. Someone said to me: "We are happy that you are a scientist and a priest; we scientists cannot easily do what you are doing because people don't know us and don't trust us as much as they trust a priest." Many people open up to me because I am also a priest and tell me, for example, if they associate a disease with witchcraft. I can then respond to their concerns by drawing from scientific knowledge as well as offering spiritual advice and praying for and with them. Faith is always present during my conversations and counseling. We cannot separate the priest from the scientist. I always let clients know that I am praying for them when I do psychological education. It is not just education but also spiritual guidance and direction. Because Alzheimer disease is very aggressive and the person is dying progressively, and because we don't have medication to cure those afflicted with this condition, my role is often to let them understand that and to help them prepare for the increasing impact of the disease on their functioning and well-being. I also make it a point to remind families that the individuals losing their memory always remains their brother, sister, father, mother, uncle, aunt or someone else. This is when being a priest is

Jean Ngeyeye Ikanga, SVD speaking at a national conference of the Alzheimer Association in the United States on the prevalence of dementia in Kinshasa, Democratic Republic of the Congo.

Jean Ngeyeye Ikanga, SVD being a panelist at a conference of academics researching Alzheimer and dementia.

important. The scientist and psychologist need the priest, and the priest needs the scientist and psychologist.

Alex:
Thanks. You are also a teacher who trains future psychologists. Can you elaborate on how you integrate being an SVD priest and a university lecturer and what this means for our mission?

Jean:
Teaching is very important to me. We SVDs often say that the world is our parish, and we not only serve in actual parishes as pastors but consider it important to serve beyond the geographical parish boundaries in a wide range of ministries, even outside of formal ecclesial structures. Today, many people rarely or never go to church. We can only meet them outside the church. When I teach at the university, there are many young people whose lives I can touch. Many don't even like the Church. However, seeing a professor who is also a priest and who cares for them and their education, sometimes opens their hearts and minds to consider both the church and faith. Teaching at a university is evangelization. Teaching is not just a job; it is my mission. In fact, many of my students are starting to appreciate the Catholic Church because they have come to know a priest who can teach them and is personally dedicated to them. Teaching as a priest in a university might even be compared to preaching, giving a Sunday homily at a local church.

Alex:
Is there something you would like to say to our young SVDs who are discerning where God wants them to be and how to prepare for their mission?

Jean:
We SVDs are talking today about mission to frontiers. The most important frontier is human suffering. Christ calls us to accompany persons who are suffering as well as their families and friends who are suffering with them, trying to be a good friend for them during a very difficult time. Jesus said to his followers: "I was sick, and you looked after me" because, what they "did for one of the least of his brothers and sisters" they did for him. When we touch the life of people during times of suffering, we not only do what Jesus asked us to do, but the sick will remember and perhaps open upto both Jesus and his church. Healthcare, clinical research and clinical praxis are some of the frontiers where we as missionaries need to be present. Let's not be afraid to go and serve at the mission frontiers.

Jean Ngeyehe Ikanga, SVD with students at the Catholic University of the Congo.

Alex:
Thanks for this insightful and inspiring conversation about your mission as an SVD, a priest and a neuroscientist.

7

"ONCE A NURSE, ALWAYS A NURSE": NURSING SHAPING AND PERMEATING MY MINISTRY

Melvin Paul James, SVD

USW - Western Province

Alexander Rödlach (Alex):

Mel, could you briefly summarize your pathway to and in the SVD?

Melvin Paul James, SVD

Melvin Paul James (Mel):
I was born on February 20,1945, in the nation's capital, Washington, and grew up seven blocks from the White House, the residence of the President of the United States. There were nine of us in that house. I entered the SVD high school seminary at Conesus in upstate New York as a brother candidate when I was 16. I did two years in the high school, and I also worked in the tailor shop. I still tailor today and make a lot of vestments and miters for bishops. I just made one for the new cardinal of San Diego. There are

about 16 cardinals I made vestments for and many bishops and priests. I have even exhibited some of my work. It was on display in Chicago at an international exhibit that included seven pieces of my work and seven pieces from the Holy Spirit Missionary Sister Maria Antonia, SSpS. The two of us were the biggest contributors to the exhibition.

Alex:
You mentioned that your association with healthcare started when you joined the Junior Red Cross at age fourteen and did volunteer work at Walter Reed Hospital in Washington, United States. That was the beginning of your association with healthcare.

Mel:
Walter Reed Hospital is the hospital in Washington where the U. S. President goes for his physical checkups. Volunteering with the Red Cross and at the hospital nurtured my interest in nursing and, because of this experience, I was put in charge of the infirmary during my novitiate years. I took care of an elderly priest who suffered from Alzheimer disease. He would get confused and get up at three o'clock in the morning and start to scream. He would often wake up the whole seminary, shouting “Hello, is anybody home?” We tried to get him to sleep. As there was an SVD winery on the property, we gave him wine to drink so that he would sleep. By the time he finally fell asleep, he had consumed three or four small glasses. However, often he said, “I don't want to drink alone.” In fact, he refused to drink alone. So, the novice master gave me permission to have one glass of wine with the elderly priest every night. I was the only novice whoever was given such a permission!

Alex:
You were already interested in healthcare before you joined the SVD. Was your volunteering experience for the Red Cross and the Walter Reed Hospital a motivation for joining?

Mel:
As a volunteer, I took care of patients and helped them to get up in the morning and get dressed. However, providing such care did not directly influence my decision to join the SVD. I wanted to be a priest in my diocese and even took the admissions test to enter the seminary. I passed the test and was even eligible to receive a scholarship. When I went with my mother to the vocation director, he asked questions about my family. As my parents were divorced, I was not accepted into the seminary. My mother cried all the way home. I still felt that I was called to some type of religious vocation and told myself that if God doesn't want me to be a priest, then there is something else. As I was taught in a school staffed by brothers of a religious congregation, I thought that perhaps God was calling me to be a brother. At that time the SVD published a quarterly magazine called Brother America. Each issue included a card inviting young men to join The Future Brothers' Club. So, I sent in the card and received a free pen and a membership card to the club. Then different novices sent me handwritten letters inviting me to make a free retreat. "It's a free retreat," I said to myself. "Okay, I'm going to go." I made it clear, however, that I definitely wanted to return to my school at home. I wanted to finish my high school where all my friends were. However, during the retreat I was asked, "Why don't you come to our school here at Conesus?" I kept responding, "Well, in two years maybe I will return to Conesus and the brother's formation program." Then, before I left for home, I went to the SVD gift shop to buy some presents for my mother. Brother Norbert, SVD (also known later as Brother Pat Hogan, SVD) was running the store at that time. You might not believe it, but he had the biggest brown eyes you could imagine. He looked straight at me and said, "Are you coming back to join us next month?" I don't know what it was, but at that point I just said, "Okay I'll join!" His big eyes got me into the Society! Later, when I returned to Conesus, I was shocked to learn that I would be living with the brother novices. I was a novice! Of course, I was asked to follow the

daily routine of the novitiate, including designated times for meditation and prayers. That helped me, I believe, to discern my vocation.

Let me tell you a funny story about a priest with dementia. I was assigned to take care of him. He was eighty-eight years old. I would walk him to the chapel where I'd hand him over to a seminarian who would serve his Mass. Father would sometimes become forgetful during the celebration. One day he consecrated the wine in the chalice, but forgot to consecrate the bread. The seminarian reminded him, "Father, please go back here in the missal." He pointed to the words of consecration, but the priest refused to listen. Frustrated, the seminarian almost started crying! I was kneeling nearby and noticed what was happening and so got up and went up to the altar. I put my index finger on the place in the missal and said, "Father, here, pray this." Because I was his nurse, he listened to me.

Alex:
You volunteered at the infirmary and later you asked to be trained as a registered nurse, right?

Mel:
At that time, it was difficult for SVD brothers to ask to be trained in various professions. I asked to be trained as a registered nurse as I knew there was a Licensed Practical Nurse – Licensed Vocational Nurse (LPN-LVN) program at Holy Cross Hospital nearby, run by the Sisters of St. Casimir. After I finished that program, the superiors came to me and said, "Oh, I found this Registered Nurse (RN) program for you. It's a two-year program." I was angry because I had just finished a two years program and was trained as an LPN. Eventually, there were three brothers trained as nurses. Two of us were LPNs and one was an RN, but none of us were assigned to work as nurses when we finished our training. Brother Mark, SVD, LPN, was put in charge of our winery. Brother Timothy, SVD, RN, started

teaching biology at the high school. I began working at St. Anselm's Youth Center in Chicago and helped Brother Albert, SVD in the tailor shop. He was a master tailor, trained in Germany. There was also Brother Gerard, SVD who was a very experienced tailor as well. They say that when he was sent to tailoring school, he was more experienced and competent than his teachers. Albert and Gerard taught me how to tailor! At Techny, there was a brother in charge of the infirmary, but I felt he was threatened by me, since he was not a trained as a nurse like I was. I think the superiors sent him to stay for six weeks with the Alexian Brothers, who were nurses, so that he could gain some practical nursing experience from them. That's all the training he had. Understandably, he kind of felt threatened by my presence. A couple years later, when I was a seminarian and he wanted to go on vacation, he needed somebody to fill in for him in the house infirmary. I took his place for two weeks. It was then that he began to like me.

Alex:
And later you were the school nurse in Iowa.

Mel:
Yes, I studied at Divine Word College in Epworth, Iowa. When they reviewed my transcripts, only the credits for the LPN courses I had taken in biology and science were accepted. I told the priest in charge, "Well, you know, I think you can certainly accept my biology credits for the college. After all, I did work in a lab where they were cutting up people and not only pigs." Reluctantly, he gave me credit for what I had studied and accepted it for the science requirement of the college. Of course, I had to take all the courses in philosophy. While I was there, I was also the school nurse. That turned out to be good because the college was going through a process of accreditation and the fact that it had a resident nurse was a plus. A priest had been placed in charge of the infirmary but I felt that he stood in my way and was not supportive and, at times, did not let me do what

needed to be done. I was the one talking with the doctors about the patients, using medical terminology which I learnt in school. When he experienced this, he just left me alone, but at that time a priest had always to be in charge. During the summers I would do nursing at SVD summer camps for boys. We had five such camps in the United States and they all needed nurses. So, I nursed at East Troy and Perrysburg for several summers where there up to 300 campers, all boys, starting at age five.

Alex:
Later, you decided to switch from being a brother to being a priest.

Mel:
That's what I had wanted to do initially though I had given up on it. In 1971, however, I switched from the brotherhood to study for the priesthood. I was ordained in 1975.

Alex:
In 2015, you made a retreat at a monastery of the Eastern Rite. During the retreat your nursing skills and knowledge were again needed.

Mel:
The expression “once a priest, always a priest” is also true for nursing: “once a nurse, always a nurse.” I did not do full-time nursing until 2015, when I went to make a long retreat at an Eastern Rite monastery in Northern California. I looked for a monastery to make a 40-day retreat because I was preparing to celebrate the 40th anniversary of my ordination to the priesthood. At the monastery there was a layman whose name was Jack. He had no family. In fact, he was in hospice and the monks had been taking communion to him. The guy didn't want to die alone. The abbot, therefore, invited him to stay with the monks at the monastery. There were only six monks in the monastery at that time. None were trained in a health profession; they didn’t know

Jack, who received palliative hospice care in the Eastern Rite Catholic monastery by its monks and Melvin Paul James, SVD.

what Jack was going to need and what hospice care would involve. I showed up for the retreat and shortly after my arrival the abbot found out that I was a nurse. It was like the bells went off! Jack was preparing for death. Caring for him became part of my retreat. This brought back all that I had learned and practiced over the years as a nurse.

Alex:
As you reflect about being a nurse and a priest, how did being a nurse influence your ministry?

Mel:
When I make sick calls as a priest, I am more attentive to what the patients need at that moment. I might be a little more sensitive to the physical needs of patients than other priests who would just address their spiritual needs, anoint them and give them communion. Because of my training I know how to respond to physical, emotional and medical needs. When my mother got the news that I wasn't going to be accepted in the local seminary because she was divorced and went home crying, it was very painful for her and also for me. However, I think if I had joined that diocesan seminary, I would have quit like all my classmates did who entered it. So, it was providential that I was rejected, joined the SVD, became a brother, a nurse and even a tailor. Also, if I had joined the diocesan seminary, I would have been stuck my whole life in Washington, in a tiny diocese and perhaps a small parish, but as an SVD, I have worked in different parts of the United States, Mexico and Thailand,

and, in the process have learned other languages. As a brother I had worked on the SVD farm, learned how to tailor and became a nurse. All I did as an SVD, including working as a nurse, broadened my horizon. That door of the diocesan seminary had to slam shut for another door to open up for me. It was very hurtful at the moment, but later I realized how important that was. I am still making vestments and miters for bishops, and this is good public relations for the SVD. I made several miters this year, one for the newly ordained bishop of Louisville and one for a bishop in North Carolina. And recently I made a chasuble for the Cardinal Archbishop of Washington, Wilton Gregory. Now I am preparing to make one for the new Cardinal of San Diego, who is a good friend of mine and of the Society. This is all a part of my ministry, too. All what I have learned and done has truly influences my priestly ministry. And my various skills have been helpful for my confreres as well. Last year, for example, I took care of Joe Scott, SVD who was seriously injured when a skid of Spanish Bibles fell upon him. It's ironic that a priest would get seriously injured by the Bible! I cared for him full-time for three weeks, and then accompanied him to our assisted living facility at Techny, Illinois. What I have learned during my life as an SVD cannot really be separated; it defines both who I am and my ministry. I am now 77 years old (2023), and my days of ministry, service and nursing are

A vestment, tailored by Melvin Paul James, SVD is presented to Cardinal Wilton Daniel Gregory, the Archbishop of Washington, DC, by Deacon Mel Tardy, the President of the National Black Catholic Clergy Caucus.

coming to an end. Then, I'm confident, another door will open!

Alex:

Thanks, Mel, for your time and your thoughtful reflection about your vocation and ministry, and how nursing has permeated your and our mission.

Melvin Paul James, SVD with the Bishop of San Bernardino and the pastor of the SVD parish, during the parish's anniversary.

8

FOLLOWING CHRIST AS A MEDICAL DOCTOR AND MISSIONARY

Janusz Michałowicz, SVD
ZIM - Zimbabwe Region

I was born in the Soviet Union in what is today Belarus. My family is of Polish descent. As religious beliefs and behaviors were suppressed and even persecuted during the Soviet era, I grew up with only a marginal affiliation with the Catholic Church and very little knowledge about the Christian faith. As I did well in high school in biology and other natural science courses, I became interested in medicine. These courses are important for anyone studying medicine. Therefore, after high school, I first studied medicine in Belarus and then moved to Poland to study general surgery. After completing my studies, I remained in Poland to practice medicine. It was very rewarding to help people who struggle with all kinds of ailments to regain their health. Medicine felt right for me. However, something was missing in my life. Over time, I became increasingly interested in religion and felt drawn to religious life. I came across books about faith and, as I was reading them, became more and more curious about the Catholic faith and intrigued by religious life. Reading helped me to deepen my faith and reflect on my commitment to the church. As time went by, I felt called to become a priest and a mission-

ary, and when I read about the SVD, I decided to apply for admission. When I joined the SVD, I was already much older than my classmates and other seminarians. During formation I continued to practice medicine at a clinic near the seminary, about three kilometers away. In other words, during my formation in the SVD, I was not only a student but also a practicing physician. At the end of our formation we submitted our *petitio-missionis.* I expressed my interest to work in Africa. Zimbabwe was on top of my list. With the years, it has become clear to me that I wanted to serve as a missionary in Africa through priestly ministry as well as medical practice.

Janusz Michałowicz, SVD (sitting on the right) with other confreres of the Zimbabwe Region.

I was assigned to the Zimbabwe Region and arrived in the country as a missionary, but it was initially not possible for me to practice medicine. I needed about two years to receive the official permission from the government to work as a medical doctor. The Archdiocese of Bulawayo in Zimbabwe was operating several healthcare facilities. As one of them, St. Anne's Hospital, did not at that time have a resident physician, it was decided that I should work there as a medical doctor. For the Zimbabwe region it was something new to have a member in the region who primarily works as a health professional and not as a priest or brother in purely pastoral and parochial settings. We somehow worked it out and the scope of missionary practice was broadened through my ministry as a physician.

I am currently assigned to St. Anne's Hospital at Brunapeg Mission. This mission is in a very remote, rural and poor region of southwestern Zimbabwe, near the border to Botswana. Only few people in this area are Catholic. The nearest government hospital is about 100 kilometers away and can only be reached by car, driving three hours. I am the only Divine Word Missionary in Brunapeg. The nearest SVD community is in Plumtree, 120 km from Brunapeg. Two diocesan priests are working at the mission. Also, three sisters of the Congregation of the Precious Blood are working at the hospital and its nursing school. The hospital now has a second physician, and I am currently the hospital's medical superintendent, in charge of the daily operations of the hospital. Even though the hospital staff and patients know that I am a priest, I am a missionary in Brunapeg primarily through my medical practice, giving Christian witness to patients and staff at the hospital through the clinical services I provide. This has some practical reasons. It is not common to administer the sacraments in the hospital; the majority of patients in the hospital are not Catholic. Also, the two priests at the mission are the ones entrusted with providing pastoral care. However, when I speak with the patients at the hospital, I not only attend to their physical pain but also respond to their spiritual concerns and pray with them, if they so wish. In such cases, I help them get closer to Christ and his church.

Janusz Michałowicz, SVD with nursing staff at St. Anne's Hospital in Brunapeg.

Occasionally, I preside at Mass at the main church of the mission near the hospital or in the small chapels in the surrounding area. This is very rewarding for me as such occasions bring my calling to the priesthood to the foreground. I vividly remember the Christmas

Eve Mass last year. Christmas coincides with the rainy season in southern Africa, and it was raining a lot on that day. Only few people made it to the church to attend the Mass, during which I baptized seven children. It was a beautiful and inspiring service. We did not have electricity in the church; only a few candles provided some light. It reminded me and the faithful of the first Christmas in Bethlehem. The surroundings were simple and modest, but we all felt the presence of God, remembered the birth of our Savior, and expressed our joy that the Church received new members through baptism. The celebration reminded me of the words of Pope Francis, who said that we are sent to the last, the least and the lost. Being in a remote and poor region of Zimbabwe is an example how we SVDs serve the last and the least. They are sometimes forgotten by others but not lost! God is with us through his Son, whose birth we remembered. Making those who live on the margins aware that God is with them and that he is their Emmanuel, is the mission of the church and the SVD.

Janusz Michałowicz, SVD baptizing an infant during the Christmas Midnight Mass.

Celebrating the mass and the sacraments with the faithful gives me joy and energy. However, despite occasionally administering the sacraments, by and large I am a missionary through my medical practice. I show patients through my clinical practice that God loves them and cares for them, especially when they are in pain and suffering. This is the time when God is nearest to them. I hope that my care and smiles give them hope and bring them closer to God. In other words, my clinical care and how I practice medicine is

comparable to a homily about God's love for them. When we work as SVDs in parishes or within ecclesial structures, we often serve primarily those who are already in or near the church. Through my medical practice, I can reach people who have no connection with the church but might be seeking and searching.

I feel called to be a doctor and a priest and am grateful to the SVD for supporting my vocation to witness among the sick that Christ loves them and wants to heal their bodies and save their souls. I am strongly convinced that it is important for the SVD to train more of its members who feel called to serve the Gospel through healthcare, as dedicated healthcare professionals. It is an invaluable apostolate for the called. It is a missionary way to heal and make whole those who otherwise may never have the opportunity to experience God's love in and through the church.

9

INTEGRAL HEALING THROUGH MINISTRY AND PHYSIOTHERAPY

Tim Norton, SVD

AUS - Australia Province

I was born in 1958 in Sydney, Australia. After completing high school, I studied physical sciences at the university level and graduated with a degree in Applied Science in Physiotherapy. I worked in hospitals in and around Sydney for three years prior to joining the Society of the Divine Word.

Tim Norton, SVD

I took first vows with the SVD in 1986, and final vows in 1990. I was ordained a priest in 1991. My first mission appointment was to Mexico, where I had been for the OTP. I worked in parish ministry in Mexico City for 5 years prior to returning to Australia to work in initial formation and province leadership. Afterwards, I worked in Nemi, Italy for the past 8 years as the Director of SVD Courses prior to returning to

Australia at the end of 2021. Throughout my initial formation, I was very aware of my identity as a physiotherapist. In fact, I found my initial studies in theology and philosophy very challenging as I was used to studying matters that are much more physical, like bones, tendons and muscles. I requested that my pastoral placements during my initial formation were in environments where I could practice physiotherapy. It seemed only logical to me that my practice of healing as a therapist could be enhanced through the healing that religious priesthood offers.

In my final year of theological studies, I had a weekly physiotherapy session at Pentridge Prison in Melbourne, Australia. Although I was genuinely surprised and dismayed at the number of violence-related injuries among the inmates I was treating, I enjoyed this work, and believed I was contributing to the mission of God in the world through these physiotherapy sessions. On one occasion, I was asked to treat a prisoner in solitary confinement. As I was given entry to his cell, one of the prison guards accompanying me told me to make sure I "hurt" the prisoner while I was treating him. I was confused by his suggestion. The man I was to treat had recently been hospitalized after a severe beating by other prisoners. He had significant and persistent pain in his neck and shoulders. This was the reason I was asked to treat him. I gently worked on his cervical spine as he lay face down on the treatment table. And, as it very often happens during treatment sessions, he began to tell me his story. He spoke of a traumatic childhood with regular physical and sexual abuse. As an adult, he became a substance abuser and had no significant relationships in his life. He then told me that he was in prison because he had harmed two children. I found myself becoming increasingly uncomfortable as I attempted to heal a man who had hurt children. As I drove back to the seminary that afternoon, I wondered if I was actually doing something unethical by treating this guy.

The following day, I went to my regular class in systematic theology at Yarra Theological Union, the theological college that our SVD students attended. I was still feeling very uneasy about the treatment session the previous day. As the class progressed, I summoned the courage to raise my hand to explain to the lecturer the situation I was facing. He immediately told my classmates to close their books. He then asked us all to think about this situation and discuss the ethical issues that it raised. He conducted what was for me an enormously helpful open conversation with the whole class. There were members of the class who made a case that I should discontinue the treatment on moral grounds, while others encouraged me to continue, adding that we are all sinners. We talked about church doctrine as well as moral and biblical considerations. We spoke of attitudes of Jesus to those who were outcast in his society.

We did not come to any specific conclusions, however I returned to the prison much clearer in my resolve to continue providing treatment to that prisoner. After all, if I were only going to treat people whose behavior I approved of, then I should be doing something else. This was a very good example of the deeply practical and compassionate approach that my theological studies provided for me.

While I was in Mexico in the early 1990s, I worked in pastoral leadership with another confrere in a small chapel, which was part of a large urban parish in a densely populated *barrio*[2] of Mexico City. Our geographical area of administration was about 2.5 square kilometers in size, with four separate worshiping communities, and anywhere between 80,000 and 100,000 residents. The great majority of them were Catholic. I have been told that the area of the small chapel alone has since become three independent parishes. There was a significant amount of sacramental

[2]A *barrio* is a neighborhood in a town or city, usually referring to one with a high poverty rate.

work to be done in the chapel, including approximately 1,000 first communions and multiple baptisms and wedding each year, not to mention the large number of *quinceañeras*.[3] Being a relatively poor *barrio*, there was little access for people to health services. So, I decided to offer some limited physiotherapy services to those who may require it. The parish offices were already a very busy place with many families seeking advice concerning their spiritual needs from the secretarial staff and the catechists. After I began to treat needy parishioners, the parish offices only became busier. The demand for physiotherapy services was so great that the time I had for other parish pastoral work became very limited. My own health began to suffer from the phenomenal demand for physiotherapy services. With advice from my confreres, I eventually had to make the difficult decision to discontinue my work as a physiotherapist in order to concentrate on the pastoral needs of these fast-growing communities, and to concentrate on my own well-being. I found it very challenging to enact this decision as many people continued to ask for the services I had been providing. Nevertheless, with the support of my confreres, and for my own health, I had to stop providing these services.

One evening a member of the parish Marriage Encounter ministry came to the parish house with his 16-year-old son. He showed me a deep and poorly stitched wound in the boy's right hand and told me this was the result of an accident in the tire-making factory where the boy worked. Although the wound was healing, the haphazard stitching done at the local hospital had left the boy with the prospect of a permanently flexed and deformed wrist that would make it difficult for the boy to find manual labor for income. Although the father was aware of my decision not to work in the barrio as a physiotherapist, he appealed to me once

[3]This is a celebration of a girl's fifteenth birthday and her transition from childhood to adulthood, typically involving a mass followed by a party.

more that I treat his son. I explained yet again that, despite the serious nature of the boy's deformity, I could not begin to provide physiotherapy services as it was affecting my own health. He looked very sad and turned to his son to explain my response. I watched as he communicated with his son in sign language. It dawned upon me that this young man was not only deaf, unable to speak (and poor) but was facing a life with a permanent disability that would make any manual labor almost impossible. My resolution dissolved in that moment, and I invited them both into the house for his first treatment. I swore them to secrecy as I did not want other parishioners to discover I was treating the boy. After successive treatments he was able to move his wrist to the neutral position, which at least allowed him to return to work in the tire factory.

After 9 years as provincial leader of the Australia Province, I was asked by the General Council to take up the position of SVD Course Director at Centro Ad Gentes (CAG) in Nemi, Italy. Over the years I was in this position, a significant number of confreres took advantage of the SVD Renewal Courses, Third Age Courses and Courses for Formators and Vocations Directors. As I got to know my confreres, I became aware that the health profiles of some of them were very poor. I introduced course work on Men's Health and, with the help of the CAG manager who is an SVD brother from Ghana and a qualified engineer and accountant, we put together a small gym where many of the confreres would exercise. I assisted some of the confreres in their exercise programs while they remained in Nemi. In Australia, much of the pain relief medication prescribed by medical professionals is taken orally, mostly in the form of tablets. In Italy doctors are more likely to prescribe pain relief that is to be injected into the soft tissue for more rapid uptake. Although I had never previously done this, it soon became my role to apply the pain relief to those confreres who required it, by injecting them with a syringe. My background in physiotherapy at least allowed me to seek appropriate instruction in order to assist my confreres. I treated some confreres

with musculoskeletal issues and advised others on pain management techniques and associated health issues. I was also active as spiritual director in retreats we offered in all our courses in Nemi. I felt that my role as a healer was very much enhanced by my skills in physiotherapy.

Tim Norton, SVD

Now that I am back in Australia, I am more in contact with close friends from my time studying physiotherapy. I have been invited to marry some of their family members and baptize some of their grand kids. Almost all of them are still active in physiotherapy. This helps me to remain up to date about advances in understanding and techniques associated with the profession. Very few of them are Christian, but they are all happy that I have returned to Australia, albeit to Brisbane, which is 1,000 kms from Sydney where we all studied and worked. They are intrigued about some of the characteristics of my new "job" as a bishop – as am I! I was ordained bishop in 2022 and am the Auxiliary Bishop of the Archdiocese of Brisbane.

My identity as a physiotherapist is still strong within me. I no longer work professionally as my skill set would require much updating, and the insurance costs for practicing physiotherapy are prohibitive. Nevertheless, I am grateful for my training and the opportunities I have had to help heal people, including my confreres. My sense of my own body as a gift from God has always been strong within me and has fueled my desire to heal others. I have been able to touch people in ways that have enhanced my understanding of integral healing of body and soul.

10

PREACHING THE GOSPEL THROUGH DENTISTRY

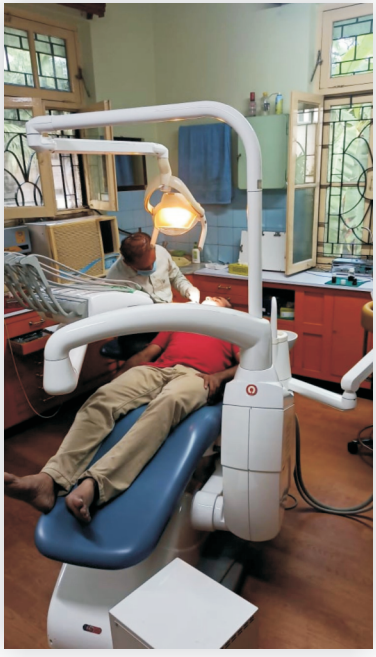
Michael Prakasam, SVD
INC - India Central Province

I belong to the Central India Province. Having completed the initial formation as a Divine Word Missionary, I was ordained in 1999 and then appointed to a parish to gain some pastoral experience for a year. Afterward, in 2000, I started dental education. First, I received the Bachelor of Dental Surgery in 2004, followed by the compulsory dentistry internship in 2005. Immediately afterwards, I was allowed to pursue postgraduate studies and graduated in 2008 with a Master of Dental Surgery (MDS) with a specialization in oral and maxillofacial surgery.

Having completed the MDS degree in Chennai in southern India, I returned to the Central India Province and was appointed assistant director in the renowned St. Patrick Dental Clinic in Indore, which was established by the late Br. Aidan Courtney, SVD, an Irish missionary brother. I joined Br. Joseph Kallakavunkal, SVD who was working with Br. Aidan Courtney, SVD and is the first Indian SVD dentist. In the city of Indore, St. Patrick Dental Clinic is well known and valued since it was established in the year 1972.

At the moment, Br. Kalaimani Paulraj, SVD and I are working in the clinic. We serve both rich and poor patients. Many people from the city come to the clinic for dental treatment. Both of us are working from Monday to Saturday, from morning till evening. Whenever poor patients come to the clinic for treatment, we do the necessary treatment even if they cannot pay for it. Our ministry is to address the pain of all and not just of those with means. With our income we also support the province treasury financially. Both of us also practice dentistry in the dental department of St. Francis Hospital, run by the Catholic Diocese, Indore.

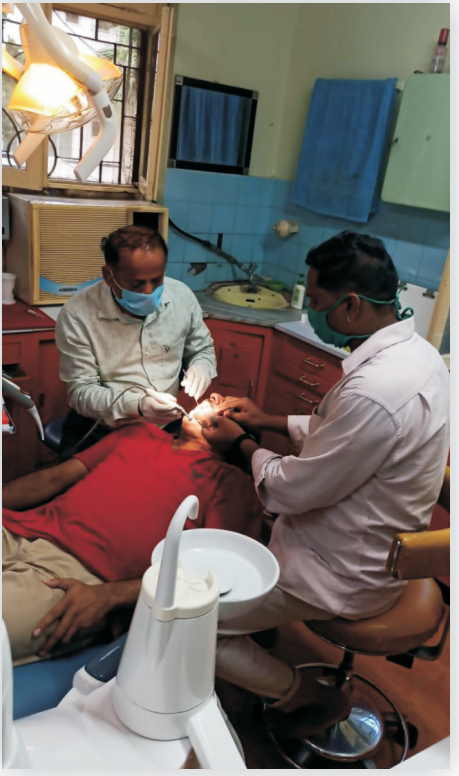
When I joined St. Patrick Dental Clinic, I also started to teach at a private dental college, Modern Dental College and Research Center. Having taught ten years at the college I was promoted to professor in the Department of Oral Surgery in 2018. After Br. Joseph Kallakavunkal, SVD passed away in March of 2021, I found it very difficult to find sufficient time for working both in the clinic and at the college as we get a lot of patients in the clinic. Therefore, I decided to reduce my teaching time at the college and am currently working there only as a part time professor. Much of my time is spent at the clinic.



Michael Prakasam, SVD with one of his patients during dental work.

When people come to know that I am a priest and a dental surgeon, they are surprised. They say, “How come you are a priest and a doctor?” Yes, being both a priest and a dentist is a rare combination, but that is what I am. I feel called to be both. I am happy that

the SVD had allowed me to do dental studies when I expressed my desire to pursue further studies. When I asked to study dentistry, there was a dire need for someone to get a degree in this field. Br. Aiden Courtney, SVD and Br. Joseph Kallakavunkal, SVD were not any more very young and it was necessary to prepare someone to succeed them if we wanted to continue this ministry. I am happy that I can serve many people in the clinic.



Michael Prakasam, SVD during dental surgery, assisted by an employee at the clinic.

The dental profession has given me the opportunity to meet people of various and diverse backgrounds, belonging to different religions and socioeconomic classes. They come to the clinic because their teeth ache or something needs to be done to address their dental issues and pain. As I meet them in the clinic, I meet them as a priest and a dental professional. I try to strike a balance between my two vocations, responding to the different needs of my patients. Often, their needs are primarily of a physical nature, and I respond to them using my expertise in dentistry. Sometimes, in addition to physical pain, they have spiritual concerns and so I relate to them as a priest and spiritual counselor. In addition, I also get involved in pastoral ministry in the local parish. I attend Mass at the cathedral, which is our local

parish. I am also involved as an animator in a group that reflects on spirituality and faith. Having said that, being a health professional demands much of my time and energy because of the local population's need for dental services. Often, I have to spend the entire day in the clinic. And then there is also the teaching at the college. Practicing dentistry and educating dental students is the center of my ministry and mission as a Divine Word Missionary.

When I reflect on my missionary vocation in the light of my healing ministry, I recognize that God has called me to reduce the pain of many people. I am a missionary through dentistry. Jesus healed many people in his life. As a dentist, I follow Jesus through dentistry and imitate him as a healer. He is the exemplary healer and teaches me the importance of alleviating physical pain so that people recognize Jesus as the healer and the church as a place of healing and health. When I communicate with patients, I try to communicate Gospel values through the way I interact with them. I may not be involved in explicit and direct evangelization, but I preach the word of God through my work and my life. I pray that the Lord calls more young Divine Word Missionaries to discern a vocation to missionary work through dentistry and other health professions. Yes, I hope that the SVD gets more involved in the medical apostolate, directly or indirectly. The healing ministry was one of the ways Jesus used to establish God's Kingdom on this earth.

11

CLINICAL PASTORAL EDUCATION: A LIFE-CHANGING EXPERIENCE FOR AN SVD MISSIONARY IN FORMATION

Baruch Zinthe Maoudjlo Zinsou, SVD
USC - Chicago Province

I am Beninese and a missionary in formation in the Society of the Divine Word. I was born and raised in a practicing Catholic family. Before starting my religious formation in 2013, I earned a Bachelor of Arts degree in geography from the University of Abomey-Calavi, Republic of Benin, and taught geography and history at a middle and high school. I left my country nine years ago. From 2013 to 2016 I was in Togo, where I studied philosophy and earned a Bachelor of Arts in Philosophy from the Institut Supérieur de Philosophie et des Sciences Humaines Don Bosco (ISPSH Don Bosco) in Lomé, Togo. In August 2016, I came to the United

Baruch Zinthe Majoudjlo Zinsou, SVD

States. I spent my first two years in the U.S. learning English (and I am still learning). After completing the English as a second language (ESL) program, I spent a year and a half earning an Associate of Arts degree in Intercultural Studies from Divine Word College in Epworth, Iowa. I am currently doing a Master of Divinity and a Master in Spirituality at Catholic Theological Union (CTU) in Chicago.

The first time I heard about the Clinical Pastoral Education (CPE) program was in December 2016 and I was immediately interested in it. After completing my first year of theology in May 2022, I had the opportunity to do the CPE program, which is required for my religious formation program in the Chicago Province. It is usually done after the first year in theology. The reason why I wanted to do this program is that CPE is a wonderful educational program that helps people discover the beauty, fragility and value of life. By doing the CPE program, my expectation was to learn more about life, to learn how to respond to the suffering and pain of people, and how to be present to people, no matter their social, cultural or religious background. In other words, I expected that this program would help me prepare myself to be a better missionary in hospital settings or any setting where people in physical and emotional pain need spiritual support. My motivation for participating in CPE did not change throughout the program but my goals did change. In fact, my initial goals were centered on how I can best serve patients. During the course, I came to realize that my goals should first focus on myself because I am to be an informed tool to serve patients.

I did my CPE program at Bergan Mercy Medical Center (BMMC) in Omaha, Nebraska (USA), which is part of Creighton University and Catholic Health Initiatives (CHI), which belongs to Common Spirit, the largest non-profit health system in the United States. I was assigned to the Oncology Unit. Besides the Oncology Unit, I also ministered

almost every day in the emergency department at BMMC as a pastoral liaison between patients and patients' families. I also served in the Neonatal Intensive Care Unit (NICU), the Intensive Care Unit (ICU), the Short Stay Hospital (SSH), and in many other units. At BMMC, I had the privilege to visit patients, listen to them, and give them as much hope and support as I could. Also, I was engaged in helping patients complete their advance directives, which is a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. I was also engaged in an honor walk for a dying person, who agreed to be an organ donor. Finally, I had experienced being on-call at the Immanuel Medical Center.

In the Oncology Unit, I ministered to patients with cancer. It was edifying to serve them, to see some of them still having hope and find meaning in their suffering. In general, my different activities in this unit at BMMC have helped me discover in some way the beauty, fragility and value of life. My supervisor and instructor, Thomas Backer, and my chaplain mentors, Michael Bingeman and Barbara Lenz, were supportive and a source of motivation. With open hands, minds and hearts, they taught me from their experiences many ways to provide a pastoral response. They were always available to help me grow as a hospital chaplain and as a human being. I could not wish for better mentors.

One of the most significant learning experiences, that I had during the CPE, has been about active listening and reflective listening. Both active listening and reflective listening are complementary skills that are paramount for good pastoral care. These two skills are two aspects of the same piece. In my daily life, in my pastoral care ministry and any other ministry, these two skills help to serve and to care for other people appropriately. But they also help me to become the best version of myself as a human being.

My understanding of active listening was not quite clear and sometimes I suffered from not being able to connect to people's feelings when they disclosed their experiences, feelings and thoughts. In this unit, I have come to learn and develop the skill to actively listen to verbal and nonverbal communication with a non-defensive attitude. That helps me to accurately paraphrase the patients and to ask them the right questions to help them process their worries, thoughts and experiences as a patient in the hospital. In fact, after learning what active and reflective listening are, I have integrated this new knowledge into my pastoral visits. With active and reflective listening, I realize that patients were more willing to share with me what they were going through, their emotions and their concerns. That helps me not only to be effective as a chaplain intern but to be fully present to the patients who are eager to find care givers who listen to their concerns. I visited a patient who was with his wife in the room. When I was about to leave, the wife asked me if I were a priest. I explained to her that I am a seminarian. She then told me, "You will be a good priest and a good chaplain. You really listen to people." During another visit, a patient told me that he would like me to visit him again because I was actively listening to him. The patient said, "Chaplain," (I definitely wished that he called me chaplain intern), "I want you to come again, every day if you can!" Those patients' and their family members' reactions showed me how important listening (active and reflective) is in pastoral care or any ministry, as well as in daily interactions with people.

Baruch Zinthe Majoudjlo Zinsou, SVD with one of his chaplain mentors in the CPE program.

Before I started the CPE, I thought active listening was about listening carefully and being able to paraphrase or summarize what someone was telling me. During the program, I came to realize that paraphrasing or summarizing what patients are telling me was not enough for a pastoral visit. I have to go beyond that by asking relevant questions, which show patients how attentive and present I am, but also motivates them to disclose more. It helps them to release their emotions, process their thoughts and feelings and so find some peace. Active and reflective listening also taught me to not be afraid of what patients tell me, thinking that I need to have an answer ready. I don't have to be afraid of this, because it is not necessary to come up with a solution for patients' concerns and worries, since the process generally guides patients to find solutions to their concerns by themselves. That is the reason why I plan to use active and reflective listening in my daily life and in my ministries, especially in clinical pastoral care. With active and reflective listening, I can stop taking the lead during such visits. I just follow the patients' lead and try to meet them where they are. I now avoid having an agenda. That helps me to be more relaxed and open to any unexpected situation.

From my CPE experience, I learned that the real need of patients is not always their disease or physical suffering. They often talk about spiritual and emotional distress that is not always related to their illness. As a chaplain and a missionary, my role is to identify the needs of patients through effective active listening. For instance, when I visited some patients who seem to enjoy their hospital stay, I realize that they have a lonely life and the hospital provided them opportunities for personal interactions with staff and others, which they missed in their homes. Having people care for them addresses a deep social need.

During my clinical pastoral practice, I integrated some conceptual understandings presented in the curriculum of the CPE program such as active listening, reflective listen-

ing, keeping silence and being patient centered. For instance, when having pastoral visits in the hospital units, I try to focus on the patients and meet them where they are. That was not easy because the chaplain does not have control over the nature and the focus of the visits, but the patients do. On the first day in the hospital, I had an experience that showed me why it is important to visit patients without setting an agenda or structuring the pastoral care conversation according to one's own expectations and plans. I visited a patient who raised a question about why God allows human suffering. I was about to share with him my theological understanding of suffering but then realized that he was not looking for answers; he was expressing concerns and worries about his own suffering. So, I let him talk and offered him empathic and active listening. Such an approach needed a lot of practice and only after some weeks I felt comfortable with it. Through that experience, I discover that a missionary needs active listening in order to understand and appropriately respond to people's needs.

Baruch Zinthe Majoudjlo Zinsou, SVD at the CPE graduation event with one of his chaplain mentors in the CPE program coordinators at CHI Health in Omaha; the program director is in the back.

I had another significant learning experience during the CPE, also related to being open to God's grace that can come from any human encounter or situation. As a chaplain intern, I was blessed to be ministered to by a patient and her daughter. They are Christians but not Catholic. One day, after attending two trauma cases, I visited a patient that a nurse referred to me. I walked into the room and saw the patient in the bed and her daughter sitting in a chair. I was intimidated by the daughter's stare. I felt uncomfortable

and it made me feel unconfident. I started thinking about what to say or do. Knowing that the patient was referred to me by a nurse because of her strong and profound faith, I focused on the white board in the room which had the following written on it: "Can God? God can! Fear not!" Then, I told the patient that I am aware of her deep and strong faith. I expressed to her and her daughter my admiration for their faith in the moment of sickness and confessed my lack of confidence at the beginning of the visit, doubting my ability to serve them as a chaplain intern. After that, the patient and her daughter shared with me words of support and encouragement. The visit went well and built up my confidence. I observed that the patient was happy to have helped boost my confidence. Because she had been helpful, she also felt useful. I learned from that experience that no matter our religion we can learn from one another with mutual respect.

Reflecting on that visit, I realized that my anxiety and lack of confidence were based on my desire to be in control of the visits. I need to allow God to be in charge. In words and deeds, I have to put God in the center and in charge of my visits since it is not I who gives hope but God. Through the nurse who referred the patient to me and through the patient and her daughter I gained confidence. As a missionary, even though there is a certain distance between me and the ones I serve, I realize that I am not superior to them and they are not inferior to me. The main difference is in terms of function. We all can learn from each other.

In conclusion, having a CPE experience has been beneficial for me as a person, as a Christian and as an SVD missionary in formation. I have experienced the grace of God working with people from different cultural, educational, social, political and religious backgrounds. I have learned to work and serve them with love and dedication. I definitively experienced many faces in one heart.

II

THEOLOGICAL APPROACHES

12

DISABILITY AND MISSION

Brian Junkes, SVD
USC - Chicago Province

2019 was a transitional year of sorts for me. It was the final year of a decade, the year when COVID-19 began to spread, the year when I professed my first vows as an SVD, started studying theology in the Master of Divinity program at Catholic Theological Union, and began serving people with intellectual and developmental disabilities with the Special Religious Development (SPRED) program of the Archdiocese of Chicago, United States of America. Little did I know that disability would have greater meaning and impact on my life and mission than I anticipated.

I began being involved with SPRED not long after I started studying theology at Catholic Theological Union. A confrere, who was already active in SPRED, invited me to come and see what it was about. SPRED does religious formation for children and adults with intellectual and developmental disabilities to "become prepared to participate in the liturgical life of their parish" (Special Religious Development, 2022). SPRED was established by Fr. James McCarthy in 1966 as an agency of the Archdiocese of Chicago that would grow into a ministry in several dioceses in the United States and other countries. SPRED uses the "symbolic method" in religious formation. It relies on the senses, relationships

and experiences of all involved rather than teaching catechism in a traditional classroom setting. When words alone or speaking eloquently is not enough for catechesis, then relating life experiences to faith, utilizing the senses during bonding and sharing everyday experiences can point towards the love and goodness of Jesus (Gallagher, 2010). This is what caught my attention and appealed to me from the very beginning of getting to know the ministry of SPRED.

I accepted my confrere's invitation and went to a pizza party that included some of the staff of SPRED and some of the people that the ministry serves, who we call "friends." During the meal, I was able to have wonderful conversations with my new friends that focused on various topics, which ranged from movies that we like to watch to painful personal experiences of being bullied in primary school. This soon led to me becoming a catechist assistant for the adult group at the SPRED Center. This ministry would have a profound impact on how would come to see myself, view theology, consider seminary formation and much more. As I continued in my ministry at the SPRED Center, my perception of people with disabilities began to change. I started the ministry with little to no knowledge about disability, including the stigma and discrimination that people with disabilities face. I myself have a learning disability that was diagnosed in my childhood. Even though I have a disability, I was unaware of what other people with disability were experiencing. SPRED helped me to explore my identity as a person with disability, to become more educated on the topic and grow more as a person and an SVD.

During my first year of theology, I reflected and pondered on what I had in common with the people I serve at SPRED. I did so not only because of our shared humanity and faith, but also because of my learning disability. During reflections, I became increasingly aware that being a person with a disability, I have also experienced ableism, which is discrimination towards persons with disabilities. Common

forms of ableism are bullying, exclusion from social events or gatherings and groups, ridicule or micro aggressions for being considered different and even weird. Having had such problematic experiences made it difficult for me to perform certain tasks, not because of having a disability but because of experiencing subtle and not so subtle violence and aggression and being unable to engage in certain events that were not prepared to facilitate participation of individuals with disabilities. When I started at SPRED, I often felt uneasy around the friends and felt different from them. Feeling uncomfortable, I asked myself what I could do for them, without feeling a common bond. Over time, I became aware that these feelings are the result of my own internalized ableism. Recognizing this, I began to change and learned to maintain a presence, to listen, to let friends guide me and to adapt to whatever situation I was in. This is not just important for relating to individuals with disabilities but is also the essence of being a missionary in another culture. The experience at SPRED helped me to understand what it means to pass over into another culture, being a missionary and an SVD, and being able to recognize Christ in others. This made the experience of SPRED so profound for me. It taught me how to live my religious vocation.

My friends at SPRED taught me to just be myself and not to worry about the difficulties I face in life, studies and ministry, or even what others thought of me. All I needed to do was to be me and to accept that my presence is welcome. After adopting such an attitude, I began to look forward to going to SPRED. Even now I cherish this ministry and recognize its importance for my personal growth and formation. I began to see how understanding my disability and accepting my identity as a person with a disability were extremely important to being more accepting of myself and to becoming a better SVD missionary. In other words, learning about and better understanding my own disability is an integral and valuable part in my personal seminary formation, alongside learning about other aspects of life,

such as my family of origin, the traumas I may have experienced, possible addictions I may struggle with, and other facets of human life. What I learned and experienced through and with my friends at SPRED has been personally transformative.

I applied what I learned at SPRED when I ministered as a hospital chaplain during my Clinical Pastoral Education (CPE). I met many people with disabilities and even served in an epilepsy and seizure unit, making rounds and visiting patients. A good number of the individuals that I visited did not have many visitors and would share their own experiences of ableism with me, such as being called stupid and slow, and gas lighted into believing they were not worthy to have someone assist them with support needs. The experience at SPRED even informs my current ministry in North Africa, as I am do my Cross-Cultural Training program (CTP) in Chad. I frequently meet people with disabilities, who participate in communion services and to whom I bring communion. Many of them only have family members that visit them. There are others, who have no one caring for them. When the catechists and I visit, we are the only people who come to see them in the hospital. They have been abandoned by the community and their families because of their disability.

As I have continued to learn more about disability and how integrate such knowledge with theology and to apply to my ministry and vocation, I have come to learn that a lot of people don't know much about disability, even in the church. This is problematic because no matter where you are as a seminarian, priest, or brother and what ministry or work you do, you are bound to meet someone with a disability. Plus, if you do not have a disability now, you are likely to have a disability later in life. As we age and our body and mind become increasingly frail, we have to learn how to live with personal disabilities. It's important to understand that disability and its challenges are part of life. One also has to

deal with problematic and discriminating responses received, at times, from members of society. The statistics and other data on what people with disabilities go through are evidence of this. The United Nations estimates that world-wide there are one billion people with disabilities in the world. That is about 15% of the world's population and 80% live in developing countries (World Health Organization, 2022). Only forty-five countries in the world have anti-discrimination laws to protect people living with disabilities, making sure they can thrive like anyone else (United Nations, 2022). According to UNESCO (2020), children with disabilities are 2.5 times more likely not to attend school. The International Labor Organization (2007) records that of the 386 million working-age people who have disabilities, many face unemployment in their home countries and employers often assume they are unable to work. This ignores the fact that most people with disabilities are able to be productive members of their society if minor adjustments and accommodations are made to their workplace, schedule and routine.

There are also statistics and data on churches and people with disabilities. It is estimated that 46% of families with children with disabilities have never been asked by a faith leader how to include their children in the life of the church (Understood for All, 2018). More than 90% of families with children with disabilities cited a "welcoming attitude" as most helpful for them and their children to become part of a church community (The Banquet Network, 2018). In my ministry with SPRED, I heard many stories from families that they were about to give up and leave the church entirely until they discovered SPRED. These families were told that their children could not participate in religious education for first communion and confirmation because of their disabilities. They were not given any alternatives to prepare for the sacraments. When the church excludes people with disabilities, it is excluding their families as well. Of the total global population of people with disabilities, it is estimated

that only 5 to 10% are effectively served by the church (The Banquet Network, 2018). This means that people with disabilities are one of the groups most excluded from Christianity. It was SPRED that welcomed these families and created a space where their children and family members with disabilities could fully participate. SPRED continues to do so, as I discovered.

Jesus spent much of his time with people with disabilities. The ministry and mission of Jesus Christ primarily focused on people who were excluded, marginalized and oppressed. Some people that come to mind are prostitutes, tax collectors, fishermen, Samaritans and people with disabilities, such as the blind (John 9:1-41; Mark 10:46-52), the deaf (Mark 7:31-37), the paralytics (Mark 2:1-12), and people suffering from chronic illnesses (Mark 5:25-34). There are many additional narratives and passages in the New Testament that mention people with disabilities. In short, people with disabilities were important to the ministry and mission of Jesus of making God's reign present. His ministry would ultimately lead to his passion and resurrection. He himself became disabled from the wounds he received during his passion. If people survive something so horrific and recover, it would leave their bodies physically disabled and emotionally scarred. The passion and resurrection of Jesus, not only shows who Jesus is, revealing the mysteries of the incarnate God, it is also showing Jesus as the one who identified with the human experience, especially with those who are marginalized, such as people with disabilities. The life, death and resurrection of Jesus is something we can identify with and participate in through the ministry of SPRED, journeying and fostering relationships with people with intellectual, developmental and other disabilities, or as SVDs participating in mission and passing over to people of cultures different from our own. For me, who has a disability, I can also see my own experience with disability reflected in the Gospel accounts of Jesus Christ.

The miracles that Jesus performed for people with disabilities play important roles in his earthly ministry of making God's reign present. However, when we focus on the miracles themselves, there is the danger that the people who were marginalized and excluded, become objectified as instruments for theological messaging. We can forget that those who were healed are real people! We have to remember that Jesus restored broken relationships through healing and brought the sick and disabled back into the community of the people of God. Even though we may not be able to perform miracles like Jesus, we have the capacity to establish relationships, reintegrate the sick and disable into the community which excluded them and pushed them to the margins. We can help people with disabilities participate in God's mission by bringing the Good News to others. It is important that we make sure the church is accessible to people with disabilities.

There are ways that we Divine Word Missionaries can use to make sure the church is accessible to all. We are already doing something, such as making our buildings handicap-accessible and bringing communion to people with disabilities, unable to attend church services because of their disability. There are other things that can be done to make our parishes, schools and communities more welcoming, supportive and accessible. This can also be achieved by hiring people with disabilities, hold education workshops on disability and starting ministries for people with disabilities. This can be done in our schools, formation houses and our communities to foster understanding and acceptance, get rid of ableism and incorporate people with disabilities into God's mission.

In conclusion, disability has not only played an important role for me to know who I am, it has also helped me to discern my vocation as an SVD and to recognize that people with disabilities are one of many different groups of people and cultures that are integral to our mission. Taking time to

learn and understand disability has helped me to become more whole as a human being and an SVD who wants to serve God's people. It has made me more aware of how even God's people can be marginalized, excluded and alienated. It has taught me the importance of being empathic and prepared to go to the margins and journey with others in need of God's love and grace.

13

INTERCULTURAL MINISTRY IN MUTUALITY WITH THE "DISABLED"

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When Jesus encountered the ten lepers (Luke 17:11-19) and the Gerasene demoniac (Luke 8:26-39), he was an instrument of healing of physical, social, mental and spiritual illnesses. In the former, the lepers suffered from a very serious skin sickness, social isolation and most likely related mental and psychological anguish. Through Jesus' ministry, they were healed physically, socially and mentally. Jesus told the one who returned to thank him, "Get up and go on your way; your faith has made you well" (Luke 17:19). Jesus acknowledged the faith and spiritual wellness of the leper. The man, possessed by evil spirits and living naked among the tombs, suffered socially, mentally, spiritually and physically. Imagine the social isolation for people like him who would sometimes be "kept under guard and bound with chains and shackles" (Luke 8:29) for his own protection and that of others. In Mark's account, "Night and day among the tombs and on the mountains, he was always howling and bruising himself with stones" (Mark 5:5). Through Jesus, the person was freed from social, mental, spiritual and physical hindrances. He was able to

move from living in a cemetery to return to his home (Luke 8:39) - from being among the dead and excluded from society, to returning home, being among the living in a caring and supportive environment.

The focus of Jesus' mission was the message and embodiment that the Kingdom of God is at hand. Jesus preached about the Kingdom through the parables and witnessed to the inclusivity of God's invitation to the Kingdom through his encounters with the non-Jewish Canaanite/ Syrophoenician woman (Matthew 15:21-28; Mark 7:24-37), the Samaritan woman at the well (John 4:1-30) and his table fellowship with marginalized Jewish persons (Luke 5:29-30; 7:36-38; and 19:5-6). In the two healing incidents introduced above, Jesus had also moved beyond his Jewish geographical and cultural boundaries into the Gentile country of the Gerasenes and the region between Samaria and Galilee. Furthermore, the leper who returned to thank Jesus was a Samaritan. Jesus' boundary-breaking mission not only extended beyond ethnic, social and religious boundaries, but Jesus' inclusive and holistic ministry included spiritual, physical and psychological healing. He forgave sins, cast out demons and healed all types of physical and mental impairments. The Kingdom of God is intended to impact every aspect of our life.

How do we situate this holistic healing and inclusive Kingdom of God ministry within the SVD theology and practice of mission? The 2012 SVD General Chapter highlighted the importance of interculturality in terms of both the *ad extra* dimension of mission work and the *ad intra* dimension of internal SVD life. "Our intercultural mission is a way of giving witness to the unity and diversity of the Kingdom of God…" (Society of the Divine Word, 2012b:16, par. 5). "Interculturality is a distinguishing feature and an essential part of our identity" (Society of the Divine Word, 2012b:23, par. 26). The SSpS had already highlighted the theme of interculturality in their 2008 General Chapter,

and both congregations have continued developing their understanding and practice of interculturality through the joint Resource Committee of Interculturality (RCI), programs in Nemi and Steyl and recent General Chapters (Society of the Divine Word, 2018:28-33, par. 27-33). Interculturality is understood as a mutually enriching and challenging encounter among individuals and groups of different cultures. It is essential to note that "culture" here is understood from its postmodern understanding to include: ethnicity, race, language and nationality; social change (due to, e.g., social media, COVID-19, virtual learning and workspace); social location (e.g., female/male, rich/poor, social status, power dynamics, generations); and particular communal circumstances. Making any of these distinctions between ourselves and those who are different from us (the "other") can often lead to inappropriate attitudes, behaviors and judgments based on prejudice. In other words, prejudice, misunderstanding, misjudgment and mistreatment (even violence) grow out of these various "us/them" categories.

Recently, I have become aware of another "us/them" cultural category--that of the abled and disabled. In my 2021 Fall semester course of "Praxis for Intercultural Transformation" at Catholic Theological Union (CTU), I followed the Paolo Freire method and facilitated the creation of a "community of learners" among teachers and students (Freire, 1970:57-74). One of the students, David Gayes, who has significant physical disabilities, has been very involved on the local and national levels in advocacy for the rights of people with disabilities, such as those protected through the Americans with Disabilities Act (ADA) policies. During his contributions to the "community of learners" dynamic, David helped me and others in the class to understand how ability and disability are treated as one of the "us/them" categories. We are not only striving for toleration, understanding, accessibility and inclusion for people with disabilities (which are all very important issues), but

we need to go further to strive to be mutually enriched and challenged by the "other" within both Freire's circle of learners' process and the vision of interculturality.

Before proceeding, we need to acknowledge that the term "disability" itself is a problematic concept. First of all, who determines who is mentally, physically and/or socially disabled? Usually, those with power and/or considered in the "mainstream" make those determinations, and these categorizations differ across contexts and cultures. In contrast, Jesus reached out to the marginalized and extended his ministry to all. Within this framework, "disability" should be understood to be a socially constructed category, since locating disability within the individual's mind or body is inaccurate and stigmatizing. As we learn from individuals with impairments, "their disability primarily stems not from their physical differences but from the ways others respond to those differences and from the choices other have made in constructing the social and physical environment" (Weitz, 2010:132). In other words, we create disability through social arrangements and how the majority structures society.

Secondly, I propose that we consider "disability," however it is defined, in terms of a human variation instead of a deficit. Thirdly, from the perspective of acknowledging human imperfection and woundedness, based on biblical teaching (i.e., earthen jars), we are all "disabled" in one way or another. I am reminded of the late Millie Henke, a woman with significant physical disabilities. She was on the CTU staff for many years since the 1970s when accessibility with a wheelchair was very restricted, for example, in terms of access to buildings, use of sidewalks and restrooms, and special parking spaces. At the same time, Millie was like a spiritual director and companion for many of us, including myself. I never forgot her words, "Roger, we are all disabled… my disablement is just more visible."

In June 2022, I was part of an in-person panel during the annual conference of the American Society of Missiology (ASM), on "Re-imagining Mission Through Disability." I was asked to provide a missiological response to three papers. The first presentation was by Benjamin Connor, author of *Disabling Mission, Enabling Witness: Exploring Missiology Through the Lens of Disability Studies* (2018), director of the graduate Certificate in Disability and Ministry at Western Theological Seminary (Holland, United States), and father of someone considered mentally disabled. In his presentation, *Toward a Disability Missiology: Framing the Conversation* (2022), Benjamin Connor proposed the following insightful question: "How can people with disabilities enrich our shared understanding of what God is doing in the theology and practice of Christian witness?" This challenges missionaries and ministers to shift the understanding of mission and witness from competencies, skills, or intelligence to how we participate in God's mission simply through our presence and being with people. The renowned theologian Leslie Newbigin asserts that the participation of people with disabilities in mission is a reminder that all ministries should reflect the weakness and vulnerability of the cross and true reliance on God. Newbigin made this strong statement regarding the gift of persons with disabilities: "Only with this witness as part of its total message does the Church's message measure up to the heights and depths of the human situation.... If the Church does not ensure that [peoples with disabilities] have a place at the very heart of its life then it denies and dishonors him who reigns from the cross, who saved others, but would not save himself" (1979: 25).

In other words, the mission of the Church would be incomplete if it does not acknowledge and value the contributions of all people, including people with disabilities, who in particular witness the link between vulnerability and the self-giving love of Jesus and those who follow him.

The second person on the ASM panel was Andrew Opie, who has been blind since he was twenty and is currently a doctoral student at Trinity Evangelical Divinity School (Deerfield, United States). He developed his paper, titled *Clay Jars, Disability, and Who Is 'Able' to Go?* (2022), around the person and writings of St. Paul, particularly the image of the earthen jar in Second Corinthians. Rather than using triumphalist imagery, the treasure of God's light and life is contained in ordinary, unadorned vessels, used for daily purposes, "so that it may be made clear that this extraordinary power belongs to God and does not come from us" (2 Corinthians 4:7b). And clay jars have cracks which metaphorically represent human broken-ness, prejudices, limitations and disability. Paul found himself dismissed for not measuring up to Corinthian standards and expectations regarding proper behavior and being dismissed possibly because of poor speech (stuttering?), appearance, ability and/or physical limitation. Paul himself acknowledged his weakness as what he called his "thorn in the flesh" (2 Corinthians 12:7-10). The image of the clay jar challenges the understanding of who is "able" to be involved in mission and ministry. God's treasure is seen through the limitations and "cracks" in all human lives.

Delving deeper theologically, biblical scholar Michael Gorman (St. Mary's University, Baltimore, United States) has pointed out that Philippians 2:6, "…Christ Jesus, who, though he was in the form of God, did not regard equality with God as something to be exploited…," could be translated as "…because he was in the form of God, did not regard equality with God as something to be exploited" (Gorman, 2015:107, note 6). In its revision of the original 2003 document on disability, *The Gift of Being: Called to be a Church of All and for All* (2016), the World Council of Churches supported the alternative interpretation of Philippians 2:6 of "because he was in the form of God," by pointing to the essential connection between God's love and God's vulnerability (paragraph 100). Therefore, those

persons considered "disabled" remind all of us that being created in God's image, who was vulnerable on the cross, calls us to accept and embrace our vulnerability (humanness) as we experience and express God's love. In Paul's words, "So, I will boast all the more gladly of my weaknesses, so the power of Christ may dwell in me" (2 Corinthians 12:9).

The third paper at the ASM panel on disability was presented by Audrey Seah, who teaches at Loyola University Maryland (Baltimore, United States) and works with the Roman Catholic deaf community. For her presentation on *Deaf Contributions to a Postmodern Theology of Liturgical Inculturation* (2022), she drew upon her disciplines of liturgical inculturation and interculturality and her experience with the deaf community. Similar to the two preceding papers, Seah showed how the perspective and experience of persons with disabilities can contribute to mission theology and practice in the church. Within the context of liturgical inculturation, the liturgy for the deaf witnesses to hospitality, inclusiveness and the variety of possible expressions of prayer and worship. Furthermore, it is an effort to inculturate and adapt the liturgy to the context of a congregation, which in this case includes deaf persons with and without speech, with and without knowledge of sign language and family members and friends who can hear and speak. Such a liturgy and community can also expand the church's vision of the great diversity and giftedness of God's people, beyond simply ethnicity, race and nationality.

Several years ago, I had the privilege to preside at a Sunday eucharist at the SPRED Chapel of the Archdiocese of Chicago (Special Religious Development, 2022) which ministers to people with intellectual and developmental disabilities and their families.

The scripture readings were proclaimed through interpretative movement and dramatization and every action and

aspect of the liturgy included both abled and disabled persons, except for the Eucharistic presider. The homily consisted of the following two sentences which I repeated three times as I moved from one section of the congregants to another in the fan-shaped worship space: "You are God's children and God loves you." The environment and artwork also beautifully complemented the inculturated liturgy for the "multicultural" SPRED worshiping community of disabled and abled congregants of various ages and circumstances. I was reminded of this experience as Seah described the liturgy for the deaf community. How it broadened my image of the church and of God! The variety of people created in God's image. In the words of ex-slave Sojourner Truth, "Oh, God, I did not know you were so big" (Truth, 1996:173).

What can we learn from these three conference papers? First of all, Connor points out that our understanding and practice of mission can be enriched and challenged by people with disabilities, who are marginalized in our society and church. Our definitions of the "who", "what" and "how" of mission need to be expanded, and in this process, we are reminded that mission is primarily about God's grace and not our own abilities. Opie takes this further by reminding us that we are all clay jars with our "cracks" of broken-ness, prejudice, human limitations and inabilities (disabilities) in various forms. In this way, we are reminded that mission is to be done out of a sense of humility, vulnerability and trust in God. Finally, Seah situated us within the context of liturgy, whereby just as a community of abled and/or disabled persons need to find their particular ways of experiencing and expressing God's love in their own appropriate (inculturated) way, so must every worshiping community do so according to their context. These papers contributed to my identification of people with disabilities as another "us/them" category which needs to be encountered with the lens of interculturality.

Earlier, I defined the SVD mission of interculturality as the mutual enrichment and challenge among those who are considered "others." Similar to this dynamic among people of different ethnicities, races, generations, genders and economic classes, in this chapter I have explored the vision of interculturality between the abled and disabled, however that is defined. I have focused on how the Church and missionaries, ministers and all Christians can be enriched and challenged by those considered people with disabilities. On a human level, how do we look at and value those with disabilities, and then how can perceptions of our own self-worth be stretched beyond the list of certain abilities and accomplishments? In the church, how do we offer hospitality and acceptance to people with disabilities in our worship and ministry settings, and then what can we learn from them in terms of a spirituality of vulnerability? As missionaries, how do recognize the giftedness of every person, disabled and abled, for participating in God's mission, and how does this challenge and enrich our understanding of the practice of mission? Theologically, persons with disabilities enrich our understanding of the Reign of God with all people being invited to share in the banquet.

At the same time, people with disabilities can be enriched and challenged by the hospitality, accompaniment, openness and affirmation of abled persons. In a recent Zoom conversation with a novice with cerebral palsy, she was so thankful for the acceptance and encouragement from her "abled" parents for her to be the best person she was called to be. She also appreciated being accepted as a candidate and now a novice in a women's religious congregation. Not all congregations were open for that. As those who are committed to interculturality and mission, the SVDs are challenged by the probing question of Connor: "How can people with disabilities enrich our shared understanding of what God is doing in the theology and practice of Christian witness?"

In conclusion, I propose that the SVD (and SSpS) use the perspective of interculturality to situate all the chapters in this volume on *Participating in God's Mission to Heal* within the SVD understanding and practice of mission. In each of these scenarios and vocations, the SVD authors are reaching out to the "other" and in this way, they are crossing an "us/them" category. We are being instruments of an integral boundary-crossing ministry, as Jesus did for example with the lepers and the Gerasene demoniac. We are participating in the extension of the Reign of God to all peoples, and we at the same time are being enriched and challenged by the "other" in those encounters.

14

BRINGING CHRIST TO CHRIST: THE SACRAMENTAL AND TRINITARIAN HEART OF THE CHURCH'S HEALING MINISTRY

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This marvelous collection of reflections and stories from those Divine Word Missionaries called to the ministry of healing across the globe - in Chicago, Iowa, Austria, Kenya, Tanzania, the Philippines, India, Taiwan, Democratic Republic of the Congo, Australia, Zimbabwe and more - gives moving testimony to the depth of the SVD charism of healing and evangelization and the real power of the gospel in the 21st century. It witnesses an integral and wholistic understanding of health and healing, taking a myriad of forms as appropriate to different places and contexts, a mission lived in and sustained by a vibrant, collaborative community.

In my contribution to this volume, I wish to affirm these stories and the SVD mission by situating them within their historical, ecclesiological and theological contexts. In the first section, I outline the history of the church's commitment to caring for the sick - a practice rooted in Christ's own

ministry that has flourished in multiple forms in every place Christianity has gone over the past two thousand years. The centrality of this work of caring for the sick to the mission and witness of the church has been re-affirmed in the Second Vatican Council and a variety of magisterial voices, which I bring into our conversation in the second section. In the third section, I turn to the words of Pope Francis, showing how he theologically reorients this healing mission, not only reprising millennia of tradition but also making visible once again its fundamental sacramental and Trinitarian dynamism.

I hope that these reflections affirm the lifelong vocation embodied via the health professions of so many Divine Word Missionaries and encourage the next generation to continue this critical work of embodying and expanding the health apostolate, participating in the work, as the title suggests, of bringing Christ to Christ.

Pilgrims Continuing a Long Tradition

Sitting in a clinic in rural Tanzania or in a hyper-industrialized hospital in the United States, one might be excused for feeling that one is at a remote outpost, a pioneer in uncharted mission territory, far afield from the church. Yet in seeing a Maasai patient in a dispensary or counseling street dwellers in Chicago or the Philippines, one stands in a two-thousand-year tradition of the church's apostolic ministry of caring for the sick. You are pilgrims, we might say, on the most recent leg of a long camino[4] that stretches back to the Gospels.

As those devoted to the Word know so well, healing the sick was one of Jesus' main activities prior to his passion, death and resurrection. The United States Bishops capture this

[4]This Spanish language noun refers to a road or a path that leads to specific destination.

succinctly at the beginning of their document *The Ethical and Religious Directives for Catholic Healthcare Services* (2018). As they say, Jesus: "…cleansed a man with leprosy (Matthew[5] 8:1-4; Mark 1:40-42); he gave sight to two people who were blind (Matthew 20: 29-34; Mark 10:46-52); he enabled one who was mute to speak (Luke 11:14); he cured a woman who was hemorrhaging (Matthew 9:20-22; Mark 5: 25-34); and he brought a young girl back to life (Matthew 9:18, 23-25; Mark 5:35-42). Indeed, the Gospels are replete with examples of how the Lord cured every kind of ailment and disease (Matthew 9:25). … Jesus' mission fulfilled the prophecy of Isaiah: 'He took away our infirmities and bore our diseases' (Matthew 8:17; cf. Isaiah 53:4)" (United States Conference of Catholic Bishops, 2018).

The Gospels are indeed replete with healing stories. Mark includes seventeen healing stories, Matthew and Luke twenty-one each. John's gospel, which is slightly different than the other three, contains four lengthy healing stories (John 4:46-54, John 5:2-17, John 9:1-41 and John 11:1-53). Overall, healing is mentioned at least once, and often more than once, in 56% of the chapters in Mark's gospel, 50% of the chapters in Luke and 36% of the chapters in Matthew.

Given the centrality of healing to Jesus' mission, it is no surprise that he extends participation in this healing ministry to his followers, specifically commissioning those who follow him to include care for the sick as a key part of their work (e.g., Mark 3:13-15, Mark 6:6-13, Matthew 10:1,8, Luke 9:1-3,6, Luke 10:1-3,8-9). Caring for the sick is central in the paradigm parable of the Good Samaritan (Luke 10:29-37). And in Matthew 25, Jesus proclaims that a key criterion for being welcomed into the Kingdom of God

[5]While this and other quotes from published sources use abbreviations of Biblical books and letters, the names of Biblical texts have been written out in this chapter to be consistent with the rest of the publication.

is whether or not a person cares for the sick: "For I was hungry and you gave me food, I was thirsty and you gave me drink, a stranger and you welcomed me, naked and you clothed me, *sick and you visited me*, in prison and you visited me. Then the righteous will answer him and say, 'Lord, when did we see you hungry and feed you, or thirsty and give you drink? When did we see you a stranger and welcome you, or naked and clothe you? *When did we see you ill or in prison, and visit you?'* And the king will say to them in reply, 'Amen, I say to you, whatever you did for one of these least brothers of mine, you did for me' (Matthew 25:34-40)" (emphasis added).

Despite our contemporary habit of treating these words metaphorically, Jesus makes clear that those who have attended to the material and corporal needs of their neighbors are saved and those who have not are condemned (Matthew 25:46).

Based on this Gospel witness and commission, caring for the sick was an integral part of the lives of the earliest Christian communities from the beginning. One of the earliest references comes in the Epistle of James, with its discussion of anointing the sick (James 5: 13-15). A document titled *The Apostolic Tradition of Hippolytus*, dating from around the third century, outlines what might be called early canon law. Prior to admitting catechumens to baptism, the Church at this time specifically asked whether they had been faithful in visiting the sick—a requisite for becoming a member of the Body of Christ (Easton, 2020: no. 20). The canons also obligated bishops to visit the sick in their own houses. Medical anthropologist Hector Avalos and sociologist Rodney Stark credit the early Church's care for the sick as an important factor in the rise of Christianity itself.[6]

[6]For those interested in reading more about the practice of caring for the sick in the early church, see: Avalos (1999), Stark (1997), and Ferngren (2009).

Although it has taken different forms over the centuries, this Christian commitment to caring for the sick laid the groundwork for our contemporary practice of healthcare. In 370 CE, Basil the Great, bishop of Caesaria, created what many count as the first public hospital (the basileum), mirroring institutions called xenodocheia established to care for the poor in the Eastern church. Following the demise of the Roman Empire, monastic communities carried the Church's commitment to caring for the sick forward, sustaining the knowledge of medicine through the Middle Ages and being one of the main locations for medical care. By the 11th century, caring for the sick began to shift out of the monasteries, especially in urban settings. Bishops began building *hospitalia*, often attached to cathedrals.[7]

In the same period, in response to various plagues and epidemics, a series of religious orders devoted specifically to caring for the sick and the dying were established, multiplying over the centuries—the Alexian Brothers, the Cellites, the Camillans, the Brothers of St. John of God, the Vincentians, the Daughters of Charity, the Sisters of Mercy and more. In 2013, there were at least 176 Roman Catholic religious orders in the US alone that include healthcare as a focus of their charism and ministry.

In the United States, the history of Catholic healthcare began in 1728, when fourteen Ursuline sisters arrived in New Orleans to establish a hospital for the poor sick (Kauffman, 1995; see also: Wall, 2011). In 1823, physicians at the University of Maryland opened an infirmary in Baltimore that was staffed by five Sisters of Charity. As a result of the work of the thousands of religious men and women who staffed the mission fields of the United States, the Catholic health ministry is now the largest group of nonprofit healthcare providers in the United States.

[7] For more on this early history see Risse (1999), particularly chapters 2 and 3.

Comprising more than 640 hospitals and 1,600 continuing care and other health facilities. Catholic healthcare institutions care for one of every seven patients annually (Catholic Health Association, 2022).

The Roman Catholic Church is also the largest non-governmental provider of healthcare services globally, managing an estimated 26% of the world's healthcare facilities (Catholic News Agency, 2011). As of 2013, it was overseeing approximately 5,500 hospitals, 65% of them outside of the US and Europe (Calderisi, 2013: 40). Catholic healthcare provides the bulk of the care in the Philippines and comprise roughly ten percent of the provision in Australia. With over 18,000 clinics, the Catholic health ministry plays a crucial role in Asia, India, Africa and across the Global South.

One of the Most Vital Apostolates of the Ecclesial Community

Beyond simply continuing a long tradition, the SVDs who embody their vocation via caring for the sick are affirmed in this work by the Catholic theological tradition. From the Second Vatican Council, we hear that the work of caring for the sick in its many forms is both a continuation of Christ's mission and one of the most vital apostolates of the ecclesial community. While many voices could be marshalled to demonstrate this, I will simply highlight three - the United States bishops, Saint Pope John Paul II and the Council itself.

The United States Conference of Catholic Bishops opens the *Ethical and Religious Directives for Catholic Healthcare Services* (2018) with a powerful theological affirmation: that Catholic healthcare is connected both to the historic person of Jesus as well as to the ongoing work of the risen Christ in the world. As they state:

> The Church has always sought to embody our Savior's concern for the sick... The mystery of Christ casts light on every facet of Catholic healthcare: to see Christian love as the animating principle of healthcare; to see healing and *compassion as a continuation of Christ's mission;* to see suffering as a participation in the redemptive power of Christ's passion, death, and resurrection; and to see death, transformed by the resurrection, as the opportunity for a final act of communion with Christ (United States Conference of Catholic Bishops, 2018; emphases added).

In this short passage, the bishops note three key points. First, by locating the healing ministry within the continuation of the work of Christ, they are also locating it within ecclesiology, as an essential component of the Church itself. Second, as with the early church, they see it as a responsibility not only for members of religious orders or healthcare professionals, as important as these are, but as central to the practice of the faith for all members of Christ's body. And third, they note - as we will discuss further in section three - that this work itself is thickly infused with grace and Christ's presence.

Saint Pope John Paul II expands on these affirmations. Consider, for example, his 1987 address to the leaders of Catholic healthcare in the US. Here he makes clear that even at the highest levels of the Roman Catholic Church, Catholic healthcare is understood to be one of its most fundamental works:

> In you, Jesus Christ continues his healing ministry, "curing the people of every disease and illness" (cf. Matthew 4, 23). This is the high dignity to which you and your colleagues are called. This is your vocation, your commitment, and the path of your specific witness to the presence of God's Kingdom

> in the world. Your healthcare ministry, pioneered and developed by congregations of women religious and by congregations of brothers, is *one of the most vital apostolates of the ecclesial community and one of the most significant services* which the Catholic Church offers to society in the name of Jesus Christ... Today in the United States, Catholic healthcare extends the mission of the Church in every state of the Union, in major cities, small towns, rural areas, on the campuses of academic institutions, in remote outposts and in inner city neighborhoods. By providing healthcare in all these places, especially to the poor, the neglected, the needy, the newcomer, *your apostolate penetrates and transforms the very fabric of American society. … All concern for the sick and suffering is part of the Church's life and mission. … You must always see yourselves and your work as part of the Church's life and mission.* You are indeed a very special part of the People of God. You and your institutions have precise responsibilities towards the ecclesial community, just as that community has responsibilities towards you (John Paul II, 1987: nos. 1-3 and 6).

Here we hear again the healing ministry affirmed as a continuation of Christ's own work. But even more, it is named as one of the most vital apostolates of the ecclesial community, as an extension of the mission of the Church, as part of the Church's life and mission and as a special part of the People of God that embodies the communion of the Church.

In affirming the privileged status of caring for the sick as a ministry of the Church, the Bishops' and the late-Pontiff are drawing on the Second Vatican Council. While the Council recognizes that the mission of the Church in the world can take many forms, it considers activities that particularly

reflect the work of Christ in the Gospels to be essential. We see this, for example, in the *Council's Decree on the Apostolate of the Laity* (1965). There they note:

> Preeminent among the works of this type of apostolate is that of Christian social action which the sacred synod desires to see extended to the whole temporal sphere. …While every exercise of the apostolate should be motivated by charity, some works *by their very nature* can become specially vivid expressions of this charity. Christ the Lord wanted these works to be *signs of His messianic mission* (cf. Matthew 11:4-5). … So, too, in every era [the Church] is recognized by this sign of love, and while it rejoices in the undertakings of others, *it claims works of charity as its own inalienable duty and right. For this reason, pity for the needy and the sick and works of charity and mutual aid intended to relieve human needs of every kind are held in highest honor by the Church.* Wherever there are people in need of food and drink, clothing, housing, medicine, employment, education; wherever men lack the facilities necessary for living a truly human life or are afflicted with serious distress or illness or suffer exile or imprisonment, there Christian charity should seek them out and find them, console them with great solicitude, and help them with appropriate relief (Second Vatican Council, 1965: nos. 7-8; emphasis added).

The centrality of these particular forms of the apostolate to the nature and identity of the Church is signaled in part by their integration into the curial structure of the Holy See. In 1985, the centrality of healthcare for the nature and identity of the Church was affirmed in the establishment of the Pontifical Council for Healthcare Workers. In 2017, that office became part of the Dicastery for Promoting Integral Human Development.

Bringing Christ to Christ

We earlier heard from the 25th chapter of Matthew's gospel. That passage is one in a series of parables about the Kingdom of God and judgement, parables that Jesus tells right before he sets his face for Jerusalem for the passion and resurrection. We hear of the foolish maidens, the strange parable of the talents and then he turns to the judgement of the nations. In the fifth of what are now the six "corporal works of mercy," Jesus turns to the sheep and says, "I was sick and you visited me."

Yet, if we hear this as simply affirming our unidirectional care for the sick, we miss the profound reversals or inversions central to Jesus' parables. This reversal is captured in the jarring words "I was sick." Cutting to the heart, Jesus makes clear that in the person of the sick we meet not solely a person in need of care, but Christ himself. In a radical incarnational move, Christ proclaims that he himself is present in each concretely embodied sick person.

This fundamental Christological affirmation shaped Catholic healthcare for millennia. It is captured in chapter 36 of the *Rule of St. Benedict*. As he says to his novices and monks:

> Before all things and above all things special care must be taken of the sick or infirm so that they may be served *as if they were Christ in person*; for he himself said "I was sick and you visited me," and "what you have done for the least of mine, you have done for me" (Kardong, 1996).

Based on this Benedictine commitment, a distinguishing mark of Christianity was that the sick from the earliest days of the church were ministered to "as our Lord Christ." This commitment is captured by the Second Vatican Council in, again, the *Decree on the Apostolate of the Laity* (1965) where, in continuing the passage cited above, they affirm that "…it is altogether necessary that one should consider in one's

neighbor the image of God in which he has been created, and also Christ the Lord to Whom is really offered whatever is given to a needy person" (Second Vatican Council, 1965: no. 8).

Thus, at the heart of the Christian tradition is a Christological reconfiguration of the sick person. The primary theological reality of caring for the sick is that in the person of the sick, we – astonishingly! - meet Christ, or perhaps more precisely, Christ encounters us.

The second moment of the phrase -"and you visited me" - is equally parabolic, rich with complex theological resonances. On the one hand, the word "visit" (in Latin as well as the original Greek term used in Matthew, *epeskepsasthe*) denotes the commonsense meanings of to go to, the action of taking concrete steps to attend to the sick. But it also contains two important nuances. First, the word "visit" derives from the Latin roots *visere* or *videre* - to see." In the gospels, to the act of coming to see is the act of faith - it is the act of coming to see who Jesus is, which often brings with it healing and is marked as a moment of conversion, of bringing the one who newly-sees to discipleship. It also echoes intertextual references throughout the Hebrew and Christian scriptures of God's act of "visiting" - those events where God's presence is brought to a person or place, events which are experienced as annunciation, comfort, salvation or judgement.

Thus, here we find those who visit the sick reconfigured as well. For while the phrase is nested in a parable of judgement, it is not judgement of those who are sick - it is a judgement of those who attend to the sick or who do not. In the act of visiting, those who attend the sick come to see Christ anew, come to faith anew, are, perhaps, converted anew. At the same time, in bringing God's presence to the sick, those who care for the sick participate in the dynamic life of the Trinity, where God (as visitor) is present to the Son (as sick) through the work of the Holy Spirit.

This is a sacramental dynamic. It is captured beautifully in the words of St. Vincent de Paul, words that lie at the heart of the story of the Daughters of Charity. As the first apostolic - or non-cloistered - order of women religious, they often felt a tension between spending time in prayer or caring for the poor and the sick. St. Vincent advised them repeatedly and variously:

> When you leave prayer and Holy Mass to serve the poor, you are losing nothing, because serving the poor is going to God and you should see God in them (de Paul, 1634:4).[8]
>
> To leave God [only] for God, that is to say, to leave one work of God to perform another, either of greater obligation or greater merit, is not to leave God (de Paul, 1647:384-385 and 614).

Thus, St. Vincent saw a sacramental resonance between the work of prayer and the work of accompanying the sick. Both are sacramental.

This image of recursively encountering God both in prayer and in the sick permeates the work of Pope Francis as well. Although he speaks more generally of the poor, the theology captured in his papal statements fleshes out this dynamic we see in Matthew 25. For Pope Francis, the first step in the dynamic is the Eucharist. The Eucharist is the primary "encounter," the first moment in his "culture of encounter" - the place where God in Christ encounters us.[9] As he says in *Lumen Fidei* (Francis, 2013b), in the sacraments, Christ - who is the Light - encounters us, transforms us, enabling

[8]See also: "If you must leave prayer to attend the sick, leave it, and as you leave God in prayer, you will find God with the sick. Keep your rules and they will keep you" (de Paul 1658: 1118).

[9]In this claim, that resounds throughout Pope Francis' corpus, he explicitly connects to his predecessor: "I never tire of repeating those words of Benedict XVI which take us to the very heart of the Gospel: 'Being a Christian is not the result of an ethical choice or a lofty idea, but the encounter with an event, a person, which gives life a new horizon and a decisive direction'" (Francis, 2013a:, no. 7, citing *Aparecida*, no. 12).

us to see all things anew (Francis, 2013b: nos. 4, 13, 44). In other words, the sacramental encounter with Christ provides the lens for seeing and knowing reality in new ways. It does so through our union with or participation in the Christ who encounters us.

> In faith, [Francis says, again in *Lumen Fidei*] Christ is not simply the one in whom we believe, the supreme manifestation of God's love; he is also the one with whom we are united precisely in order to believe. Faith does not merely gaze at Jesus, but sees things as Jesus himself sees them, with his own eyes: it is a participation in his way of seeing (Francis 2013b: no. 18).

The word "participation" here is key. In encountering the Christ who is always already there, waiting to encounter us, Christ enables us to see and to encounter others. "Transformed by the love to which [we] have opened [our] hearts in faith," as Francis says in *Lumen Fidei* (Francis, 2013b: no. 21) we are enabled to share Christ's love, mercy, joy and peace. But this is not our work - rather, in these encounters, Christ works in, with and through us. Thus, in Francis' vision of a missionary church, we are sent out into the world to bring the presence of the Christ who has encountered and transformed us to persons, to cultures, to the peripheries.

But this vector between us and the peripheries - in our case, the sick - is (again) not unidirectional. Rather, by going to the peripheries, we not only bring God's grace - as importantly, we are again encountered by God in Christ, this time among God's wounded people. For Pope Francis, the poor are a second *locus theologicus* (2013a: no. 126). This is why Francis "wants a Church which is poor and for the poor" and for those on the peripheries. Because they evangelize us. As he notes:

> [The poor] have much to teach us. Not only do they share in the *sensus fidei*, but in their difficulties they know the suffering Christ. We need to let ourselves be evangelized by them. The new evangelization is an invitation to acknowledge the saving power at work in their lives and to put them at the centre of the Church's pilgrim way. We are called to find Christ in them, to lend our voice to their causes, but also to be their friends, to listen to them, to speak for them and to embrace the mysterious wisdom which God wishes to share with us through them (Francis, 2013a: no. 198).

Thus, again, as in Matthew 25, as for St. Vincent, in the sick, Christ encounters us. In this way, the sick are sacramental - perhaps, we could call them, a *locus sacramentum*. They are for Francis a place where the suffering, wounded body of Christ is truly present,[10] where in caring for the sick, we "[touch] the suffering flesh of Christ in others" (Francis, 2013a: no. 24). But we could also say that this dynamic is Trinitarian, for as we move from the Eucharist - from Word and sacrament - the Christ in us meets the Christ on the peripheries, again and again and again, mirroring the perichoretic[11] dynamic of the Trinity, where the Persons encounter endlessly encounter one another in creative, redemptive and transformative joy.

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[10]For Pope Francis, "our brothers and sisters are the prolongation of the incarnation for each of us" (Francis, 2013a: no. 179). He continues beautifully: "'As you did it to one of these, the least of my brethren, you did it to me' (Matthew 25:40). The way we treat others has a transcendent dimension: 'The measure you give will be the measure you get' (Matthew 7:2). It corresponds to the mercy which God has shown us: 'Be merciful, just as your Father is merciful. Do not judge, and you will not be judged; do not condemn, and you will not be condemned. Forgive, and you will be forgiven; give, and it will be given to you… For the measure you give will be the measure you get back' (Luke 6:36-38)."

[11]Perichoresis describes the relationship of the Trinity's three persons. The Greek term can be translated as "co-indwelling," underscoring that each person shares in the life of the two others. The Trinity is a "community of being" in which each person, while maintaining its distinctive character, penetrates the others and is penetrated by them (Twombley, 2015). As we care for the sick, we are drawn into this "community of being."

Conclusion:
The Word Made (Wounded and Scarred) Flesh

As Alexander Rödlach, SVD notes in his introduction to this volume, "'The Word was made flesh and dwelt among us' (John 1:14) and an important part of our missionary work is to show God's love by caring for the wounded and scarred flesh of those whose life we share…." Caring for the sick is an essential component of the SVD mission of caring for the wounded and scarred flesh of those on the world's many, many margins, whose lives we are called to share. Each time we do so, we meet, encounter and care for a unique, invaluable person made in God's image. And as importantly, each time we do so, we encounter in their wounded and scarred flesh the Word there incarnate. By making present God's love, hope and mercy to the wounded and scarred, we are simultaneously renewed again by the Christ encountered first in his broken and shared Body in the Eucharist. Thus, through both prayer and caring for the sick, we enter ever more deeply into the pain of the world, Christ's redemptive work and the life of the Trinity. Via the work of evangelization (embodying Christ to the world), we ourselves hear the Good News in new and ever deeper ways. What an extraordinary gift!

III

EPILOGUE

15

VERONIKA THERESIA[12] RÁCKOVÁ, SSpS
CARING WITHOUT LIMITS – A MARTYR IN CHRIST'S MINISTRY TO HEAL

Krystyna Szweda, SSpS
Congregational Historical Archivist, Rome

Preface[13]

"When the time for Pentecost was fulfilled, they were all in one place together. … And they were all filled with the Holy Spirit" (Acts 2: 1,4).[14] These words from the Acts of the Apostles were read during the Mass on Pentecost Sunday, May 15, 2016. The Catholic Church in the Diocese of Yei in South Sudan had united with the universal Church to celebrate the Solemnity of Pentecost. The Missionary Sisters Servants of the Holy Spirit (SSpS), serving in the diocese, also celebrated on that day the titular feast of their

[12]Veronika is Rácková's baptismal name and the first name in her government documents. Theresia is the name she took when she joined the congregation. As government agencies use religious sisters' names as recorded in documents issued by governments, some sisters don't use the name they took in the congregation, particularly when they apply for government documents, such as visas and passports. This is what Veronika also did. Thus, we address her in this chapter as Veronika.

[13]This chapter is based on documents in the SSpS Congregational Historical Archives in Rome. The photos are from the congregation's archives as well. The direct quotes from documents in the archives were translated into English by Krystyna Szweda, SSpS from Polish, Slovak and German.

[14]New International Version (NIV).

congregation, dedicated to the Holy Spirit. To mark the occasion, the SSpS community in Yei had invited pastoral workers, known as “Apostolic Communities,” for lunch at the sisters' convent. Like the apostles, they were all together in one place, joyfully praying to be filled with the Holy Spirit as they shared a meal, drinks and good humor. Among them was Veronika Rácková, SSpS, joyful and smiling. Afterwards, all returned home, a little tired but full of gratitude.

Later in the evening the phone rang; a doctor was urgently needed to assist two women in labor. Sr. Veronika, trained as a medical doctor, quickly got into the ambulance and drove to the woman’s house to assist her. The first birth was quick and smooth and brought great joy to everyone present as a new life was brought into the world. The second birth was difficult and required special medical attention. Veronika met with the young lady in labor and determined that she needed to be transported immediately to the Harvester’s Health Center in a nearby village. She didn’t ask another sister to go with her, because it was almost midnight, and she could drive the ambulance to the hospital by herself. Arriving at the hospital, she made sure that the mother received the attention she needed and then drove alone back to the convent. She was very tired but happy; another healthy baby girl had been delivered.

Did Veronika intuit that the last medical service she would provide her beloved people in South Sudan would be to help a young mother give birth to a beautiful child?

She was already close to the convent when shots rang out. She didn’t have time to think who was shooting or why. She did, however, feel a sudden and immense pain. One of the bullets that hit the ambulance she was driving, had entered her abdomen and hip.

Is that how a martyr is born in the healing ministry of Christ?

The Sunshine of Her Family

Veronika Rácková was born on January 8, 1958, in Bánov, a village in the Nitra Region of south-west Slovakia. Her father, Thomas, worked for the national railways and her mother, Mária, was a housewife. They loved their children and tried to pass on to them the cultural and religious values that were the foundation of their lives. They also provided them with a professional education. Veronika was the youngest child in the family; all four siblings grew up happily. Her oldest sister, Pavla, studied medicine; Michael, her brother, walked in the footsteps of his father and worked for the railways. The other brother, Peter, became a diocesan priest.

From early childhood, Veronika was lively, full of ideas and always active. She was known and loved by both her family and the local community. One of the many stories from her childhood illustrates her energetic temperament. Women usually cleaned the village church. Veronika, who lived nearby, was often among them. The women were told not to switch on the public address system during the cleaning of the church and to be especially careful with the microphones. Taking advantage of the priest's absence, Veronika went to the pulpit and tried to preach a sermon, speaking and gesturing with both hands. Just as she got into it, the church door opened and the pastor came in. He pointed his finger at her, saying "Verona,[15] come here." Of course, she was duly admonished not to play with the public address system in the church and not to use the microphone. She was obedient and never again played with the microphone.

Education and Search for Meaning in Life

Veronika attended primary school in Bánov from 1964 to 1973. After graduating, she continued her education at the

[15] "Verona," that's how the family and others called her.

secondary school in the nearby town of Šurany from 1973 to 1977. The church in Slovakia was persecuted at that time,[16] but young people like her were yearning and searching for spiritual values. In the church in Šurany, some of them met with the Norbertine Sisters (Oprem)[17] who worked in the village of Lipová at an institution for children with intellectual disabilities.[18] Among the sisters was Zita, whom Veronika always recalled with emotion. In fact, she traced the beginnings of her own religious and missionary vocation to Zita's positive influence. Veronika found Zita to be a kind and balanced person who enjoyed working with the disabled. Veronika remembered that her encounter with Zita inspired her to ask herself: "Why couldn't I too belong to Jesus?" She began to realize that her heart's desire was to help people, especially children in need.

Since her own sister, Pavla Rácková, was a medical doctor, Veronika's dream was also to dedicate her life to God through that profession and alleviate people's suffering by providing them medical care. So, after her high school graduation in 1977, Veronika studied at the Medical

[16]The Catholic Church responded to persecutions by establishing an underground church, the so-called Secret Church, which clandestinely ordained many priests, who were not allowed to officially serve in pastoral ministry but who were providing spiritual and pastoral care outside the formal ecclesial structure controlled and constrained by the government. Thanks to the activities of the Secret Church, small religious groups and communities started to be established in the 1970s, sustaining Catholic beliefs and keeping the faithful alive through illegal and clandestine prayer meetings and religious instruction. These brought together mainly young people, who gradually began to lose their fear of being persecuted by the totalitarian regime (Ústav Pamäti Národa, 2023).

[17]The Norbertine Sister's congregation's Latin name is Ordo Praemonstratensis, abbreviated as OPraem. It is one of the branches of the Norbertine Order, which live according to the inspiration of St. Norbert and the rule of St. Augustine.

[18]During the communist period young women secretly joined religious congregations and secretly took vows. The sisters were working, without wearing habits, in many different types of work, depending on their education. Nobody knew that they were religious sisters. Formation and community life were always done in secret.

Faculty of the Karlová Univerzita in Prague.[19] During summer holidays she attended retreats organized by the Missionary Sisters Servants of the Holy Spirit (SSpS). It was then that her vocation was both nurtured and strengthened. At that time, the retreats had to be held secretly in family homes, due to the persecution of the Catholic Church by the totalitarian and oppressive political regime in Czechoslovakia.

Veronika Rácková was officially welcomed into the congregation on November 1, 1982, in Zlaté Moravce, which at that time was the SSpS regional house[20] in Czechoslovakia.[21] She was still a student at the Medical Faculty of the Charles University in Prague, when she secretly started the pre-novitiate program of formation.[22] Her last exam at the university was on May 24, 1983; she graduated on July 8,

[19]The Faculty of Medicine at Charles University in Prague was founded in 1348 by Emperor Charles IV and is one of the oldest schools of medicine in Europe. It is a state university and the language of instruction for international students is English.

[20]The SSpS began to work in Czechoslovakia in 1931. The SSpS Region was established in 1941 and the SSpS Province in 1984.

[21]The dissolution of Czechoslovakia took effect on December 31, 1992, as was the self-determined split of the federal republic of Czechoslovakia into the independent countries of the Czech Republic and Slovakia.

[22]When the communist government in Czechoslovakia forced religious women to live in so-called concentration convents or deported them to work in factories in 1950 and 1951, it had a single aim: to take them out of public life and let the congregations gradually die out. During the Dubcek government from 1968 to 1972, the political system became more open, the religious could return to more visible apostolates and vocations were accepted into their congregations. However, in 1972 a new government again forbade accepting new members to any religious congregation. However, religious women had been working in homes for people with disabilities or for the elderly. Hence, they were "visible." People could visit them, meet them and talk with them. This was an opportunity for young women to join them, but it had to be done in secret. They, for example, could work with the sisters in the same home, not as fellow sisters but as employees. These homes usually had a manager who was appointed by the government, but all the work in the home was done by the sisters. The sisters could, with the consent of the manager, employ other women. Other groups of young religious were employed in factories, hospitals, administrative offices and so on. Two to three of them lived together in a flat or a rented house. On weekends the novice directress, dressed in lay clothes, would visit them for formation classes. That was the reason why their novitiate took 3 years instead of the usual two years. The time of pre-novitiate, also called postulancy, could last up to five years.

1983 (Rácková, 1988). During her studies in Pragues he kept in touch with the SSpS and, when she had time, visited their community in Brtníky, near the German border. She was welcomed into the congregation during her last year of studies with the intention that she would begin her novitiate after graduation.

From 1983 onwards, some of the young SSpS who had taken at least their first vows, began to secretly leave Czechoslovakia in order to serve as missionaries. They were approached by Mária Miksová Aleška, SSpS who at the time was the novice directress and later the provincial leader. One day, Aleška asked Veronika if she would like to secretly leave her home country and join one of the overseas missions of the SSpS. After reflection and prayer, she agreed. In those days in Czechoslovakia young medical doctors, who had just finished their studies, were expected to work for three years in government institutions. Afterward they received their accreditation, called *atestácia* in Slovak, that enabled them to work independently as medical doctors. However, it was never certain that a graduate would ever be allowed to go abroad. Therefore, Aleška suggested to Veronika that she should go abroad before receiving the "*atestácia*" and continue her religious and medical formation outside the country. Veronika agreed and, after a year of working in the hospital in Bánovce and Bebravou, she left Czechoslovakia on September 7, 1984, and secretly and illegally emigrated to Germany, via Rome, traveling with a group of tourists from her country. Early in the morning on September 13, 1984, she arrived at the SSpS Generalate in Rome, to the surprise and joy of the SSpS community there. In order to protect her from the communist regime, the sisters called her Theresia and addressed her as a medical doctor (Chronik der *Kommunität des Generalates* in Rome, 1984). As was usual in such situations, the communist government had assigned a young woman to travel with Veronika to guard her all the time. Veronika recalled:

> It was very stressful. I didn't know how to get away from her. At one point I thought “it's now or never.” It happened on a beautiful morning when sightseeing in Rome. As a group we had stopped at a traffic light. When the light turned green, the group moved forward. I bent down and started doing something with my shoes. And then I ran to a standing taxi and gave the driver the address of our generalate in Rome. Shortly afterwards, I arrived at the generalate and met our SSpS sisters, having with me only a few documents in a small bag. So, I disappeared and didn't see the rest of the group again. I had made it! It must have been the Holy Spirit who guided me and gave me strength, because afterwards, when I was abroad, I felt a deep inner pain thinking of home and my parents. I realized that I would never see them again. My family knew about my departure, but we couldn't communicate about it openly. It was all very carefully kept inside. I felt a great inner pain and my heart was about to burst, but I survived. I went on, but it was not without tears, even when I was abroad (Kongregácia, 2021: 60-61).

After arranging the necessary documents in Rome, Veronika went to the SSpS convent in Laupheim, Germany, where she arrived on October 26, 1984. For five months she studied German in order to prepare to enter novitiate, to be able to communicate with the sisters and to continue her medical studies and work as a doctor.

A True Missionary Life

One of the community chronicles recorded that “postulant Veronika received the religious habit on August 15, 1985 and was given the religious name of Theresia” (Chronik des Dreifaltigkeitsklosters, Laupheim, 1985). Veronika had chosen that name because her patron saint was St. Teresa

of Ávila. She officially began her novitiate in Laupheim, Germany, and on April 21, 1986, moved to the SSpS mother house in Steyl, Netherlands, to prepare to pronounce her first vows. She spent more than a year in Steyl and then returned to the SSpS community in Laupheim on July 29, 1987, where she took her first vows on August 15, 1987 (Chronik des Dreifaltigkeitsklosters, Laupheim, 1987).

After taking a medical language course in Ulm, Germany, she received a certificate that allowed her to practice medicine as a doctor at the Laupheim District Hospital, the "Kreiskrankenhaus," from 1988 to 1993. At the same time, she continued her education and in April 1993 passed the medical examination in Tübingen for specialization in general medicine (Chronik des Dreifaltigkeitsklosters, Laupheim, 1993).

Veronika did her tertian-ship in 1993 in the SSpS community at St. Koloman in Stockerau, Austria, and prepared to make perpetual vows. In her request to the SSpS Congregational Leadership Team in Rome to take perpetual vows, she expressed her readiness for a total and life-long commitment to God as a sister and physician. With great gratitude for the gift of her missionary vocation and, above all, for the opportunity to complete her medical studies, she asked permission to take perpetual vows. During her formation she had clearly integrated both of her vocations. She was a doctor, providing medical care to relieve people's suffering, and provide healing as an SSpS ambassador of God's love to those in need. She felt called to be a religious and missionary through the practice of medicine. On February 6, 1994, she professed perpetual vows in Laupheim, Germany. Afterwards, she continued her medical education in Berlin, Germany, and a year later received a diploma in tropical medicine. With great joy she accepted her first missionary appointment to Flores, Indonesia, where she worked as a medical doctor at St. Elisabeth Hospital in Lela. After three months, unfortunately, her Indonesian visa was not renewed, so her mission appoint-

ment was changed to Ghana. Before leaving for Africa, she went to England in 1995 to learn English in Bristol.

Dedicated Medical Doctor in Ghana

In Ghana, Veronika served at West Gonja Hospital in Damongo, from January 1996 to June 1999. Due to her specialization in tropical diseases, she was able to provide much needed medical services to the afflicted. In 1998 she also served as the local leader of the SSpS community in Damongo. In October 1998, the District Health Management Team in Damongo announced a Cholera outbreak. The very next day, she discovered that some of her patients were infected, in need of a rapid response. Veronika was the hospital's Senior Medical Officer and acted very quickly and effectively. She reorganized the wards, quarantined the Cholera patients, and moved patients to other wards so that they would not be infected by the Cholera patients. A loving and caring doctor, she won the trust and hearts of the patients with her gentleness, tenderness and kindness. She had a sincere smile and a caring respect for her patients. Her dedication to the sick and suffering has been recognized by others. AFRICAID, a medical mission organization that promotes research into tropical diseases, medicines and vaccines, awarded her the "Most Dedicated Doctor" award. The West Gonja Hospital in Damongo, where she ministered, also received the award for "Excellence in Medical Service."[23]

In June 1999, after four years of dedicated service as the hospital's Senior Medical Officer, Veronika went on her first home leave to visit her family in Slovakia. This was possible since the communist regime was no longer in power. After this visit, in order to be able to serve people better, she did additional studies for three months in Leeds, United Kingdom, obtaining a degree in Public Health. At the beginning of 2000, she returned to Ghana, this time to the Holy

[23]This special event took place at the "Golden Tulip Hotel" in Accra, Ghana on March 13, 1999.

Spirit Convent in Wiaga where she was the senior doctor at the Wiaga Clinic's maternity ward (Chronicle of Holy Spirit Convent in Wiaga, 2000). She professionally prepared the staff at the clinic, both sisters and lay employees, to operate the clinic on their own, without her, as she discerned another calling from God. She wrote, "I feel that after 19 years of work as a general practitioner, God is calling me to a deeper life and to a specific service in the healing ministry" (Rácková, 2002). While she enjoyed her mission in Ghana and considered it meaningful, she asked to be transferred to another province. Clearly, she felt called to join a new SSpS community in South Africa and serve there in the church's HIV/AIDS apostolate. In June 2002, Veronika left Ghana for good and, after she visited her home country Slovakia, she pursued further studies in Ireland and England. From 2002 to 2003, she attended the Kimmage Mission Institute (KMI) of Theology and Cultures in Dublin, Ireland, and graduated with a diploma in theology. She had also participated in the "Ruhama Project: Women in Prostitution" (Ruhama, 2018). In 2003-2004 she graduated with a Diploma in Counselling from the Institute of St. Anselm in Kent, United Kingdom.

Provincial Leader in Slovakia

In 2004, she was elected provincial leader of the Slovak Province and willingly accepted this service, dedicating her work and life for six years not only to the local province but also to the community's mission in Europe. She was the chair person in the office of the SSpS Euro-Council (SSpS Euro Council, 2021: 66-67). As a responsible leader of the Slovak Province she did not neglect her medical vocation; she showed concern for the sick by providing care for the elderly sisters at every opportunity. She was committed to her work but, at times, also showed signs of irritation. This is how the sisters of the Slovak Province remember her: "…after the storm, there appeared a smile adorned with genuineness and joy" (Peštová, 2016).

Her heart burned with missionary zeal and, after completing her leadership service in Slovakia and Europe, she asked for a missionary appointment back to Africa. Her request was granted! In 2010 she received the appointment to join the SSpS community in Yei, South Sudan.

The month before leaving for Africa, Veronika traveled to Austria to do a silent directed retreat, thanking the Lord for the gifts and ministry she had received, and asking God's blessing on her new mission. She spent a month at the SVD's St. Gabriel Mission House, accompanied by Ludwig Hauser, SVD who had been her spiritual director for several years.

Medical Mission in South Sudan

Together with two other sisters, Veronika pioneered the SSpS mission in Yei, Sudan,[24] settling and living among the poor. From the beginning, the sisters were convinced that they were in Sudan to bear witness as a community and not just as individuals. In September 2010, they launched with others, a campaign to support the ongoing political process in the country, called "101 Days of Prayer for a Peaceful Referendum." In February 2011, after more than 20 years of civil war, the south of the country became independent from Sudan, and the new nation of South Sudan was established. Veronika reported that "we SSpS missionaries in South Sudan, rooted in the Triune God and guided by the Holy Spirit…strive to give authentic witness as disciples in mission. Together with the people, we are committed to giving birth to new life in their brokenness" (Rácková, 2011). As the community's leader, Veronika tried to put this

[24]The first SSpS community was established in Yei, Sudan, on September 16, 2010. However, already earlier, two SSpS sisters worked in Wau as members of the "Solidarity with South Sudan" project, an inter-congregational initiative of the International Union of Superiors General (International Union of Superiors General, 2023). The SSpS community in Yei was attached to the SSpS Region in Ethiopia. Sisters in Yei lived in cone-shaped mud huts with thatched roofs, so-called tukuls, that belonged to Malteser International until they moved to a renovated convent in 2011.

into practice. She was very enthusiastic about life, never giving up on her dreams, but at the same time also a realist, recognizing what could be done in the challenging circumstances in South Sudan and Yei. She recognized that the post-war situation, with many people facing immense trauma, required the sisters to have a robust understanding of the local culture. The sisters started to learn the history, culture and the daily life of the people in their suffering new nation. She and the other sisters sought ways to identify with those who were suffering; they wanted to live in communion with them, particularly those suffering the consequences of the war. The sisters recognized the importance of understanding the language of the people in order to serve them and so they started to learn Arabic. From the beginning, they provided health and pastoral care, visited families and listened to people's stories of pain and suffering, especially their experiences during the war and then as refugees. The people visited the sisters in their common tukul, a large grass-thatched round mud hut, which served also as the sisters' dining, prayer, and storeroom. Their doors were always open, especially to receive young women and children. They worked to promote the dignity, rights and education of women and girls. Veronika reported that "being aware of our identity as women disciples, centered in God and

Veronika Rácková, SSpS holding the first baby born in the newly opened maternity ward at the health center in Yei, South Sudan. On her side is the baby's mother. The newborn girl was named Veronika.

inspired by the Holy Spirit, we strive to live our creative way of life and to work with others while sharing responsibilities. The people noticed this very soon after our arrival in Yei and appreciate it very much. The face of the Church in Yei is slowly changing and getting a feminine face too" (Rácková, 2011).

Veronika Rácková, SSpS in the health center in Yei, South Sudan, praying with members of her community and staff for patients.

From 2010 to 2016, Veronika served in various roles as leader of the SSpS community and as a medical doctor and director of St. Bakhita Health Center in Yei, South Sudan. When she first visited St. Bakhita Health Center, she experienced the shock of seeing the facility in a dilapidated state and immediately took the initiative to rebuild it. However, as St. Bakhita Health Center belonged to the local diocese and as the sisters had no funds for renovations, rebuilding the center could only be done slowly.[25] Fortunately, due to her managerial skills and success in getting sponsors and benefactors for this project, soliciting financial support from friends in Western Europe, Veronika was able to renovate St. Bakhita Health Center and to recruit additional staff, in time reaching a total of 41 staff members. Together with her team she began to improve the

[25] Veronika Rácková, SSpS reported the following on the initial hurdles the sisters faced: "A big challenge for our mission is the male-dominated society. We feel that the clergy, who are in charge of all the important apostolates in the diocese, dominate, maintain their power and do not allow us and others to move and give birth to new life. We feel blocked by them and those who work with them. The diocese tells us that it does not have money to manage the clinical and other services the SSpS are providing. Due to under funding, these services are almost collapsing with many employees resigning. In spite of everything, we are convinced that it is good that we are in Sudan (Rácková, 2011).

quality of clinical and other services at the center. She started seeing patients in October 2011 and worked tirelessly for the service of the needy of South Sudan.

Veronika managed the leprosy program, which was coordinated by the German Leprosy and Tuberculosis Relief Association and opened the medical admission rooms, improving the outpatient department at the center (St. Bakhita Health, 2016). In order to cover a larger geographical area to serve the whole Yei region, Veronika received two cars from donors, one for the SSpS community and the other to be used as an ambulance for St. Bakhita Health Center. She also hoped to obtain one more vehicle to serve the ever-growing outreach programs. She visited leprosy patients and served as their voice in their homes and in the local community. Advocacy for leprosy patient was an important aspect of her ministry because the disease was heavily stigmatized and those suffering from the disease were excluded from the local community. Together with others, she created social and formative programs that aimed at building a society in which every person, including the sick, would be respected and live with dignity. As a missionary doctor, she felt a deep compassion for the sick, an empathy with those with physical and spiritual needs. In 2013 she began a mental health program to assist the mentally ill in the Yei area. She even proposed to build a new laboratory and mental health department (St. Bakhita Health, 2016).

Veronika Rácková, SSpS in the health center in Yei, South Sudan with patients, staff and members of her religious community.

Veronika Rácková, SSpS with SSpS sisters and SVDs in front of the SSpS House in Yei, South Sudan.

Veronika loved and respected the people of South Sudan. She once wrote: "I admire them for being strong and not giving up. I am convinced that God loves them immeasurably and sends missionaries to them so that they can feel his love." She was convinced that medicine could cure disease, but not heal the sick; the sick recover only through loving care. We do not know how many sick persons she cured with medicine, how many with loving care, and how many through ardent prayer. However, we know that she was always full of gratitude to God for his presence, guidance and help. She showed appreciation to all those who supported and accompanied her missionary work. She included in her prayers the concerns of the people she served and asked her benefactors to pray for them too. “There are situations in which we feel helpless and cannot move, but we can pray and love” (Rácková, 2011).

Veronika Rácková, SSpS with her SSpS community in front of the SSpS House in Yei, South Sudan, 2015.

Veronika was a committed, generous and joyful missionary. She was a woman who believed in the love of Jesus Christ and believed that she had been chosen by the Holy Spirit to minis-

ter among those most in need. She served them with a mother's passionate heart, like a mother who does not abandon her children even when life becomes very difficult. In the name of love, she persevered faithfully in prayer and offered her personal pain and suffering for others. Her sacrifice made her love even stronger, helped her to work with greater zeal and gave her the strength to endure personal suffering more patiently. She was ready to give her life for others. She knew that her life and work in South Sudan were always at risk. When the civil war flared up anew in South Sudan at the end of 2013, she decided to remain in the country. When asked why she made this decision, despite the political struggles in the country, she replied: "Jesus went his way consistently. He did not withdraw when things became difficult. He stayed all the time among the people and did not reject them. He was even ready to accept death, because he loved people. He loved them with boundless love. As a disciple of Jesus, I follow him in the power of the Holy Spirit. I cannot leave these people in South Sudan because I love them" (quoted in: Keler, 2017).

Veronika Rácková, SSpS in St. Bakhita's Health Center in Yei, South Sudan, with one of the nurses and a patient.

From the beginning, a major challenge for St. Bakhita Health Center was to introduce and maintain transparency, develop appropriate management and accounting processes, lay out a division of responsibilities and improve communication among all working at the center. Despite many difficulties, she accepted the reality, saying that "it was sometimes a painful and challenging process. We thank God for bringing us to

Sudan, for his loving presence, guidance and blessings and for the people of Sudan with whom we strive to cross over to the other side at the dawn of a new Sudan" (Rácková, 2011). In every letter to the SSpS, she thanked them for their trust, support and help. She continued to work at the health center to improve its conditions. For example, in July 2014, she directed installation of solar panels to ensure that the facility could be open 24 hours daily. Together with others, she installed an incinerator and improved the admission wards. She then started a water project that not only provided clean water to the center but also to the primary school of Christ the King Church, the nursery school and other local diocesan institutions. If all of that were not enough, she planned to open an up-to-datesurgical center. Veronika had other long-term plans for the development of the center which included sending young South Sudanese to the nursing school in Wau, as well as expanding the living facilities for staff members (St. Bakhita Health, 2016). However, she was not able to implement these ideas and plans.

Death of a Medical Missionary

Around midnight, May 15, 2016, after taking a pregnant woman on an emergency call to Harvester's Health Center in Yei, Veronika was on her way home to the convent, when a group of soldiers attacked her car. The St. Bakhita Health Center ambulance, which she was driving, was shot at several times, wounding her gravely in the hip and the abdomen. After undergoing surgery at the Hospital for Women and Children in Yei, she was airlifted to Nairobi Hospital in Kenya on May 16, 2016, for necessary treatment and surgery. The physicians did everything possible to save her life. The SSpS communities and their friends started praying continuous rosaries for her recovery. On May 20, 2016, the feast of Blessed Mother Josepha, SSpS, Veronika passed away after nearly a week of agony. Her death was an irreparable loss for the SSpS Sisters, her family and the people she served, especially in Yei.

The body of the Veronika was laid to rest on May 27, 2016, in the diocesan cemetery of St Joseph's Parish in Lutaya.[26] Thousands of mourners from different parts of South Sudan, including representatives from various church denominations and a notable number of Muslims, attended her burial. The Mass of Christian Burial was celebrated at Yei's Christ the King Cathedral, attended by a large number of sisters, brothers and priests of the Arnoldus Family.[27] A service celebrating her life was held at her birthplace in Bánov, Slovakia, on May 30, 2016, at the Parish of St. Michael the Archangel. The Mass was celebrated by the Archbishop of Trnava, Monsignor Ján Orosch, then President of the Council for Missions at the Bishops' Conference of Slovakia. The archbishop described this moment as "unsurpassable" because he had the honor of celebrating the Eucharist "for the martyr in her birth-place."He said that the people of Bánov could be proud of her. The Mass was also attended by Monsignor Jozef Jarab, the rector of the Catholic University in Ružomberok, as well as Father Pavol Kruták, the provincial of the Society of the Divine Word, SSpS sisters, sisters from other communities, priests, the mayor of the village of Bánov, relatives, friends and classmates of Veronika. At the end of the celebration, her sister, Pavla Rácková, spoke a few words. "The witness of your life is associated with the Holy Year of Mercy," she noted. "We ask for God's compassionate love for the people who have hurt you and whom you have surely forgiven" (Rímskokokatolícka Cirkev Farnost' Bánov, 2023).

Modern Martyr

Mária Miksová Aleška, SSpS, was aware of how difficult the mission in South Sudan will be and, when Veronika was ready to start her assignment there, said to herself, "You will be our first martyr" (Peštová, 2016).

[26]The town is about 170 Kilometres south-west of the capital Juba.

[27]Arnoldus Family refers to the three congregations founded by St. Arnold Janssen: the Society of the Divine Word (SVD), the Holy Spirit Missionary Sisters (SSpS), and the Holy Spirit Missionary Sisters of Perpetual Adoration (SSpSAP).

On April 22, 2017, Pope Francis presided over a Liturgy of the Word in the Basilica of St. Bartholomew in Rome, organized by the Community of Sant' Egidio, to honor the "new martyrs" of the 20th and 21st centuries. Veronika was remembered at the service together with other modern martyrs. Her bible and stethoscope were placed in the chapel on the left side of the basilica, dedicated to the African missionary martyrs. She has a place in the Roman basilica where she is venerated with others who gave their lives for faith, justice, truth and peace. Her death is a strong inspiration for missionary lives and apostolic work. She was a daring, adventurous, heroic and prophetic religious missionary. She manifested a sincere love for God's people by giving her life totally to the service of the most deprived, disadvantaged and poor. Many people from all over the world visit the Basilica dedicated to St. Bartholomew and pray through the intercession of Veronika and other martyrs of our day. Her heroic witness inspires not only the SSpS and SVD but countless pilgrims from around the world.

"Rejoice in Hope" was the theme of another prayer vigil to invoke God's blessing on Pope Francis' apostolic visit to the Democratic Republic of the Congo and South Sudan. That prayer gathering was also held in the Basilica of St. Bartholomew (January 30, 2023). It was there, at the altar with the mementos of Veronika, that I met seminarians from Yei who knew her personally. One of them was proud to acknowledge that he had had a medical check-up with her. Today they are studying theology in Rome and wish to become priests. Kennedy La Amosa, one of the seminarians, said the following:

> One of the greatest gifts of the late Sr. Veronika, that impressed and inspired me, was her example of courage, which I can look to when I face pressure or challenges to my faith. While in South Sudan, she lived at a time of war in which even the

> citizens of the country could escape to the neighboring countries of Uganda, Kenya, Congo, and Ethiopia, seeking refuge, but, because of her patriotic and devoted heart and love for us South Sudanese, she persisted and remained in that situation, serving the most suffering. Sr. Veronika was a committed, generous and joyful missionary endowed with a charitable heart and true missionary zeal. Her death is a severe, irreversible and irreparable loss for us in the Diocese of Yei, for her family and the people she served. The good deeds of Sr. Veronika will remain deep in my heart (Kennedy, 2023).

Without doubt, the life, mission and death of Veronika have been one of the seeds of these and many other vocations.

Joseph Ratzinger, writing about martyrdom (Bachanek, 2012), stated that martyrs are witnesses of Jesus Christ in whom our Lord suffers anew. They are a sign of God's presence in the Church. In a world full of injustice, the suffering of the martyrs provides the light to find the presence of the Lord God in the midst of darkness. Their witness touches the hearts of those who do not know him; they continue to bear fruit for the future of the world Church. The memory of these witnesses is an important part of Christian identity.

Three SSpS sisters with three South Sudanese seminarians in front of the altar in the Basilica of St. Bartholomew in Rome that contains two items that belonged to Veronika Rácková, SSpS. Leema Rose Savarimuthu, SSpS (third from the right) lived in the South Sudanese community with Veronika. Kennedy Lo Amosa, second from the right of the group, is the seminarian quoted in this chapter.

Epilogue

Let us pray together, inspired by the following words of Veronika, that she will help us by her powerful intercession before God: "Our mission in partnership with others empowers our family of God to become bigger, stronger, richer and more joyful. We need each other, but above all we need Jesus, who loves us, unites us, leads us, comforts us, enlightens us, teaches us and is with us always. May he be the King of our hearts; with him in our hearts even darkness becomes light" (Rímskokokatolícka Cirkev Farnost' Bánov, 2023).

IV

APPENDIX

16

THE HEALING MISSION OF THE CHURCH
World Council of Churches[28]

Introductory Remarks

1. The present document has been prepared by a multicultural and interdenominational group of missiologists, medical doctors, and health professionals. It builds upon the tradition of the World Council of Churches' (WCC) Christian Medical Commission (CMC) and its most fruitful contribution to an understanding of the healing ministry of the church. This document does not repeat what remains well formulated in earlier texts of the WCC, such as the document *Healing and Wholeness – The Churches' Role in Health* (Christian Medical Commission, 1990), adopted in 1990 by the Central Committee. That text situates the healing ministry within the struggle for justice, peace and the integrity of creation, and remains an essential contribution, the urgency of which has even grown in a now globalized world. The

[28]The formatting of the text has been edited to conform with this volume's formatting, the spelling was changed from British English to American English, and the wording of some sentences has been slightly edited for clarity. Further, most footnotes were changed to in-text citation and references in the References Cited section, while other footnotes were removed from the original text because they direct the reader to incorrect sources.

present study document concentrates mainly on some medical and theological-spiritual aspects of the healing ministry and their link with a recent ecumenical understanding of mission. It is offered as a background document to the 2005 Athens Conference on World Mission and Evangelism (CWME) and an important contribution to a dialogue on the relevance of its theme "Come Holy Spirit, Heal and Reconcile - Called in Christ to Be Reconciling and Healing Communities." It is to be read together with the study document recommended by the CWME Commission on *Mission as Ministry of Reconciliation* (Commission on World Mission and Evangelism, 2005). The present document does not pretend to make any final statement on healing or mission but hopes to enrich the debate and enable Christians and churches to better respond to their calling.

I. The Context

The Global Context of Health and Disease at the Beginning of the 21st Century

2. Global statistics on the incidence and prevalence of diseases, on the burden of diseases for communities and societies, and on mortality rates, are based on a scientific concept of disease and epidemiological methods for measuring disease and its impact (Vries, 2001). In medical science, disease refers to identifiable dysfunction of human physiology. We have to acknowledge that this approach is inherently different from a more holistic interpretation of health and diseases used in WCC circles[29] and that is not quantifiable with current methods and therefore not easily suitable for statistical analyses.

[29]For the WCC's definition, see§ 31 in this text.

3. It may any how be misleading to describe a global context because the situation is extremely complex and varies enormously between continents and societies, and increasingly also within societies and even within local communities, depending on economic resources which influence living conditions, lifestyle behavior, and access to healthcare. Any overview will be grossly misleading if taken as an accurate description of local or regional situations.

4. Nevertheless some trends can be discerned. One can speak of a world wide improvement in health if measured in terms of premature mortality and disability-adjusted life years, except for those regions heavily affected by HIV/AIDS.Infant mortality, which is a sensitive indicator for general living conditions and access to basic health care, has reached very low levels in Europe and North America and is going down particularly in East and Southeast Asia as well as Latin America and the Caribbean. It is still very high or even increasing in a number of countries in Sub-Saharan Africa.

5. Other major trends include the global increase in chronic disease, particularly mental diseases and diseases affecting the elderly. Even in low-income countries there is an increasing number of adults suffering, e.g., from coronary heart disease, cancer, or diabetes, which are the most common causes of morbidity and mortality in industrialized countries (World Health Organization, 2004). What is most disturbing is the general trend for a long-term increase in the number of people suffering from psychiatric diseases, particularly depression, both in countries of the North and the South. Accelerated and aggravated experiences of crisis and threat following rapid globalization processes seem to put excessive pressure on the human psychic system.

6. Currently the international community is engaged in a major review of the global health status as part of the process to assess progress toward the achievement of the Millennium Development Goals (MDGs). Three of the eight MDGs are directly referring to health (United Nations, 2004).

7. The impact of human-made climate change and deterioration of the natural environment on the global health situation can not yet be sufficiently mapped and measured but raises serious concerns as to its potential devastating effects, not only locally, but worldwide. Deforestation, e.g., contributes to building up the green house gases in the atmosphere which results in the depletion of the stratospheric zone and increases ultra violet radiation. This induces the suppression of immune systems and permit the emergence of cancers and certain infectious diseases that depend on cell-mediated immune responses. Global warming leading to a rise of the surface water levels of oceans occasions the flooding of human dwelling places thereby increasing the incident of water borne diseases. Global warming also leads to the resurgence of malaria and other infectious diseases in temperate countries and increases the danger of cardiovascular illnesses.

8. Despite the advanced technology, the health state of the world is still preoccupying as shown in the 2004 World Health Organization report (2004).It has, therefore, been pointed out that health and healing are not just medical issues. They embrace political, social, economic, cultural and spiritual dimensions. As it is stated in the WCC document *Healing and Wholeness - The Churches' Role in Health,*

> although the “health industry"is producing and using progressively sophisticated and expensive technology, the increasingly obvi-

> ous fact is that most of the world's health problems cannot be best addressed in this way. It is an acknowledged fact that the number one cause of disease in the world is poverty, which is ultimately the result of oppression, exploitation, and war. Providing immunizations, medicines and even health education by standard methods cannot significantly ameliorate illness due to poverty (Christian Medical Commission, 1990:1).

Unequal Access to Health Services – Health and Justice as Ethical Challenges

9. The fact remains that in large parts of the world people have no access to essential health services. The question of affordable access to health care provisions and the commercialization of health constitutes yet other very complex and sensitive issues. On the one hand, scientifically based health care becomes ever more expensive with increased levels of diagnostic and the rapeuticsophistication widening the gap between those who can afford it and those who can't. This gets most pronounced in low-income countries but becomes increasingly visible also in high-income countries with reduced public expenditure on health. Christians have to be constantly reminded that access to health care is an essential human right and nota commodity that should be available only for those with sufficient financial resources.

10. On the other hand, there is an increased interest in addressing diseases of poverty, in particular the major infectious diseases HIV/AIDS, tuberculosis and malaria. The creation of The Global Fund to Fight AIDS, Tuberculosis & Malaria by the United Nations is a casein point. Christians have advocated strongly for increased attention to and financial resources for

diseases of poverty to achieve greater equity in the distribution of resources. Several global campaigns or initiatives testify to this concern, such as the Ecumenical Advocacy Alliance and the Ecumenical HIV/AIDS Initiative in Africa. On such global health questions, there are also increasing efforts at cooperation between various faith-based communities.

11. Even if in some instances, good health care services help to alleviate poverty, health and healing cannot be disconnected from structural organization of our societies, the quality of relationship among people and the lifestyle. Increasingly widespread unhealthy lifestyle patterns area[30] consequence of standards and interests of the food industry and of changing cultural behaviors promoted, among others, by media and the advertisement industry.

12. The present state could be summarized in terms such as: Today, in our globalized and highly commercial world, people are far from being all healthy, neither as individuals nor as communities, and this despite the many advances in preventive medicine and therapeutic skills. Many people don't have access to affordable medical care. While preventable diseases are still a major problem in many parts of the world, chronic illnesses often related to lifestyle and behavior are on the rise, causing much suffering allover the world. A growing number of people with mental illnesses are being recognized today. The costs of medical care have risen to prohibitive levels, making the technology unavailable to many, and leading to medical systems becoming unsustainable. High technology has an inhuman face leading to people feeling isolated and fragmented. Death in modern medicine is seen as

[30]Such as fast-food and other consumption trends leading to overweight of children and adults in affluent societies, addiction to drugs, over consumption of TV and video, etc.

failure and is aggressively fought to such an extent that people are not able to die with dignity.

13. People disenchanted with the established medical system are looking for more than treatment of a sick liver or heart. They want to be seen and treated as persons. Their diseases often lead them to ask spiritual questions and there is a growing search for the spiritual dimension of healing. The importance of the role of the community in creating and maintaining health is being rediscovered in many of the affluent countries.

14. Scientific researchers have started to map what they call the "religious health assets" in order to provide basic data on potential material infrastructure and spiritual contributions by religious communities to national and international health policy. A number of epidemiological studies carried out by medical professionals, mainly in the USA, highlighting the positive effect of religion and spirituality on health are enabling a new dialogue between the medical and theological disciplines (Koenig, McCullough and Larson, 2001). Scientific medicine itself has become increasingly interested in the spiritual dimension of the human person.

Healing and Culture – Different World views, Cultural Conditions, and Their Impact on Understanding Health and Healing

15. The way health and healing are defined, sickness and illness explained, depends largely on culture and conventions. In ecumenical mission circles, culture is usually understood in a wide sense, including not only literature, music, and arts, but values, structures, world view, ethics, as well as religion (Durai Singh, 1998).

16. It is in particular the combination of religion, world view, and values that impacts people's specific understanding of and approach to healing. Since culture varies from continent to continent and from country to country or even within countries and groups of people, there is no immediate universal common understanding of the main causes of sickness and illness or of any evil affecting humans.

17. There are cultures in which supernatural beings are seen as the real ultimate causative agents for ill health, particularly on mental disorders. In such world views, people go to traditional healers and religious specialists for exorcism and deliverance from evil spirits and demons. Only then can they have the guarantee that the ultimate cause of their suffering has been dealt with. This would not exclude parallel treatments of symptoms with herbs, traditional or industrially manufactured drugs.

18. Masses of people integrate popular religious beliefs and culture in their understanding of health and healing. We may call this popular religiosity and belief in health. This belief may involve veneration of saints, pilgrimages to shrines, and use of religious symbols such as oil and amulets to protect people from evil spirits or evil intentions that harm people.

19. Other, in particular Asian cultures, also point to the importance of harmony within the human body as the necessary pre-condition for a person's health, well-being and healing. *Shibashi,* e.g., An ancient Chinese practice of nature-oriented movements attune the body to the rhythm of nature producing an energizing effect. The traditional belief is that healing and health are actual effects of balance in the flow of energy that are affected from within and out side the human body. The clogging of centers of energy (*chakras*) or obstruc-

tion in the flow of energy causes illness. Acupuncture or finger pressure are other modalities of balancing the flow of energy.

20. Out of different world views culture-specific medical sciences and systems developed in some of the major civilizations of the world. In particular since the Enlightenment, these were disregarded by the Western medical establishment, but are now again increasingly considered worthy alternatives for the treatment of specific illnesses.

21. As a result of advances in medical science and of intercultural exchanges, some people, in particular in Western contexts, develop new life styles emphasizing walking, jogging, aerobic exercise, healthy diet, yoga and other forms of meditation, massage and going to sauna and spa as a way to achieve well-ness, health, and healing. These may well bring relief from stressful situation and some chronic illnesses like cardiovascular diseases and diabetes mellitus.

22. Certain forms of nature-centered religiosity and indigenous and emerging secular cultures also point to the relationship between cosmology or ecology and health and healing. There is a growing, however still insufficient awareness of the importance of linking ecology and health. The determinants of health are clean water and air and a safe space for all living creatures. Deforestation has profoundly damaged the water supply, polluted the air, and destroyed the habitats of many living creatures turning them into "pests"and creating ill health among human beings and other elements of creation. Very close associations of animals and human beings are now the cause of new forms of epidemics such as the emergence of Avian Flu, a severe and potentially fatal viral infection that is transferred from ducks and chickens to human

beings. The tsunami event and post-tsunami situation highlight the importance of taking care not only of human beings but of the whole of creation and of attuning oneself to the rhythm of nature.

II. Health and Healing and the Ecumenical Movement

23. In ancient times, the art of healing belonged to priests. They were consulted in the case of disease and often were regarded as mediators of healing. The unity of body, mind and spirit was understood and accepted.

The Centrality of Healing in the Mission of the Early Church

24. It is worth recalling that the growth of the early church in the 2nd and 3rd century was – among other factors – also due to the fact that Christianity presented itself as a healing movement to the early Mediterranean societies. The importance of the different healing ministries within the church is reflected by the early accounts of mission in the New Testament. Many writings of the early church fathers also affirm the centrality of the church as a healing community and proclaim Christ as the healer of the world over against Hellenistic religiosity.

25. In affirming that God himself in the life of his Son has lived through experiences of weakness unto even experiencing death himself, Christianity revolutionized the understanding of God and profoundly transformed the basic attitudes of the faith community to the sick, the aged and the dying. It contributed decisively to break up the conventional strategies and mechanisms of exclusion, of discrimination and of religious stigmatization of the sick and the fragile. It put an end to the association of the divine with ideals of a perfect, sane, beautiful and un-passionate exis-

tence. The different attitude to the sick, to the widows and to the poor proved to be a vital source for the missionary success and vitality of the early church. The monasteries continued to be islands of hope by caring for the sick.

Medical Science and Medical Missions

26. Over the centuries the development of science and technology, and especially since the Enlightenment, have led to a change in the understanding of the human being and of health. Instead of being regarded as an indivisible unity, the human being was fragmented into body, mind and soul. Medical professionals tend to view a disease as a malfunction of a wonderful and complicated machine to be repaired with the help of medical skills, neglecting the fact that human beings have a soul and a mind. The rise of the disciplines of Psychology and Psychiatry accentuated this divide taking over the care of the mind. As a result, there was loss of the understanding of the concept of wholeness, as well as of the role of the community and of spirituality in health.

27. Medical missions came about sometime later, i.e., in the 19th century, leading to the setting up of church-related health care systems in many parts of the world where missionaries were active. Healthcare was seen by so meas an essential part of the mission of the sending church or missionary organization. Though these mission hospitals provided compassionate care of high quality at low cost, the western medical model of health care was often super imposed on indigenous local cultures with their own therapeutic and healing traditions. However, many medical missionaries engaged in training indigenous people in the art of healing and Nursing from the very start of their medical mission.

A Holistic and Balanced Understanding of the Christian Ministry of Healing

28. A carefully designed, most comprehensive study process initiated by the WCC's CMC in the seventies and eighties showed that many factors or influences are responsible for forms of illness and broken relationships; growing feelings of void and lack of spiritual orientation in people's lives; weaken the natural defenses of the body to cope or defend oneself from infections or biochemical disturbances in bodily functions or other forms of physical, emotional, or mental disorders; cause imbalance in the flow of energy leading to obstruction and manifestation of disease; provoke enslavement or addiction from evil desires or influences that hinder the person's response to God's saving grace.

29. According to an anthropology rooted in the biblical-theological tradition of the church, the human being is seen as “multi-dimensional unity" (Tillich, 1963 and 1990). Body, soul and mind are not separate entities, but interrelated and interdependent. Therefore, health has physical, psychological and spiritual dimensions. The individual being is also part of the community; health has also a social dimension. And because of the interaction between the natural environment (biosphere) and persons or communities, health has even an ecological dimension.

30. This has led the WCC to offer the following definition of health: Health is a dynamic state of well-being of the individual and society, of physical, mental, spiritual, economic, political and social well-being–of being in harmony with each other, with the material environment and with God (Christian Medical Commission, 1990:6). Such a holistic view underlines that health is not a static concept in which clear distinction lines are

drawn between those who are healthy and those who are not. Every human being is constantly moving between different degrees of staying healthy and of struggling with infections and diseases. Such an understanding of health is close to the one emerging in the more recent debate and research on health-promoting factors.[31] Such a holistic view has also consequences on the understanding of the church's mission: The Christian ministry of healing includes both the practice of medicine (addressing both physical and mental health) as well as caring and counseling disciplines and spiritual practices. Repentance, prayer and/or laying on of hands, divine healing, rituals involving touch and tenderness, forgiveness and the sharing of the Eucharist can have important and at times even dramatic effects in the physical as well as social realm of human beings. All the different means are part of God's work in creation and presence in the church. Contemporary scientific medicine as well as other medical approaches make use of what is available in the world God has created. Healing through medical means is not to be thought of as inferior (or even unnecessary) to healing through other or by spiritual means.

31. There are churches and social contexts (particularly in western post-Enlightenment and modern societies) in which a one-sided emphasis and attention was given to the achievements of contemporary scientific medicine and the physical aspects of health and healing. Here a new openness and attention is needed for the spiritual dimensions in the Christian ministries of healing. There are other contexts and churches in which – due to a different world view and the non-

[31] One example are the discussions around the conception of"salutogenesis"developed by the medical sociologist Aaron Antonowsky, focusing on what helps maintaining health and well-being in body and soul, instead of focussing on factors producing illness.

availability of modern western medical systems – the importance of spiritual healing is highly valued. Here also a new dialogue between spiritual healing practices and approaches in modern medicine is essential.

Recent Attempts to Deepen the Understanding of the Healing Mission of the Church

32. One of the most thorough recent studies was conducted on behalf of the Church of England by a working party commissioned by the House of Bishops. It produced a remarkably encompassing report developing a definition of healing as a "process towards health and wholeness." It embraces what God has achieved for human beings through the incarnation of Jesus Christ. God's gifts of healing are occasionally experienced instantly or rapidly but, in most cases, healing is a gradual process taking time to bring deep restoration to health at more than one level (Archbishop's Council, 2000).

33. It is both significant that at the beginning of the 21st century several important ecumenical church meetings such as the Lutheran World Federation's (LWF) assembly in Winnipeg, Canada; the assembly of the Conference of European Churches (CEC) in Trondheim, Norway; the General Council of the World Alliance of Reformed Churches (WARC) in Accra, Ghana, have focused directly or indirectly on the healing ministry of the church in a world torn by suffering and violence. The following extract from the most recent mission document of the LWF shall stand for many of those efforts:

> According to the scriptures, God is the source of all healing. In the Old Testament, healing and salvation are interrelated and, in many instances, mean the same thing:"

Heal me, O Lord, and I shall be healed; save me, and I shall be saved" (Jeremiah 17:14). The New Testament, however, does not equate being cured from an ailment with being saved. The New Testament also makes a distinction between curing and healing. Some may be cured but not healed (Luke17:15-19), while others are not cured but healed (2 Corinthians 12:7-9). "Cure" denotes restoring lost health and thus carries a protological view. Healing refers to the eschatological reality of abundant life that breaks in through the event of Jesus Christ, the wounded healer, who participates in all aspects of human suffering, dying, and living, and overcomes violation, suffering, and death by his resurrection. In this sense, healing and salvation point to the same eschatological reality (Messenger, 2004:39-40).

Recent Dialogue of World views Regarding the Reality of Spiritual Powers

34. In recent years, largely because of the rapid growth of Pentecostal-charismatic movements and their influence across the ecumenical spectrum, terms such as "power encounter," "demon [ology]," and "principalities and powers," have become topics of missiological interest and research today as has the question of divine healing in particular. Exorcism, casting out evil spirits, and "witch demonology" are also terms more frequently used in certain Christian circles today. Talk about demons and evil spirits is, of course, not a new phenomenon neither in Christian theology nor church life. The Christian church, throughout her history– especially during the first centuries and later, more often among enthusiastic, charismatic renewal

movements – has either appointed specially gifted/graced persons to tackle evil forces (exorcists) or at least acknowledged the reality of spiritual powers.

35. The rapid proliferation of Christian churches among the cultures outside of the West, has also contributed to the rise to prominence of the theme of demonology. Christians in Africa, Asia, Latin America, and the Pacific tend to be much more open to the idea of the reality of these forces. In many of those cultures, there is a wide spread involvement with spiritual powers even apart from Christian faith. One of the main reasons why the Western churches- especially the main line Protestant churches- eschewed the whole topic of spiritual powers for several centuries has to do with the specific nature of their world view going back to the influence of the Enlightenment. Christian theology and the way clergy was trained did not only ignore the topic but often also helped "demythologize" even the biblical talk about demons and spiritual powers. Earlier documents of WCC on healing and health have not tackled the issue adequately either (Christian Medical Commission, 1990). Currently, a paradigm shift is taking place in Western culture–often referred to as "post modernity"- which is challenging a narrow rationalistic world view and theology.

III. Health and Healing in Biblical and Theological Perspective

God's Healing Mission

36. God Father, Son, and Spirit leads creation and humanity towards the full realization of God's Kingdom, which the prophets announce and expect as reconciled and healed relationships between creation and

God, humanity and God, humanity and creation, between humans as persons and as groups or societies (healing in the fullest sense as "shalom"– Isaiah65:17-25). This is what in missiology is referred to as mission *dei*. In a trinitarian perspective, the creational, social-relational, and spiritual-energetical dimensions of healing are interdependent, interwoven. While affirming the dynamic reality of God's mission in world and creation, we also acknowledge its profound mystery which is beyond the grasp of human knowledge (Job 38-39). We rejoice whenever God's presence manifests itself in miraculous and liberating, healing, changes in human life and history, enabling life in dignity. We also cry out with the Psalmist and Job to challenge the Creator when evil and unexplainable suffering scandalize us and seem to indicate the absence of a merciful and just God: "Why, O God? Why me, Lord? How long?" It is in a profoundly ambivalent and paradoxical world that we affirm our belief and hope in a God who heals and cares.

37. As Christians, we acknowledge the perfect image of God as manifest in Jesus Christ, who came to witness through his life, deeds, and words how God cares for humanity and creation. The incarnation of God in Christ affirms that God's healing power is not saving us from this world or above all material and bodily matters but is taking place in the midst oft his world and all its pain, brokenness, and fragmentation and that healing encompasses all of human existence. Jesus Christ is the core and center of God's mission, the personalization of God's Kingdom. In the power of the Holy Spirit, Jesus of Nazareth was a healer, exorcist, teacher, prophet, guide, and inspirator. He brought and offered freedom from sin, evil, suffering, illness, sickness, brokenness, hatred, and disunity (Luke 4:16-18, Matthew 11:2-6). Hallmarks of the

healings of Jesus Christ were his sensitivity to needs of people, especially the vulnerable, the fact that he was “touched” and responded by healing (Luke 8:42b-48), his willingness to listen and openness to change (Mark 7:24b-30), his unwillingness to accept delay in alleviation of suffering (Luke 13:10-13) and his authority over traditions and evil spirits. Jesus' healings always brought about a complete restoration of body and mind unlike what we normally experience in healings.

38. He inaugurated the new creation, the "end of time" (eschaton) through signs and wonders, which do point to the fullness of life, the abolition of suffering and death, promised by God as announced by the prophets. But these miraculous actions were not more than signs or signposts. Christ healed those who came or were brought to him. He did not however heal all the sick of his time. The Kingdom of God, already present, is still expected. "Healing is a journey into perfection of the final hope, but this perfection is not always fully realized in the present (Romans 8:22)" (World Council of Churches, 2009).

39. Jesus' healing and exorcist activity points in particular to the accomplishment of his ministry at the cross: he came to offer salvation, the healing of relationship with God, what Paul later described as "reconciliation" (2 Corinthians 5). This he did through service and sacrifice, fulfilling the ministry of the "wounded healer" prophesized by Isaiah (52:13-53:12). Christ's death on the cross is thus both protest against all suffering (Mark 15:34) and victory over sin and evil. By resurrecting Christ, God vindicated his ministry and gave it lasting significance. The cross and resurrection of Christ affirms that God's healing power is not staying apart and above the reality of pain, brokenness and dying but is reaching down to the very

depth of human and creational suffering bringing light and hope in the uttermost depth of darkness and despair. The image of the resurrected Christ maybe encountered among people who suffer (Matthew 25:31-46) as well as among vulnerable and wounded healers (Matthew 28:20 and 10:16, 2Corinthians 12:9, John 15:20).

40. In ecumenical missiology, the Holy Spirit, Lord and life-giving, is believed to be active in church and world. The ongoing work of the Holy Spirit in the whole of creation initiating signs and foretastes of the new creation (2Corinthians 5:17) affirms that the healing power of God transcends all limits of places and times and is at work inside as well as outside the Christian church transforming humanity and creation in the perspective of the world to come. God the Holy Spirit is the fountain of life for Christian individual and community life (John7:37-39). The Spirit enables the church for mission and equips her with manifold charisms, including (e.g.) The one to heal (cure) by prayer and imposition of hands, the gift of consolation and pastoral care for those whose suffering seems without end, the charism of exorcism to cast out evil spirits, the authority of prophecy to denounce the structural sins responsible for injustice and death, and the charism of wisdom and knowledge essential to scientific research and the exercise of medical professions. But God the Holy Spirit also empowers the Christian community to forgive, share, heal wounds, overcome divisions, and so journey towards full communion. The Spirit pursues thus, widens, and universalizes Christ's healing and reconciling mission. Groaning in church and creation (Romans 8), the Spirit also actualizes Christ's solidarity with the suffering and so witnesses to the power of God's grace that may also manifest itself paradoxically in weakness or illness (2 Corinthians 12:9).

41. The Spirit fills the church with the transforming authority of the resurrected Lord who heals and liberates from evil, and with the compassion of the suffering Servant who dies for the world's sin and consoles the down trodden. A Spirit-led healing mission encompasses both bold witness and humble presence.

Health, Healing, and the Concept of Spiritual Powers

42. One of the dominant traits in which the healing ministry of Jesus is presented in the New Testament is that of ultimate authority over all life deforming and life destroying powers including death (Luke 7:11-17; John 11:11; Mark 5:35-43). Biblical world view takes for granted the reality of the unseen world and attributes power and authority to spirits and the spiritual world.

43. In Jesus Christ the Kingdom of God was at hand (Matthew 4:17, Luke 11:20) making demons "shudder" (James 2:19) because they realized that Christ had come to "destroy the works of the devil" (1 John 3:8; see also Colossians 2:15). Since numerous biblical healing narratives refer to demons and evil spirits as the cause of disease, exorcism becomes-consequently-one of the most common remedies (Mark 1:23-28; 5:9; 7:32-35; Luke 4:33-37; Matt. 8:16; John 5:1-8) for diagnose is rules therapy. There is thus indeed a form of healing which in the Bible is presented as a power encounter between Christ and the evil forces, a specific form of the healing mission particularly highlighted in several churches today, especially those with Pentecostal and Charismatic background.

44. Through resurrection and ascension, Christ has overcome all evil powers. In the liturgy, the church cele-

brates this victory. Through its witness and mission, the church manifests that the powers - all the powers - have been defeated and so stripped of their binding influence on human lives. Those who follow Christ dare in his name to denounce and challenge all other powers, thus bringing good news: "Go, preach, saying, the Kingdom of heaven is at hand! Heal the sick, cleanse the lepers, raise the dead, cast out demons!" (Matthew 10:7, see also Mark 16:9-20).

45. This implies that the churches' ministry of proclaiming the Gospel has to consciously address and name the powers, taking up the struggle with evil in whatever way it presents itself. These powers are not to be tampered with but recognized, because their reality rests in the hold they have over people who relate to them as the vital coordinates in life. This issue of relationship between demonology/powers and healing needs careful study. How to interpret the reality and influence of powers in contemporary contexts and cultures is one of the urgent ecumenical debates.[32]

Illness, Healing and Sin – The"Already and Not Yet" of the Kingdom

46. Whereas in Christ evil and sin have been overcome, there are still many disasters, illnesses, deficiencies, and diseases (physical, moral, spiritual, and social) that seem to deny the arrival of the Kingdom of God. The Bible knows the tradition saying that disease or disaster can be divine answer to sin, individual or collective. The prophets have repeatedly challenged God's people to repent from its disobedience to God's word. The New Testament knows of the potential relation between sin and sickness (1 Corinthians 11:28-34). There is however a strong insistence by Jesus on denying any direct relationship between

[32]See below, section 5.

personal sin and sickness: "Who sinned? This man or his parents?... This is to manifest the power of God" (John 9:2). Similarly, in his answers to questions related to disasters, Jesus leaves open the question of their origin (Luke 13:1-5) and instead points to the urgency of turning back to God and follow the life he offers.

47. Suffering continues in the period between Easter and the end of history. The Gospels do not explain this mystery. But the Spirit strengthens the church for its healing and reconciling mission and enables people to cope with continuing suffering and illness in the light of Christ's redemption. Because Christ has paid the price for all sin and brings salvation, no power has final damaging influence on those who put their confidence in God's love manifested in Christ (Romans 8:31-39).

48. In the end, Christ will hand over the Kingdom to his Father (1Corinthians 15:24), free of illness, suffering and death. In this Kingdom healing will be complete. There is found the common root of healing and salvation (*salus*)." He will wipe every tear from their eyes. Death will be no more: mourning and crying and pain will be no more" (Revelation 21:4).

IV. The Church as a Healing Community

Church, Community and Mission

49. The nature and mission of the church proceeds from the Triune God's own identity and mission with its emphasis on community in which there is sharing in a dynamic of interdependence. It belongs to the very essence of the church – understood as the body of Christ created by the Holy Spirit to live as a healing

[33]This refers to congregations, as well as church-related healthcare institutions and specialised diaconical services.

community, to recognize and nurture healing charisms and to maintain ministries of healing as visible signs of the presence of the Kingdom of God.[33]

50. To be a reconciling and healing community is an essential expression of the mission of the church to create and renew relationships in the perspective of the Kingdom of God. This means to proclaim Christ's grace and forgiveness, to heal bodies, minds, souls and to reconcile broken communities in the perspective of fullness of life (John 10:10).

51. It has to be reaffirmed what the document *Mission and Evangelism in Unity Today* (World Council of Churches, 1999) stated, i.e., that "mission carries a holistic understanding: the proclamation and sharing of the good news of the Gospel, byword (kerygma), deed (*Diakonia*), prayer and worship (*Leiturgia*) and the everyday witness of the Christian life (*Martyria*); teaching as building up and strengthening people in their relationship with God and each other; and healing as wholeness and reconciliation into *koinonia* - communion with God, communion with people, and communion with creation as a whole."

Healing the Wounds of Church and Mission History

52. When Christian churches speak of the healing ministry as an indispensable element of the body of Christ, they must also face their own past and present, sharing along and often conflictual history with each other. Church splits, rivalry in mission and evangelism, proselytism, exclusions of persons or whole churches for dogmatic reasons, condemnations of different church traditions anathematized as heretical movements, but also inappropriate collaboration between churches and political movements or economic and political powers, have left deep marks and

wounds in many parts of the one body of Christ and continue to have a harmful impact on inter denominational relationships. Christians and churches are still in deep need of healing and reconciliation with each other. The agenda of church unity remains an essential part of the healing ministry. The ecumenical movement has indeed been and still is one of the most promising and hope giving instruments for the necessary processes of healing and reconciliation within Christianity. What such processes mean and imply has been described in the document *Mission and the Ministry of Reconciliation* recommended by the CWME commission in 2004 (World Council of Churches, 2005).

The Local Christian Community as a Primary Place for the Healing Ministry

53. The Tübingen consultations[34] in 1964 and 1967 (World Council of Churches, 1965; McGilvray, 1981) affirmed that the local congregation or Christian community is the primary agent for healing. With all the need and legitimacy of specialized Christian institutions like hospitals, primary health services and special healing homes it was emphasized that every Christian community as such–as the body of Christ–has a healing significance and relevance. The way people are received, welcomed and treated in a local community has a deep impact on its healing function. The way a net work of mutual support, of listening and of mutual care is maintained and nurtured in a local congregation expresses the healing power of the church as a whole. All basic functions of the local church have a healing dimension also for the wider community: the proclamation of the word of God

[34]Two consultations held at the German Institute for Medical Mission (Difäm) in Tübingen, Germany, who were at the origin of the creation of the CMC and the health work of the WCC.

as a message of hope and comfort, the celebration of the Eucharist as a sign of reconciliation and restoration, the pastoral ministry of each believer, individual or community intercessory prayer for all members and the sick in particular (Christian Medical Commission, 1990:31-32). Each individual member in a local congregation has a unique gift to contribute to the overall healing ministry of the church.

The Charismatic Gifts of Healing

54. According to the biblical tradition the Christian community is entrusted by the Holy Spirit with a great variety of spiritual gifts (1Corinthians 12) in which charisms relevant to the healing ministry have a prominent role. All gifts of healing within a given community need deliberate encouragement, spiritual nurture, education, and enrichment but also a proper ministry of pastoral accompaniment and ecclesial oversight. Charisms are not restricted to the so-called "supernatural" gifts which are beyond common understanding and/or personal world view but hold to a wider understanding in which both talents and approaches of modern medicine, alternative medical approaches as well as gifts of traditional healing and spiritual forms of healing have their own right. Among the most important means and approaches to healing within Christian tradition mention should be made of the gift of praying for the sick and the bereaved, the gift of laying on of hands, the gift of blessing, the gift of anointing with oil, the gift of confession and repentance, the gift of consolation, the gift of forgiveness, the gift of healing wounded memories, the gift of healing broken relationships and/or the family tree, the gift of meditative prayer, the gift of silent presence, the gift of listening to each other, the gift of opposing and casting out evil spirits (ministry of deliverance) and the gift of prophecy (in the personal and socio-political realms).

The Eucharist as the Christian Healing Event Par Excellence

55. The celebration of the Eucharist is considered by the majority of Christians as the most prominent healing gift and unique healing act in the church in all her dimensions. While the essential contribution of the Eucharist for healing is not understood in the same manner by all denominational traditions, the sacramental aspect of Christian healing is more deeply appreciated and expressed in many churches today. In the Eucharist, Christians experience what it means to be brought together and to be made one, constituted again as the body of Christ across social, linguistic, and cultural barriers, however not yet across denominational divides. The remaining division between churches, which prevent a common celebration at the Lord's table is the reason why many Christians have difficulties in grasping and experiencing the Eucharist as the healing event par excellence.

56. The Eucharistic liturgy provides however the setting and visible expression for God's healing presence in the midst of the church and through her in mission to this broken world. The healing dimension of the Eucharist is underscored by the tradition reaching back to the early church requesting reconciliation with the brother or sister prior to sharing the sacrament. It is expressed also through the mutual sharing of the peace and forgiveness of sins between God and the believers in the liturgy of confession. Very early evidence is also there for the Christian practice to share the Eucharist with the sick and to bring it to homes and hospitals. The body of Christ broken for the suffering world is received as the central gift of God's healing grace. Every Eucharistic celebration restores both the community of the church and renews the healing gifts and charisms. According to

ancient sources the liturgical tradition of anointing the sick with oil is rooted in the Eucharistic celebration. In both Roman Catholic and Orthodox traditions, the oil used for anointing the sick[35] is sanctified by the local bishop in the liturgy of benediction of the oil during Holy Week (chrismation mass), there by rooting the healing ministry of the church both in the Eucharist and in the cross and resurrection of Christ.

The Healing Dimension of Worship in General and Special Healing Services

57. For all Christian denominations and church traditions it holds true that the worshiping community and the worship itself can have a deep healing dimension. Opening oneself in praise and lament to God, joining the others as a community of believers, being liberated from guilt and burdens of life, experiencing even unbelievable cures, being enflamed by the experience of singing and of praise are a tremendously healing experience. It must however also be acknowledged that this can never be taken for granted. In appropriate forms of Christian worship including triumph alist "healing services" in which the healer is glorified at the expense of God and where false expectations are raised, can deeply hurt and harm people. In many places, still, special monthly or weekly services are experienced as authentic witness to God's healing power and care. Indeed, in such worship, explicit recognition is given to the needs of those seeking healing from experiences of loss, of fragmentation, of despair or physical illness. In many church traditions worship events combine the Eucharist with the ritual of personal prayer for the sick and the laying on of

[35]It was only in the middle ages that they were narrowed down to a sacramental sign reserved to the dying as “extreme unction”.

hands and are an appropriate response both to the mandate of the church and the longing for healing within the population. The contribution of Pentecostalism and the charismatic movement both within and outside the historical churches to the contemporary renewal of the understanding of the healing dimension of worship and of mission in general has to be acknowledged in this context.

Deepening a Common Understanding of a Christian Healing Spirituality

58. It is clear for all Christian traditions that Christian healing ministries cannot be seen as mere techniques and professional skills or certain rituals. All of them depend on a Christian spirituality and discipline which influences all spheres of personal as well as professional life. Such spirituality depends on faith in God, following Christ's footsteps, on how the body is treated, how the limitations of space and time are dealt with, how pain and sickness are coped with, how one eats and fasts, prays, and meditates, visits the sick, helps the needy, and keeps silence in openness to God's Spirit. There is a need for discernment as to what constitutes authentic Christian spirituality. There exist theologies and forms of Christian practice that do not contribute to healing. Distorted forms of spirituality or piety can lead to unhealthy lives and questionable relationship with God and fellow human beings.

The Ordained and the Laity in the Healing Ministry

59. In many congregations it can be observed that only ordained people are allowed to extend signs of blessing and prayers of healing for people who are in need. Biblical evidence reminds us however that the Spirit and the Spirit's gifts have been promised to all mem-

bers of the people of God (Acts 2:17, 1 Corinthians 12:3 ff) and that every member of the church is called to participate in the healing ministry. Churches are encouraged to support the gifts and potentials particularly of lay people both in local congregations as well as in health care institutions. Empowering people to act as ambassadors of the healing ministry is an essential task of both the ordained ministers and deacons in the church as well as the Christian professionals working in various health related institutions.

60. How each church can best recognize the mandate of the local community, express the responsibility of the ordained ministry and of lay people in the healing ministry, depends on its own tradition and structure. The Church of England has, e.g., appointed in many places a healing advisor on the level of the diocese. This minister is responsible for encouragement, education, and also spiritual and pastoral advice for emerging healing ministries in cooperation with the regional bishop. The healing ministry of the church there by receives a visible recognition and support in the church as a whole instead of just being delegated to specialized institutions or restricted to the local situation.

The Need for Educating Christians for the Healing Ministry–Integration Versus Compartmentalization

61. There is a growing consensus that education for the different forms of Christian healing ministry is not as widespread and developed as it ought to be in the various sectors of church life. Explicit teaching on a Christian understanding of healing in many programs of theological education is absent or still underdeveloped. However, recently efforts have been made to include HIV/AIDSin the curricula of institutions of theological education in Africa. But many training and

educational programs are taking place only within the different fields of specialized competence. Nurses, doctors, diaconical workers are educated within their own professional fields. There is no interaction between different education programs and fields of competencies, and there is a lack to introduce issues and basic themes of Christian healing within the mainline stream of ministerial and adult education in general.

The Healing Ministry of the Community and Healing Professions

62. The deliberations of the consultations at Tübingen in 1964 and 1967 and the setting up of the CMC in 1968, with the development of the concept of Primary Health care (PHC) in the1980s created a PHC movement that began with great hope for change but has not been sustained. The divide created between high technology-based medicine on the one hand and primary health care on the other has been detrimental to the struggle for a better and healthier world. While committed Christian professionals developed outstanding programs in primary health care, the congregational involvement in the PHC movement was patchy and minimal. Though the access and justice issues were addressed to some extent in that movement, the spiritual aspects were not addressed appropriately. Traditional systems of medicine in many countries have been unnecessarily condemned by the modern allopathic system of medicine and have developed in isolation and in competition to it, creating problems of relation between Christian communities and traditional health specialists.

63. Additional dramatic changes in society and health systems have brought increased tensions in recent

years for many of those who are working within the established medical systems, in particular in industrialized countries and centers. Increasing pressures to rationalize healthcare, to reduce costs and medical personnel tend to prevent doctors, nurses and assistants to relate to a holistic approach in health and healing. At the same time, the need for addressing the whole person in health care has become more than obvious in many parts of the world. How medical personnel will be able to respond to these contradictory requests remains an open question. It is encouraging to discern signs and signals of anew quest and openness for cooperation with religious organizations, particularly Christian churches, in many secular institutions of the established health system.

64. Christian churches should be open and receptive to listen and learn from the situation of those facing the ever more growing contradictions and shortcomings within the established medical systems. The health professionals on their part should recognize that health issues move beyond the individual to the community which is a social network with many resources and skills that can promote health. Health professionals are challenged to see themselves as part of a broader network of healing disciplines that include the medical, technical, social and psychological sciences, as well as religions and traditional approaches to healing. This wider view will help the professionals to integrate suffering into the concept of health and enable people with incurable physical problems to be healed persons. It will also encourage the health professionals to share information with and empower the patient to feel responsible and take decisions for their own health.

65. The primary health care approach in the community should be backed by adequate secondary and tertiary

care facilities. The referral system should be reciprocal and mutually supportive.

Healing Ministry and Advocacy

66. While this document concentrates on the medical and spiritual aspects of the healing ministry, it acknowledges that there exists a wider definition of healing which includes efforts of persons, movements, societies and churches for fundamental transformation of structures which produce poverty, exploitation, harm, and sickness or illness. The earlier CMC study of 1990 (Christian Medical Commission, 1990) is still considered a valid guideline for that wider aspect of the healing ministry, which gained even more urgency with the HIV/AIDS pandemic. The1990 document considers health to be a justice issue, an issue of peace, and an issue related to the integrity of creation. Consequently, it requests a healing congregation to "take the healing ministry into the political, social and economic arenas: advocating the elimination of oppression, racism and injustice, supporting peoples' struggle for liberation joining others of goodwill in growing together in social awareness, creating public opinion in support of the struggle for justice in health" (Christian Medical Commission, 1990).

67. All Christians, especially those active in healing ministries and in medical professions, those gifted with the charisms of prophecy, are called to be advocates for such a holistic approach on national and international political scenes. Because of their specific competence and experience, they bear a special responsibility to speak with and on behalf of the marginalized and the underprivileged and contribute to strengthen advocacy networks and campaigns to put pressure on international organizations, governments, industries, and research institutions, so that the present scan-

dalous handling of resources be fundamentally challenged and modified.

Training

68. Because of all these aspects of the church's mission in terms of health and care, training for medical and health professionals will be a key area for appropriate action. Congregations and those who work in the pastoral areas too need training on the holistic approaches to health and the specific contributions they can make as alluded to in this document.

69. The challenge is for Christians to continue to engage communities - in such away as to incorporate the pedagogy of healing in the church, so as to motivate and mobilize communities to identify the core issues of ill health, to own the issues and to take effective action Identify with the holistic understanding of the healing ministry in the Gospel Work with wider societies to bring about difference in people's health and life.

V. Open Questions and Necessary Debates

70. This chapter contains items on which there is ongoing debate among Christians from different denominational traditions and/or cultural backgrounds. This does not mean that all affirmations be low are contested. But the scope and consequences of some are subject of debate.

All Healing Comes from God – Christian Healing Spirituality and Non-Christian Healing Practices

71. That all healing comes from God is a conviction shared by most if not all Christian traditions (World Council of Churches, 1965:36). There is however a debate as to the consequence of such an affirmation for the

approach of people and traditions or healing practices of other religions.

72. Affirming the presence of God's healing energies at work in the whole of creation, thanks and praise should be given for all different means, approaches and traditions which contribute to the healing of human persons, communities as well as creation, by reinforcing their healing potentials.

73. In many contexts where a strong longing for healing is felt both within as well as outside the Christian churches the question of Christian openness towards and reliance on healing practices rooted in other religions (such as various traditional religious medicinal approaches, but also Yoga, Reiki, Shiatsu, Zen-Meditation etc.) is however much debated within churches and Christian health related institutions. To what extent is Christian healing spirituality compatible with healing practices from other religions? Are those reconcilable and in harmony with basic principles of Christian spirituality?

74. Christian spirituality should show openness to all means of healing offered as part of God's ongoing creation. At the same time there are healing practices which associate themselves with a religious world view which can be in contrast to basic Christian principles, and some Christians are particularly attentive to such dangers. For other Christians still, caution is requested, because evil spiritual powers might disguise their destroying effect behind apparently beneficial healing practices.

75. No healing practice is just neutral. It needs critical theological assessment. This is not to say that any Yoga or Reiki practices, e.g., Have no place in Christian parish centers. They can be practiced, many

Christians in the West believe, in ways which do not lead to a dissolution or fundamental distortion of Christian faith and the Christian community. The church has always been aware that God can reveal aspects of how creation works and contributes to healing through peoples of other languages, cultures, and even religious traditions and this also applies to the realm of medical treatment, alternative medicine, and alternative healing practices.

76. But caution or even explicit rejection are recommended wherever religious dependency is created on the healer or Guru, absolute spiritual, social or economic obedience is demanded, human beings are kept in a spirit of threat, anxiety or bondage due to healing practices, the success of a healing is made dependent on fundamental changes in the religious world view of Christians.

77. As the biblical tradition shows, Christians are invited and commissioned to test everything, hold on to the good and abstain from every kind of evil (1 Thessalonians 5:21-22). When encountering practices of healing and energetic therapeutic work rooted in other religions, Christians should always first of all feel encouraged to rediscover the rich diversity and ancient spiritual traditions of healing with in the Christian church itself.

Debate on the Concepts of Demonology and Power Encounter

78. Traditionally, the term "demonology" in Christian theology has been part of the doctrine of angels (angelology). Demons/demonic powers denote the “dark”side of the spiritual reality. The term"power[s]" in theological and ecumenical discourse is used in more than one way. Often and in particular in ecu-

menical circles it is used in relation to political violence and oppressive social structures.

79. Among Pentecostal-Charismatic Christians-but also beyond, among those who continue in the tradition of classical Christianity-the term "powers" usually mean spiritual powers, evil spirits, demons. Consequently "power encounter" is understood as an encounter between the (spiritual) power of God and other gods/spiritual realities. These Christians believe that the true God will show off God's power over others. While it is important that such dialogue does not simplify the complex intricacies of spirit worlds thriving in– and alongside – the age of post-modernismitshould at the same time resist any attempt to turn the Holy Spirit into a powerful means to an end as if the church had to vindicate God.[36] The church is to witness for the living God. She has not to prove God right.

80. An ecumenical challenge to the churches is to acknowledge the various meanings assigned to the talk about powers and try to resist reductionism. While the traditional way of relating "powers"to spiritual forces seems to be the primary biblical connotation, the understanding of powers in terms of social and political realities is also present in the Bible (e.g., The temptation story in Matthew 4:1-11 and Luke 4:1-13) and can be seen as a legitimate interpretation of the Christian message.

81. The Pentecostal-Charismatic interest in power encounter poses serious challenges and can be subject to theological and pastoral concerns. The idea of "power encounter" as explained above may lead to a

[36]God vindicates the church instead: Matthew 10:19-20; Luke 21:15; Mark 13:11.

triumphalist, aggressive presentation of the Gospel. In some cases, "spirits" are attributed influence and power beyond what appear to be appropriate theologically, blurring the meaning of individual and collective responsibility.

82. This being the case demonology and exorcisms present cognitive and spiritual challenges to those churches whose frame of reference and theology is shaped by a post Enlightenment scientific rationality as is that world view to the one explaining events through referring to spiritual beings. An appropriate intercultural and ecumenical dialogue for the sake of the churches' ministry of healing as a whole seems urgent.

Sharing Resources and Insights in Christian Healing Within the Ecumenical Fellowship

83. Many church traditions have their own rich insights and liturgical as well as theological treasures and can contribute to a holistic understanding and new appreciation of the Christian ministry of health and healing today. The Anglican, Orthodox, and Roman Catholic traditions offer distinct and different healing liturgies. It is encouraged to make these known among other denominations and traditions and to share such formulas which exist within the ecumenical community of churches.

Study and Dialogue on Demonology

84. It would be a worth while task for the WCC mission desk to initiate a wide scale study process on the topic of demonology and powers since, as mentioned, it is a topic that Christians and Christian communities are tackling in their everyday life. One part of the study

task would be to consider the issue of rehabilitating the office of exorcist as Christian ministry in those church traditions where it does not exist.

Ecumenical Initiative on Healing Spirituality

85. It could be well considered whether for the years to come an ecumenical initiative is needed to deepen the Christian healing spirituality and to encourage related formation courses for voluntary workers, professional healthcare workers and ordained ministers.

The Need for Roundtables on the Future of Health, Spirituality and Healing

86. Established institutions of health care in many countries are in a process of transformation and institutional crisis, partly due to economic factors and financial instability, lack of proper management and leadership, rising costs of high technology medicine, changed patterns in the behavior of patients, lack of compliance of the patients and the demographic imbalances in many Western societies. Historically speaking Christian mission had played a pioneering role in bringing about and shaping the health systems in many countries of the South. It also has a responsibility in contributing to overcoming the crisis of the established institutions of healthcare at the beginning of the 21st century. In accordance with the tradition of the Christian Medical Commission and recent proposals it is recommended that the various Christian medical commissions and associations existent in the different regions of the world join hands and establish interdisciplinary dialogue forums on the future of healthcare and health systems both in the West as well as in the South. Ways of exchanging and strengthening the collaboration between the various

regional Christian medical associations should besought in order to give new profile to the Christian ministry of healing and make it more visible and effective before the eyes of the world.

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