THE SOUREST FLOODING OF THE EARTH
ARE THE POOR PEOPLE'S TEARS,
SILENT AND SECRET TEARS:
WATER AND BLOOD WHICH SWELL THE RIVERS
OF ALL COUNTRIES.
David Maria Turoldo

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Union of Superiors General Men
International Union of Superiors General Women
USG - UISG

IN LOVING SERVICE

A Global Analysis of the Commitment of Religious Institutes against HIV and AIDS

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PREFACE

HIV and AIDS is a global pandemic with over 40 million estimated to be living with the syndrome. It is one of greatest disasters and challenges facing humankind at the beginning of this millennium. Religious sisters, brothers and priests have been involved in outreach right from when the condition was first identified. We have always been of the opinion, without having precise proof, that the Catholic Church was one of the most involved bodies and one of the biggest players in the battle against this plague largely through the work of the religious sisters, brothers and priests. But our involvement as religious had many limitations due to weak coordination among ourselves, inadequate visibility, under-valuation, insufficient advocacy and limited access to funding due to negative perception of our work.

So the overall objective of this mapping project was to provide a truer picture of the extent of the outreach of Catholic Church related activities in response to the global pandemic of HIV and AIDS. We sought to detail exactly what religious congregations were doing in this field. But the overriding objective was to provide data which might lead to a still more effective response to the HIV and AIDS plague on the part of religious as we are very conscious of the need for good social analysis.

You have before you the result of our survey or mapping exercise on the involvement of religious in the battle against HIV and AIDS. Our gratitude goes to Sr. Maria Martinelli of the Comboni Sisters, who was released by her congregation to coordinate the project, and has seen it through to its conclusion with the help of her work group. We are also indebted to Mrs. Sally Smith and numerous others people at UNAIDS for their active interest encouragement and advice. Dr. Jack DeGioia, President of Georgetown University, and Jessica Raper, Special Assistant for Policy Analysis to Dr. DeGioia, arranged for the university's contributions to the report; his faculty, including Dr. Irene Jillson, analyzed the data and collaborated in writing this report,; Nancy Crowell created the database and the Google maps and carried out the statistical analysis and participated in report-writing; Ruya

Norton and Andrei Stoica assisted in the data analysis; Camille Boostrom edited drafts of the report; Dr. Betsi Stephen and Dr. Betsy Sigman created an initial version of the data base. We are most grateful to Mgr. Robert Vitillo of Caritas Internationalis for his enthusiasm, encouragement and forthright expert advice at all stages.

There are numerous issues which emerge from the findings of the mapping survey and for this reason it is intended to organize a Forum after Easter 2008 on the results and implications of the mapping survey so as to plan the way forward with some clear guidelines.

I was personally very struck by the incredible amount of work which is being carried out in this field by religious and their lay collaborators. I was saddened that not all religious involved in this field responded to our questionnaire.

I was encouraged by the fact that most religious working in this field saw involvement in combating the stigma which accompanies AIDS as a priority in their projects. I was upset by the fact that those religious involved at the coalface risk burnout because of their work load which is doubled due to the fact that they spend half of their time travelling the world looking for funds to operate their projects thus losing valuable time which could be more profitably spent sharing their professional skills with those most in need.

There are numerous challenges for us religious in the justice, pastoral, ethical, and educational areas, but we are also invited to overcome the fragmentation which presently exists among ourselves so as to speak with one voice and establish a new culture of cooperation and communion. There are developing countries where Christians provide as high as 40% of healthcare delivery, but have no voice, and are left to fight their battles on an individual basis with poor results.

The survey raises the profile of the Church involvement in the pandemic and already other bodies have requested permission to share our text and methodology as they attempt similar projects.

It is quite clear from the responses that Guidelines are required that would establish a coherent and sustainable approach for religious which can be adapted to the local circumstances in dealing with the dif-

ferent issues resulting from HIV and AIDS – testing of candidates for religious life, dealing with our own religious with AIDS, with employees…

We have been given valuable information by our painstaking researchers. It is now our obligation to use it to better the situation of some of the world's most vulnerable sufferers. We believe that in the case of HIV and AIDS that we are called to be a voice for the voiceless.

FRANK MONKS
Health Commission
USG/UISG

INTRODUCTION

Closely following Christ's example, the Church has always considered the cure of the sick as an integral part of her mission. Therefore I encourage the many initiatives promoted, especially by ecclesial communities, to eradicate this sickness, and I feel close to AIDS sufferers and their families, invoking upon them the help and comfort of the Lord.

Pope Benedict VII, November 2005

From the beginning of the global HIV and AIDS epidemic, members of Roman Catholic Religious Institutes (commonly known in some regions as religious orders)[1] have played critical roles in providing direct care to people who are infected with HIV and who are suffering with AIDS. They have prevented HIV among people with high risk behaviors and the general population, provided treatment to those with HIV and AIDS, and addressed the cultural, political and socioeconomic factors that contribute to both proliferation of the disease and to its consequences. These dedicated men and women – approximately 1 million members of Religious Institutes (consecrated religious) and 3 million lay persons – work in close to 1000 hospitals, over 5000 dispensaries and 800 orphanages in Africa alone.[2]

Their work has extraordinary impact on the lives of those for whom they care and on the prevention of HIV in the communities they serve. Catholic religious leaders in Uganda, including members of religious Institutes, were significantly involved with the Ministry of Health in its successful prevention policies since the very beginning of the epidemic. Priests of several religious Institutes in Jamaica have engaged in prevention services and provided palliative care since the mid-1980s.[3] In

[1] For purposes of this report, the term "institutes" is used to refer to those organizations that comprise groups of Catholic Religious Men and Women. Terms that could also be used are "Congregation", which may be considered the most appropriate in terms of ecclesiastical language, or "Orders" although this term may be construed as referring only to the large, older religious groups.

[2] Source: Catholic Church "Statistical Yearbook" 2002.

[3] Jillson, IA (2005) Youth in Jamaica: Current Realities and Future Possibilities. Bethesda, MD: Master Key Consulting.

1985, Mother Teresa established the first hospice for AIDS patients in New York[4] —an act that is considered by many to have helped to reduce the stigma against the disease which was then even more pronounced than it is now in the United States. Often, these services were built on a long history of caring for vulnerable populations, including the poorest of the poor, orphans, and those living in areas of conflict and post-conflict.

Although it has been reported by Vatican officials that the Catholic Church sponsors approximately 26,7% of all AIDS-related services,[5] the breadth and depth of the role of these Catholic individuals and organizations is largely unrecognized and under-funded. Most of the services is provided voluntarily but with an urgent need for medications, supplies and equipment necessary for prevention and treatment.

[4] http://www.ewtn.com/motherteresa/vocation.htm

[5] Barragan, JL (2006) Statement by Cardinal Javier Lozano Barragan, President of the Pontifical Council for Health Pastoral Care Presented at the United Nations General Assembly. New York: United Nations.

GLOSSARY

Advocacy	Speaking or acting in support of, or on behalf of, the poor and other vulnerable populations in accordance with their rights and needs
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral (drug)
Counselling	Relationship in which a person helps another in understanding and solving his/her problem connected with his/her HIV status and related health and social consequences – can be provided by a trained clinician (e.g., nurse) or other trained individual and can be individual or in group sessions
Environment	All conditions that can create difficulties, including for example the natural environment (e.g., availability of potable water), economic, political and social
FBO	Faith-based organization
HIV	Human Immunodeficiency Virus
NGO	Non-governmental organization
OI	Opportunistic Infections
Peer education	HIV and AIDS education provided by trained, self-identified members of the target population to groups of their peers. Peer educators usually serve as role models, demonstrating to their peers behaviours that promote risk-reduction
Phitotherapy	Treatment of sickness with plants
PLWHA	Persons living with HIV and AIDS
PMTCT	Prevention of mother-to child transmission
Stigma	Negative social attitudes or display of hostile or discriminatory behavior; in the case of HIV and AIDS, this often relates to PLWHA, people in high-risk categories
TB	Tuberculosis
VCT	Voluntary counselling and testing
UISG/USG	Unions of Superiors General of Religious Institutes of Women and Men
UNAIDS	Joint United Nations Programme on HIV and AIDS
WHO	World Health Organization

1
THE "MAPPING" PROJECT

Overview

The lack of recognition of the role of Religious Institutes, their members and lay volunteers in addressing HIV and AIDS is a barrier to a broad understanding of the global response to this disease, the social and economic value of voluntary services, and the ability of those providing care to elicit funds to support the urgently needed care they provide.

The "Mapping" Project was conceived as means of overcoming this barrier. Specifically, it was designed by the Unions of Superiors General of Religious Institutes of women (UISG[1]) and men (USG[2]) to facilitate both enhanced understanding of the range of HIV and AIDS services carried out by the Institutes and the creation of informal networks of Catholic Church-sponsored HIV and AIDS activities at the local, regional, national and global levels. The informal network will include a planned website that will serve as a forum for exchange of ideas and sharing information about HIV and AIDS services, related issues at the local, national and global levels, and problems that the Catholic Church faces with regard to sponsored activities in the field.

[1] The International Union of Superiors General (UISG) is a worldwide membership organization for the superiors general of institutes of Catholic women religious. Established in 1965, the Union has its headquarters in Rome. All superiors general of the Catholic orders of women religious are entitled to membership. The purpose of the UISG is to promote understand of the religious life of Catholic women religious throughout the world and to foster its development in the Church and in society. The Vatican Yearbook for 2004 reports that there are 782,932 women religious in the world. They belong to the various religious orders, the superiors general of which comprise the membership of the UISG.

[2] The Union of Superiors General (USG) represents the counterpart organization for superiors general of religious orders of men. The Vatican Yearbook for 2004 reports that there are 137,724 religious priests and 54,828 religious brothers in the world. They belong to the various religious orders, the superiors general of which comprise the membership of the USG.

It can also strengthen the capacity of the religious Institutes, their members and lay associates to carry out HIV and AIDS care by providing a venue for mutual support. The enhancement in visibility could encourage new sources of funding and elicit voluntary technical assistance for Catholic organizations involved in HIV and AIDS services. The information will also contribute to the efforts of UNAIDS and other organizations to "map" HIV and AIDS services provided by faith-based organizations (FBOs) generally.[3] These organizations – Buddhist, Christian, Hindu, Jewish, Muslim and other – contribute importantly to addressing the individual and societal health, socioeconomic and other consequences of the disease, and importantly to its prevention.

Methodology

In December 2005, representatives from a number of different Religious Institutes involved in HIV and AIDS activities met with UNAIDS and other relevant partners to develop a plan to conduct a survey within the Catholic religious Institutes of women and men to identify the types of HIV and AIDS activities in which they are currently engaged. The project was overseen by the Joint Commission on Health Care that was recently established by the UISG and USG. The surveys were designed by UISG and USG with technical and financial support from UNAIDS and Caritas Internationalis. Under the auspices of the Office of the President, Georgetown University faculty and students analyzed the data and created the Mapping Database.

The survey, see Appendix 1, comprised nearly 50 questions in five categories: prevention, care and support, treatment, additional activities (e.g., networking with other NGOs), and financing, including fundraising activities. Respondents were also asked to indicate the specific types of services provided and the number and types of persons served. The survey also included an open-ended question designed to elicit other information that the respondent might care to offer.

[3] See, for example, discussion of FBO involvement in HIV and AIDS prevention and treatment in: Keough, L and Marshall, K (2007) *Faith Communities Engage the HIV/AIDS Crisis: Lessons Learned and Paths Forward*. Washington, DC: Georgetown University.

The UISG and USG distributed the surveys to all of the national and international Institutes of men and women religious active in more than 200 countries. A total of 446 individuals representing their communities returned partially or fully completed surveys to USIG/USG. Rev. Msgr. Robert J. Vitillo, Special Adviser on HIV and AIDS of Caritas Internationalis, played a major role in encouraging religious Institutes throughout the world to participate in this important survey, contributing to the response rate. Notably, the USIG/USG also received letters and incomplete surveys indicating that, while the individuals do not directly carry out specific HIV and AIDS activities, they keep those who have HIV and AIDS or who are at-risk for the disease in their prayers. Some also indicated that they indirectly engage in HIV and AIDS activities through general public health services and/or education – including for example educating young children about self-esteem and healthy habits. The surveys were then forwarded to Georgetown University for the purpose of data analysis, including mapping of HIV and AIDS services provided by respondents. The database created by Georgetown – including quantitative and qualitative responses – will be maintained by the UISG/USG.

Becoming Visible: Revealing Roles to Strengthen Them

Hopefully this survey will reveal the work of so many religious men and women throughout the world, who since the beginning of the pandemic were not afraid to be beside those suffering of AIDS and their families—providing companionship as well as care, had the courage to tell the truth about the ways the disease is transmitted, about their role in prevention and education programmes, and how they work with young people to offer them positive values as foundation for their life.

2
HIGHLIGHTS OF FINDINGS

The Context

> *"The biggest concern … in the local parish school is that the parents of students are dying at the rate of one per week" (a priest's observation in South Africa).*

An astonishing 33 million persons were estimated to be living with HIV and AIDS in 2007, and 2.9 million died of the disease – 10% of the total 25 million who have died since 1981 (CDC, 2007). According to a recent study conducted by the World Health Organization (WHO), HIV and AIDS will be the leading cause of burden of disease in middle- and low-income countries by 2015.[1]

Beyond the tragic loss of individual lives are the effects that these deaths have on families and society: UNAIDS estimates that in 2005 there were more than 15 million children under 18 orphaned as a result of AIDS, more than 12 million of whom lived in Sub-Saharan Africa.[2] Young people under 25—the future of all communities and nations – account for half of all new HIV infections worldwide. Health and social service systems are significantly over-burdened, providing care for the wide range of contagious, chronic and other health problems that abound in addition to providing HIV and AIDS care. Antiretroviral medications (ARVs), although increasingly available, are not being received by nearly two-thirds of those who need them. In low and middle-income countries, an estimated 28% of the 7.1 million individuals in immediate need of ARVs at the end of 2006 were receiving these

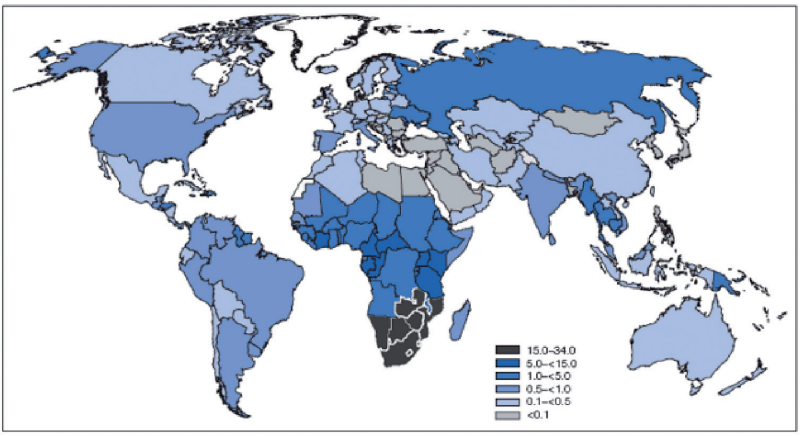
[1] Mathers, CD and Loncar, D. (2006) Projections of Global Mortality and Burden of Disease from 2002 to 2030. PLOS Medicine. Retrieved October 14, 2007 from http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371%2Fjournal.pmed.0030442&ct=1

[2] UNAIDS (2006) Report on the Global AIDS Epidemic, Chapter 4: the impact of AIDS on people and societies. New York: UNAIDS.

life-extending drugs.[3] Geographical and national differences in the incidence and prevalence of HIV and AIDS 25-year course of the epidemic have been, and remain, marked. Figure 1 depicts the prevalence of HIV among adults, by region (and where available, country) in 2005, the year in which respondents reported services provided.

Figure 1: HIV prevalence in adults, 2005

Estimated percentage of adult population* living with human immunodeficiency virus (HIV) infection, by country – worldwide, 2005†



Source: Joint United Nations Programme on HIV/AIDS (UNAIDS). 2006 report on the global AIDS epidemic. Geneva, Switzerland, UNAIDS, 2006.
Available at: http://www.unaids.org/en/hiv_data/2006globalreport/default.asp
*Aged 15-49 years.
†The worldwide estimate of the number of persons living with HIV is 38.6 milion.

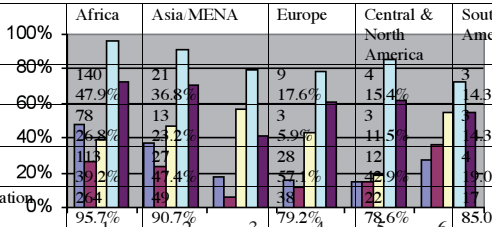
[3] WHO/UNAIDS/UNICEF (2006) Significant growth in access to HIV treatment in 2006 More efforts needed for universal access to services. Retrieved on October 14, 2007 from: http://www.who.int/mediacentre/news/releases/2007/pr16/en/index.html

Geographic Distribution of Services Offered

The distribution of voluntary counselling and testing (VCT), PMTCT, ARV treatment, education, and stigma eradication services provided by the Institutes and diocesan organizations, as reported by respondents to this survey, is shown in Figure 2 and Table 1. Appendix 2 presents the numbers and percentage of services provided by country, region and type of service; maps depicting the distribution of services by region are presented in Appendix 3. It should be noted that the regions depicted are geographical, not political regions – so Asia includes the Middle East and North Africa (MENA) and Central and North America are combined, rather than the more commonly known Central and South America.

There are notable regional differences in types of services offered – for example, a higher prevalence of voluntary counselling and testing (VCT) in Africa, Asia/MENA and Oceania than in Europe and Central, North and South America, and the significantly lower prevalence of ARV services in South America than in other areas. This may reflect a number of circumstances over which the Religious Institutes have no control, including for example, availability of public services, or lack of ARV medications in the country.

Figure 2: Services Provided, by Region



Service	Africa	Asia/MENA	Europe	Central & North America	South America	Oceania	Total
VCT	140 47.9%	21 36.8%	9 17.6%	4 15.4%	3 14.3%	3 27.3%	180
PMTCT	78 26.8%	13 23.2%	3 5.9%	3 11.5%	3 14.3%	4 36.4%	104
ARV	113 39.2%	27 47.4%	28 57.1%	12 42.9%	4 19.0%	6 54.5%	190
Information-Education	264 95.7%	49 90.7%	38 79.2%	22 78.6%	17 85.0%	8 72.7%	398
Stigma Eradication	205 72.2%	70 70.2%	21 41.2%	17 60.7%	13 61.9%	6 54.5%	332

The percentages refer to Institutes that have answered to the survey.

1 = Africa 2 = Asia/MENA 3 = Europe
4 = Central & North America 5 = South America 6 = Oceania

Light violet = VCT Red= PMTCT Yellow = ARV
Light blue = Information Dark violet = Stigma Eradication

Table 1: Number and Percentage of Programs That Provide Specific Services by Region

Nonetheless, for those who toil at the local level to provide urgently-needed services to their populations at risk for HIV or who are infected with HIV and AIDS, the comparative numbers are not of real concern; what matters to them is each individual, each family to whom they are committed. This is clear in the degree to which they provide services under dire circumstances and with scant financial resources.

Overview of Services Provided

In one village in Uganda, the Comboni Samaritans provide school sponsorships for 86 children who are orphaned and who are heads-of-household – an extraordinary burden. They also assist in caring for their 618 siblings.

Just under 40% (180) of respondents reported that the Institute-operated programs in which they worked provided voluntary counselling and testing (VCT) services, with a mean of 911 HIV tests performed by each organization in 2005. Fewer (22.8% or 104 programs) offered preventing mother-to-child transmission (PMTCT) services; of these, services were provided to a mean number of 432 mothers. Notably, provision of services varied by geographical region (see Figure 2 and Table 1), although a number of caveats need to be considered in interpreting these differences, including significant differences in the numbers of respondents from the regions. Respondents from Africa were much more likely to provide VCT services than those from other areas, but less likely to provide ARV care than others, with the exception of those from South America. The variability in access to ARV medications during the time the survey was conducted should be noted (see paragraph *Treatment*).

Above all, Companionship

It was in 2000 that Mathieu, 2 years old, was hospitalized several times. His father died of AIDS a year before and his mother, looking after him and Alexis, his four year old brother, was on palliative treatment. That day, when Mathieu was dying, and while I was trying to alleviate his suffering, a watchman of the Hospital came to me with Alexis, whom he found wandering in tears towards the town. As I held him in my arms, asking him where he was going and why, he answered in a way that left me speechless and with an enormous sense of powerlessness that invaded my heart. He said: "*I was going to market to sell myself for $4 so that my mom has enough money to buy good medicines for my brother*".

In these few words were synthesized both my challenges and frustrations facing the HIV and AIDS scourge: life-saving ARVs were not available yet in the country, except for very rich people buying them from abroad.

> Most of all, Alexis was obliged to witness the long, painful dying process of his father and his little brother, and he was somehow conscious of the fact that he was to be left alone very soon. This is only one of the hundreds stories I carry in my heart and give a sense of what I am doing now: working on HIV and AIDS is not just a matter of huge numbers, nor of seeking funds, nor of diagnosing the disease and providing medicines. Beyond this, it is also a matter of caring for each individual child and adult in the face of their fears, tears, anger and depression. It is also a matter of being able to look in their eyes and remember their names, and to be their companion, give them a hug and a hope, while acting to find a solution.
>
> How many families such as that one had I already met since 1988? How many children whose future was so uncertain like that of Alexis or so short like that of Mathieu? How long would it have taken before the poor in that country could have access to ARVs? How can we halt this terrible epidemic and all the suffering it was bringing about? *(Sister Maria, Chad)*

Stigma Eradication efforts and other HIV and AIDS-related services go hand in hand; those programs that provided VCT, PMTCT, or ARV services also were highly likely to provide stigma eradication and education services (See Figure 2 and Table 1) and only one-third (32.5%) of those programs engaged in stigma eradication efforts were not involved in the provision of VCT, PMTCT, or ARV.

Education and Prevention

> *During the 12 months prior to the survey, the respondents provided education/information services to 3.9 million individuals.*

By far, the majority of these Catholic religious men and women were engaged in the provision of *information/education services*: 91% (or 398) of respondents reported that they did so, primarily to their own church and organization members (73%), through schools (70%), to workers in their communities/neighborhoods (63%), and parish groups (59%).

The types of education/prevention mechanisms used by respondents include peer education (46%) and peer groups (68%) and, to a lesser extent, dissemination of information through the radio (22%). These information/education activities reached a total of 3,925,304 individuals, with a mean number of nearly 15,000 beneficiaries for each responding organization. The respondents reported that, in their programs, a total of 1163 religious Institute members were involved in

education and information services – as were 6744 volunteers and 3483 paid staff members. In one community, the religious institute has initiated a project through which they provide HIV and AIDS education in schools. This three-year, three-phase program uses an integrated approach that includes personal development, gender education, value education/formation (including issues in the society), sexuality education, HIV and AIDS education, and life skills education.

Youth Alive

Youth Alive clubs were established as a way to provide ongoing character formation and positive peer support. Although based on Christian faith and values, they welcome youth of all denominations and beliefs. The Clubs have both broad and specific objectives, including educating youth regarding HIV/AIDS, helping them to grow and develop their spiritual, physical, and mental capacities, and creating an awareness of moral and cultural values. The program, designed primarily for youth ages 10-14, includes a wide range of activities—ongoing character formation workshops and follow-up programs, active participation in planning for and holding rallies, music festivals, sports, music and drama, and Education for Life behaviour change workshops. These workshops were developed by Sr. Kay Laylor, MMM based on her experience in prevention and awareness education in Uganda; they are now used in several countries in Africa.

Care and Support

> *During the 12 months prior to the survey, the Religious institutions which responded to the survey provided caring and support services to 348,169 individuals.*

Nearly three-fourths of responding organizations (73%) provided pastoral care (including spirituality and prayer); 55% operated counseling centers and support groups; approximately 45% provided extended services for women and orphans.

The care that the Catholic Institutes' members and volunteers are providing for orphans – a highly vulnerable and dramatically-increasing population – is critical. This is true in part because most governments have scant resources to provide for them and because the family and social structures that would traditionally have been cared for them have been devastated by HIV and AIDS. In some cases, the services—meeting the spiritual, physical, and emotional needs of these children— are specifically for HIV and AIDS orphans; in others, they are integrated with the longstanding programs that these religious men and women have had for orphans among the populations they serve. The Farm School in Uganda is one example of an innovative program developed

by members of Catholic Institutes to address this significant social problem. Children in this school are taught farming methods, including care of small animals for example, as well as reading and writing; they also are engaged in social interaction activities.

Farm School, Uganda (Medical Missionaries of Mary).
AIDS Orphans Overcoming Grief, Learning and Enjoying Friendships.

Health services of various types were provided by approximately half of the respondents; in order of prevalence of services, they are:

Nutrition	60%
Palliative care	45%
Home-based care	43%
Hospital based care	37%
Clinical based care	35%
Alternative medical care	19%

Alternative (and complementary) care is commonly provided in areas in which "modern" medicine (including ARV, in the case of AIDS treatment) is not readily available. Notably, the use of alternative (traditional medicines) is increasingly used throughout the world as a complement to modern medicines. This is one of the reasons that in the U.S. the National Institutes for Health has created an Institute for Complementary and Alternative Medicine.

Nearly two-thirds of the respondents provided the care completely gratis; the remaining requested partial payment. Nearly half (48%) provided financial help to the sick person and/or his or her family. A total of 1476 Religious Institutes members were involved in care and sup-

port services as were 6737 volunteers and 10,989 paid staff members. They served a total of 348,169 individuals in the 12 months prior to the survey, with a mean number of nearly 1,500 beneficiaries for each responding organization.

From Tragedy, Creative Energy and Ideas for a Sustainable Future

A mother, dying of AIDS, turned to me and said "what will happen to my children when I am gone? Will you take care of them?" Moments like this prompted me to think of ways in which we could help orphans who had been obliged to drop out of school to take care of their dying parents. As well as losing one or both parents, they find they have no money for school fees, uniform and books, not even for basic food for themselves and the younger brothers and sisters left in their care. We talked about the situation among ourselves and tried to see the positive elements in this dark situation. First of all, there is the fact that the orphans have youth on their side. That means energy, ambition, young brains and the ability to learn. And then there is land. Putting these positive elements together, we saw that as well as grief counselling, we needed to give them some activity that would harness their energy, nurture their ambition and help them acquire the skills that their parents would have given them if they had lived.

It was then that we came up with the idea of creating Farm Schools. We started first with one Farm School. The idea proved to be so popular and effective that it was not long until we had to find premises for a second, a third and so on. Today, we are running six Farm Schools with about a hundred boys and girls in each, the gender fairly evenly balanced.

The boys and girls come to the residential Farm School for one week each month. They learn to read and write if they had not already become literate and to improve their literacy if they had already begun. They also learn basic mathematics, marketing, book-keeping and how to handle a bank account. There is also plenty of time for games, peer counselling and individual counselling. In this way, they get a sympathetic ear as they try to work through their feelings of loss, anger and fear. (*Suor Ursula Sharpe*)

Treatment

During the 12 months prior to the survey, the respondents provided ARV services to 90,154 individuals.

A total of 297 members of religious Institutes were involved in ARVs services as were 2332 volunteers and 762 paid staff members. They served a total of 90,154 individuals in the 12 months prior to the survey, with a mean number of nearly 527 beneficiaries for each responding organization.

However, the role of the religious organizations in providing antiretroviral therapy (ARV) was hampered by lack of ARV supplies. Seventeen percent of respondents reported that they have problems with ARV supplies – indeed, a mean of 403 patients who needed ARVs did not have access to the medication. Lack of financial resources also hampered provision of treatment: nearly three-fourths (73%) of respondents – 190 altogether – indicated that a lack of funds was an impediment to providing the services; inadequate numbers of trained personnel was cited by 43% of respondents. Moreover, in many regions, ARV medications were not available in 2005 (when the survey was disseminated), nor was specific training for health providers. In many African countries, there is also a real lack of trained health personnel, including nurses, lab technicians, midwives, doctors, caused in part—and paradoxically—by a "brain drain" of health personnel to industrialized countries.

Nonetheless, 23% of respondents directly provided ARVs, 43% referred for ARV services and nearly 10% provided home-based ARV services. Although most of these services were provided by referrals, many respondents were engaged in ensuring adequate care for these patients. Forty-four percent ensured medical follow-up of their patients on ARVs, 40% engaged with the patients to ensure treatment literacy, and 33% carried out activities that help to ensure treatment adherence. Just 17% had pediatric formulations of ARVs available for the children they serve. This is to be expected: as of 2006, only 12 of the 21 ARVs approved by the U.S. Government Department of Health and Human Services/Food and Drug Administration (HHS/FDA) for the treatment

of HIV and AIDS were approved for use with children, and of these, only seven were approved for children under the age of two years.

Training Community Health Workers (Congo R.D.C.)

Just 16% of the respondents reported that they had laboratory facilities—essential for both prevention and treatment of HIV and AIDS. This is not uncommon among FBOs, which lack the financial resources to purchase necessary equipment and supplies. In lieu of their own facilities, many FBOs— and even public sector health facilities at the primary care level—referred patients to larger health facilities for specific laboratory tests. Training of program staff is critical for their ability to expand services to include provision of ARVs. Although only 36.9% of respondents said their medical staff received specific training on ARVs, staff members who had received the formation are involved in some aspect of delivering ARVs to patients. Of those whose medical staff had specific training in ARVs:

86.0% prescribe ARVs
84.6% regularly provide ARVs for their patients
83.5% deliver ARVs in a structure
81.4% deliver ARVs at home
74.4% ensure medical follow-up of patients on ARVs

Night of Solidarity

Vigil of prayer

Saturday, 2 June 2007 at 9:00pm
at the Church of Santa Maria Maddalena
Piazza della Maddalena 53, Rome

We come together in solidarity, as the governments of the G8 countries are preparing for a summit in Germany, to call for a more comprehensive and just response for people living with or affected by HIV and AIDS.

▸▸ For more information, please visit
www.vidimusdominum.info; www.caritas.org; www.g8aidscampaign.org

This Night of Solidarity is being promoted by the Unions of Superiors General (IUSG/USG) and Caritas Internationalis in collaboration with the World AIDS Campaign.

Vigil of prayer organized by UISG / USG in collaboration with Caritas Internationalis, on the occasion of the 2007 G8 to promote the universal access to the ARVs.

Treatment in the Face of Lack of ARVs

For five years I had worked as Medical Superintendent at Mercy Hospital, but when I was able to pass over that role to practice as a local doctor, I could follow my dream – to do something to help people living with AIDS through home-based care.

You get a different picture when you see a person in their home. As the doctor on the team, I visit any patients referred to me by the nurses—whether a patient about whom the nurses need advice about or one needing palliative care.

We are very fortunate in this country that morphine is available for treatment of severe pain. Because morphine is a classified drug—an addictive opiate—there are very strict laws related to its handling, use and prescription and in many countries its importation is severely restricted or banned. It is only since the growth of the hospice movement that the benefits of morphine in terminal illness have been appreciated fully. An advantage of using morphine for palliative care here is that it is oral, inexpensive, easy to take, and provides pain relief for the dying patient.

We have twelve nurse-counselors on our Home Care Team—each one of them is gifted. They don't come to work on the mobile Outreach Program only as 'a job': this really requires dedication. They work long hours, arrive at 8 a.m. to get their things ready, and often don't get home till 7 a.m. Their day takes them over very bad roads, working with people who are sick and dying all the time. It takes someone special to do that kind of work. (*Sister Carla Simmons*)

Advocacy and other Services

Notably, more than two-thirds of respondents (67%, or 332) were involved in the eradication of stigma associated with HIV and AIDS – a significant role for Catholic religious. Sixty-three percent carried out awareness programs addressing stigma, nearly half (49%) involved people living with HIV and AIDS (PLWHA) in these programs, and 43% directed their stigma awareness programs to religious leaders.

Reducing Stigma and Providing Support through Cooperative Endeavours

The group called "Rainbow Community" – made up of HIV and AIDS positive adults and children and some volunteers— was started by the cooperation with the parish priest in February 2004. The community started with the aim of being a support for people living with HIV and AIDS. This was also the time when an International Humanitarian Christian Organization started a Voluntary Centre for Testing HIV and AIDS and people came to know their status. Some willingly and voluntarily joined the group.

The Rainbow wants to be a family through which people living with HIV/AIDS feel accepted and are supported physically, morally and spiritually. We offer them medical services, plus a weekly help of sugar and flour for porridge. Then we see the particular situation of each one. Some are rejected by the family due to this sickness and we try to talk to their relatives, to accompany them in the process of acceptance. Others need a blanket, a mosquito net, soap, particular food, and so forth, and we try to answer to the needs as much as possible. We also have a "Home care visiting" program carried on by some volunteers: when a member is unable to walk, he/she is carried by bicycle to the hospital and to our weekly meeting. We also give particular attention to the 198 Rainbow children, from birth to 18 years old. Some of these children are HIV positive; some are orphans staying with grandparents, uncles or aunties, or foster parents. Many of them need also support and help especially regarding food, health and education.

We know the Lord never abandons the poor and the needy, we trust in His Providence—our personal and communitarian support will continue. (*Sister Giovanna, Sud Sudan)*

Networking related to HIV and AIDS is another key role of these respondents: more than three-fourths (77%) were involved in these activities. Of those who specified the types of organizations and mechanisms for networking, over half (52%) were involved with local

churches, followed by 51% with diocesan AIDS projects, 47% with other faith-based organizations, 42% with government agencies, 32% with international NGOs and 24% with PLWHA networks. Thirty-five had gender-specific activities, including 31% with women's groups and 15% with men's groups. Fewer than expected respondents were involved with theological research or reflection – just 20% in reflection.

Research

> *It is sure that yesterday's research is the basis of today's therapy and today's research is contributing to the future medicine. To contribute through scientific research to improve treatment is absolutely part of our vocation to consecrated life, which is also a passion for humanity.*
>
> Prof. Fr. Jacques Simporé, MI

Few of the respondents – just 9% – indicated that they were involved in research. This may well be underreported because many FBOs actually provide data and information to donors, researchers from the United States, European and other countries, which the respondents likely do not consider "involvement" in research. Moreover, an all-too-common practice in international health research entails NGOs (including FBOs) collecting and providing data and information to international researchers studying HIV and AIDS without being engaged as "partners" in this process and without receiving the report of findings based on information they and others provide. They are, therefore, unwitting participants in research and have not been strengthened in their capacity to collect and analyze data and information and report on findings that could inform improvements in their services and demonstrate their capacity to effectively utilize funding.

Those who did indicate that they were involved directly in conducting research considered it an important part of their mission and service to others.

Prevention of Mother to Child Transmission at the St Camillus Medical Centre

Out of the 40,000 persons yearly infected of HIV in Burkina Faso, 10,000 are children contaminated during pregnancy, delivery or breast feeding. To counteract this, the St. Camillus Medical Centre was chosen by the Ministry of Health, in 2001, to be a pilot site where to test acceptability and feasibility of the recommended protocols. We confirmed the efficacy of Nevirapine prophylaxis in prevention of vertical transmission of HIV and demonstrated its feasibility and acceptability.

However, there remains a major dilemma related to basic water and sanitation and socioeconomic conditions: if the formula feeding is chosen, where no clean water is available, no refrigerator, no strict hygienic norms are followed, the baby will avoid HIV infection but not the danger of gastrointestinal infections, which will lead so easily to death.

Only an efficacious pediatric vaccine against HIV will solve definitely the problem of vertical transmission.

Financing

> *"The project has 820 registered orphans and is only able to care for 120."*

Nearly half of respondents engaged in fundraising activities specifically related to HIV and AIDS. Thirty percent carried out income-generating activities such as cooperatives (6%), microcredit (11%) and production and sales of handicrafts (14%). Twenty-five percent solicited funds from specific groups of donors. A number of respondents commented that funding from external donors and their respective government is sporadic, making it difficult to plan for and provide services. As a result, they spent considerable time and effort searching for funds, but many were hampered in doing so by lack of financial and managerial infrastructure.

These religious men and women were quite resourceful, seeking funding from a wide range of sources and engaging members of the communities they serve in cooperative and creative forms of income-generation. In addition to gaining much-needed albeit often insufficient financial resources, these activities serve to heal troubled hearts and help ensure a more livable daily existence.

3
CHALLENGES TO SERVICES

"ARVs are distributed only in the four government hospitals. As a consequence, many people in remote villages are dying without any access to treatment. Some travel 400-700 km in order to have the CD4 test, as well as collect their ARVs."

Many respondents described the circumstances under which they provide services and the devastating impact of HIV and AIDS on their community, even though this subject was not specifically included as a question. In some of the rural regions, services were scarcely available and distributed sparsely in the remote, often inaccessible areas. This lack of access to healthcare generally and to HIV and AIDS care specifically hindered the ability of providers to determine incidence and prevalence of HIV and AIDS. In some areas, lack of HIV services and testing supplies/equipment made it impossible to determine whether patients have HIV. This may not only result in underestimating the prevalence of the disease, but also may present a barrier to controlling its spread in remote rural communities and elsewhere. In some communities, local laws and prevailing social mores are serious barriers to provision of information and education, and to other preventive services, including testing and providing counselling. In some countries, government regulations requiring that only doctors distribute ARV medications have impact on the ability of the healthcare system to meet the increasing demand, even when these medications are available. On a basic level, the lack of electricity and potable water create significant ongoing problems for the Religious Institutes, HIV and AIDS patients, and their families and caregivers. This has impact not only on the ability of the Religious healthcare providers and their volunteers to serve their populations but also the ability of patients, families and communities to live in safe, habitable conditions that support recovery.

Respondents mentioned a number of specific challenges to their ability to provide services. Although many relate specifically to their particular circumstances, others are consistent across those who chose to add these comments:

• lack of medicines, in particular ARVs
• lack of equipment (medical, educational and administrative)
• training of personnel, including VCT counselors and health providers who would dispense ARVs
• transportation to improve accessibility
• poor water and sanitation, including water supplies to health facilities
• poverty and illiteracy among population served

Addressing Needs, Sharing Lessons Learned to Strengthen Capacity of Other Providers

I am a Servite Sister and a nurse by background who has been involved in providing HIV and AIDS services since 1992, most of this time at the Mildmay Hospital in London. Mildmay was a hospice for people with HIV in the early days before ARVs and we continued with the inter-disciplinary model of care. In the mid 1990s, we discovered that this model was instrumental in helping people with HIV-related Brain Impairment (HRBI) achieve a degree of independence, often contributing to their returning to some form of normal living again. This was at a time when these patients were 'written off.' Over the years we have developed this care and rehabilitation and now we are the only Unit in Europe providing this specialist care. Mildmay also has projects in Uganda, Kenya, Tanzania and Zimbabwe. We have also been invited into Eastern Europe to do teaching and capacity building. (*Sister Marie Therese Connor*)

4
REFLECTIONS AND PATHWAYS FORWARD

These findings are encouraging—the religious men and women who responded to this survey are providing urgently needed care to large numbers of individuals and communities for whom services would likely not be available otherwise. They are providing medical and palliative care, education and social services to millions of people in every region of the world. Perhaps most importantly, they are deeply involved in the eradication of stigma, which not only hinders provision and seeking of care, but burdens the heart and soul of every individual affected. This is a fundamental role for Catholic religious men and women, one that has profound impact on each one of those to whom they offer solace, but also to those who are blessed to be providers of care and those who are in positions of authority—who can, in a real sense, determine the future course of HIV and AIDS and those afflicted with this dreadful disease.

Nearly half the respondents – those actively engaged in providing HIV and AIDS care in every region of the world – are engaged in fundraising activities. The opportunity cost of the need to spend large amounts of time raising funds is significant, for it reduces the time that the caregivers could spend developing programs and providing direct services. This may also be a factor in the relatively limited involvement in theological reflection.

Apart from the notable convergence of responses with respect to addressing the severe shortage of funding to provide basic care, and adequate ARVs to address the needs of patients, the religious men and women provided a number of practical recommendations as a way forward. These include:

- Establishing policies and guidelines by and for the religious Institutes on HIV and AIDS
- Investing more resources on targeting the youth who are most vulnerable.
- Expanding and strengthening VCT services
- Providing scholarships for orphans and vulnerable children
- Expanding support groups to diverse populations (youth, parents,

prisoners, the broad community) to encourage positive living and thus prevent re-infection and further spread of HIV

• Expanding and strengthening the work that the religious Institutes are already carrying out on reducing stigma, including having doctors, nurses, care-givers, community members, key leaders and others attend sessions on stigma; encouraging self-acceptance and assertiveness on the part of PLWHA and others to be engaged in HIV/AIDS activities

• Creating awareness among teachers and nurses, as well as among educators and physicians

• Encouraging teachers, students, healthcare providers and others to participate in conferences at the national and international levels and to take part in World AIDS day activities

• Strengthening cooperation among various faith communities: other Christian group, Muslim and others

• Strengthening relationships between the FBOs and the national, regional and local governments and other NGOs

Some of these require continued dedication and expansion of services by the religious men and women who are serving those with HIV and AIDS and the vulnerable populations most at risk for this disease. Others require leadership on the part of the religious institutes or the governments of the countries in which the men and women serve. Still others require financial and other support from public and private sector organizations throughout the world. Together, based on an abiding faith, we can address this global scourge.

Samuel: Learning from Children the Way Forward

Samuel, eight years old and abandoned by his clan, was caring for his mother dying of AIDS. At the hospital the nurses were saying: "There are men in their 50s acting like children, and there are young children with maturity like adults." Samuel was caring also for his youngest sister, who was reacting to this situation by becoming aggressive. We gave him some money to be able to live, and he used it very carefully, for small daily necessities. The mother died after a short time and he become increasingly skinny and weak. One day he came to see me and said: "Sister, I am sick like my mother, I know all the symptoms of the disease." It was easy to confirm his diagnosis. A few months after this he died, so sorry for not having been able to care for his little sister, as he had promised to his mother while she was dying. *(Sister Dorina, Uganda)*

APPENDIXES

1. The Instrument for the Investigation: the Survey

2. Number and Percentage of Country Respondent Organizations that Provide HIV and AIDS Services, by Region, Country and Type of Service

3. Maps Depicting Distribution of HIV and AIDS Services Provided by Catholic Institutes of Men and Women, by Geographical Region, As Reported by Survey Respondents

4. Description of Religious Institutes Generally and of the International Unions of Superiors General

5. Common Declaration. Religious in the World and the AIDS Pandemic: Commitment, Challenge and Prophecy

Appendix 1.
The Instrument for the Investigation: the Survey

SURVEY FOR MAPPING EXERCISE OF THE ACTIVITIES OF CATHOLIC RELIGIOUS MEN AND WOMEN ON HIV/AIDS

To be filled by each local community
Time frame: last 12 months (2005)

Congregation Name	
Community	
Town	
District	
Country	
No. of comm. members	
Telephone No.	
Fax	
E-mail	

If there is a specific AIDS project:

Project Name	
Started in (year)	
Ownership (Congregation, Dioceses, other)	
Run by	
Address	

UISG/USG
Questionnaire for religious communities :
our commitment in the HIV/AIDS field

1) Prevention: do you provide services in the following areas?

	YES	NO	YEAR OF STARTING
VCT	☐	☐	☐
How many tests in 2005?	☐		
How many of them positive?	☐		
PMTCT	☐	☐	☐
How many mothers were beneficiaries in 2005?	☐		
How many children were born HIV + ?	☐		
How many children were born HIV - ?	☐		
Information - Education	☐	☐	☐
To your own members	☐	☐	
Schools	☐	☐	
Workers	☐	☐	
Parish groups	☐	☐	
Radio	☐	☐	
Peer education	☐	☐	

Which kind of educational program?

Occasional meetings ☐
Formation on regular basis ☐
Both ☐

Other ☐

	YES	NO
Do you involve peer groups?	☐	☐
How many members of your own Congregation work in prevention?	☐	
How many paid staff are involved?	☐	
How many volunteers are involved?	☐	
How many beneficiaries in the last 12 months?	☐	

Which role do religious play in the program?

Director ☐
Administrator ☐
Educator ☐
Staff ☐
Other ☐

2) Caring and support: Do you provide services in the following areas?	**YES**	**NO**	**How many people do you reach?**	**Year of starting**
Pastoral care - Spirituality - Prayer				
Counselling centres - support groups				
Extended services:				
for women				
orphans				
others				
Financial help to the sick person and/or family				
Palliative care				
Prevention and treatment of Opportunistic Infections, TB				
Nutrition				
Alternative medical care, ex: Phitotherapy				
Home based care				
Clinical based care				
Hospital based care				
Do patients receive free treatment?				
Do patients pay partially for treatment?				
Other please specify:				

How many members of your own Congregation work in caring and support? _____ How many full time? _____

How many paid staff are involved? _____

How many volunteers are involved? _____

How many beneficiaries in the last 12 months? _____

3) Treatment:	**YES**	**NO**	**YEAR OF STARTING**
Do you provide ARV services?			
Did your medical staff receive specific formation on ARVs?			
Do you prescribe ARVs in your own structure? (Hospital, AIDS centre, Dispensary)			
Do you refer patients to other structures for prescription of ARVs?			
Do you deliver ARVs in a structure? (Hospital, AIDS centre, Dispensary)			
Do you deliver ARVs at home?			
Do you ensure medical follow-up of your patients on ARVs?			
Do you provide regularly ARVs for your patients?			
Do you do treatment literacy on a regular basis?			
Do you run specific activities to ensure treatment adherence?			
Do you have paediatric formulations?			
Do you have problems in regular supply?			
Do you have laboratory facilities?			
for CD4 count?			
for haemochrome?			
How many patients do you have on ARV treatment?			
How many patients need ARV treatment but do not have access to it?			
How many members of your own Congregation work in providing ARV treatment?			
How many paid staff are involved?			
How many volunteers are involved?			
How many beneficiaries in the last 12 months?			
If you still do not have ARV in your Centre, is it one of your priorities?			

Which difficulties do you face to provide ARV?

Fund ☐ Personnel ☐ Environment ☐

4) Miscellaneous: Are you participating in any of the following activities?	YES	NO	YEAR OF STARTING
Research:			
Drug trials			
Phitotherapy			
Vaccine trials			
Other			
Advocacy			
Theological research / reflection			
Stigma eradication			
awareness programs addressing stigma			
Involvement of PLWHA for awareness programs			
Addressing religious leaders			
Networking – NGO:			
Local Churches			
Diocesan AIDS Projects			
Other Faith Based Organizations			
Governments			
International NGOs			
Networks PLWHIV			
Which partnership forum do you sit on?			
Gender specific activities			
Women groups (self support)			
Memory project with mothers			
Men groups			
Other			

5) Finances	YES	NO	YEAR OF STARTING
Financial fund raising			
Specific day in churches			
Special selling			
Involvement of target groups donors			
Other			
Income generating activities			
Cooperatives			
Micro credit			
Handicraft			
Other			

Overall budget for HIV in 2005 (indicative) $ ☐ € ☐

Christian/Church Funds	
Local resources	
Government Funds	
Donors Funds	
Total	

If you have other information, please add here below:

Appendix 2.
Number and Percentage of Country Respondent Organizations that Provide HIV and AIDS Services, by Region, Country and Type of Service

COUNTRY	VCT	PMTCT	ARV	EDUCATION	STIGMA ERADICATION
Africa	**140** **47,9%**	**78** **26,8%**	**113** **39,2%**	**267** **95,7%**	**205** **72,2%**
Angola	2 50,0%	0 ,0%	2 50,0%	3 75,0%	2 50,0%
Benin	3 75,0%	1 25,0%	2 50,0%	4 100,0%	3 75,0%
Burkina Faso	1 100,0%	1 100,0%	1 100,0%	1 100,0%	0 0,0%
Cameroun	14 66,7%	12 57,1%	12 54,5%	22 100,0%	15 71,4%
Chad	5 55,6%	1 11,1%	6 66,7%	9 100,0%	6 66,7%
Dem. Repub of Congo	9 52,9%	3 17,6%	7 41,2%	16 94,1%	8 47,1%
Equatorial Guinea	0 ,0%	0 ,0%	0 ,0%	1 100,0%	0 0,0%
Ethiopia	4 26,7%	1 6,7%	2 13,3%	14 93,3%	10 66,7%
Gabon	0 ,0%	0 ,0%	0 ,0%	3 100,0%	1 33,3%
Ghana	0 ,0%	0 ,0%	1 50,0%	2 100,0%	2 50,0%
Ivory Coast	2 50,0%	1 25,0%	1 25,0%	4 100,0%	3 75,0%
Kenya	34 43,0%	27 34,2%	27 34,2%	66 94,3%	64 83,1%
Liberia	1 50,0%	1 50,0%	1 50,0%	2 100,0%	2 100,0%
Madagascar	0 ,0%	1 25,0%	0 ,0%	3 75,0%	1 25,0%
Malawi	1 33,3%	1 33,3%	1 33,3%	3 100,0%	1 33,3%
Mali	0 ,0%	0 ,0%	0 ,0%	1 50,0%	0 0,0%
Mozambique	6 35,3%	3 17,6%	5 33,3%	16 94,1%	7 41,2%
Nigeria	6 66,6%	2 28,6%	3 33,3%	7 77,7%	7 77,7%
Repub. of Congo	3 60,0%	2 40,0%	2 40,0%	5 100,0%	4 80,0%
Rwanda	3 100,0%	3 100,0%	2 66,7%	3 100,0%	2 66,7%
Senegal	2 100,0%	2 100,0%	2 100,0%	2 100,0%	2 100,0%

COUNTRY	VCT	PMTCT	ARV	EDUCATION	STIGMA ERADICATION
South Africa	10 50,0%	3 15,0%	10 50,0%	15 75,0%	16 80,0%
Sudan	1 33,3%	0 ,0%	0 ,0%	2 66,7%	2 66,7%
Tanzania	14 50,0%	7 25,0%	9 32,1%	26 92,9%	19 67,9%
Togo	1 33,3%	1 33,3%	1 33,3%	2 66,7%	2 66,7%
Uganda	9 69,2%	3 23,1%	6 46,2%	13 100,0%	9 69,2%
Zambia	5 38,5%	1 7,7%	7 53,8%	13 100,0%	11 84,6%
Zimbabwe	4 57,1%	1 14,3%	3 42,9%	6 85,7%	7 100,0%
Asia	**21** **36,8%**	**13** **23,2%**	**27** **47,4%**	**49** **86,0%**	**40** **70,2%**
Bangladesh	1 100,0%	0 ,0%	0 ,0%	0 ,0%	0 0,0%
India	10 33,3%	9 31,0%	17 54,8%	26 92,9%	26 83,9%
Indonesia	4 100,0%	0 ,0%	0 ,0%	4 100,0%	2 50,0%
Libanon	1 50,0%	0 ,0%	1 50,0%	2 100,0%	1 50,0%
Myanmar, Burma	1 100,0%	1 100,0%	1 100,0%	1 100,0%	1 100,0%
North Korea	0 ,0%	0 ,0%	0 ,0%	0 0,0%	0 0,0%
Pakistan	0 ,0%	0 ,0%	0 ,0%	1 100,0%	1 100,0%
Philippines	0 ,0%	0 ,0%	0 ,0%	2 66,7%	1 33,3%
South Korea	0 ,0%	0 ,0%	0 ,0%	1 50,0%	0 0,0%
Thailand	3 60,0%	2 40,0%	4 80,0%	5 100,0%	4 80,0%
Timor-Leste (E Timor)	0 ,0%	0 ,0%	0 ,0%	1 100,0%	1 100,0%
Taiwan	0 ,0%	0 ,0%	1 33,3%	3 100,0%	2 66,7%
Vietnam	1 33,3%	1 33,3%	3 100,0%	3 100,0%	3 100,0%

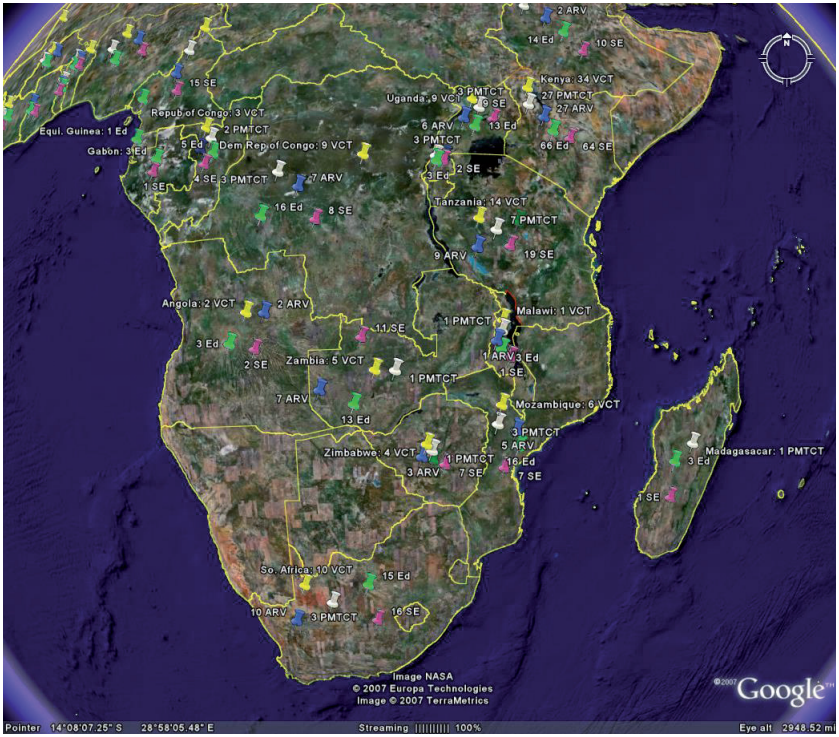
COUNTRY	VCT	PMTCT	ARV	EDUCATION	STIGMA ERADICATION
Central/South America	**3 14,3%**	**3 14,3%**	**4 19,0%**	**17 81,0%**	**13 61,9%**
Argentina	0 ,0%	0 ,0%	0 ,0%	2 100,0%	1 50,0%
Bolivia	1 50,0%	1 50,0%	1 50,0%	1 100,0%	1 50,0%
Brazil	2 15,4%	2 15,4%	3 23,1%	10 76,9%	9 69,2%
Chile	0 ,0%	0 ,0%	0 ,0%	1 100,0%	0 0,0%
Columbia	0 ,0%	0 ,0%	0 ,0%	1 100,0%	1 100,0%
Dominican Republic	0 ,0%	0 ,0%	1 100,0%	0 0,0%	0 0,0%
Ecuador	0 ,0%	0 ,0%	0 ,0%	2 100,0%	1 50,0%
Guatemala	1 50,0%	0 ,0%	1 50,0%	2 100,0%	2 100,0%
Mexico	0 ,0%	0 ,0%	0 ,0%	1 100,0%	1 100,0%
Panama	0 ,0%	0 ,0%	2 100,0%	2 100,0%	2 100,0%
Puerto Rico	0 ,0%	0 ,0%	1 100,0%	1 100,0%	0 0,0%
Europe	**9 17,6%**	**3 5,9%**	**28 54,9%**	**38 74,5%**	**21 41,2%**
Austria	0 ,0%	0 ,0%	0 ,0%	2 100%	1 50,0%
Belgium	0 ,0%	0 ,0%	0 ,0%	0 ,0%	1 100,0%
France	1 100,0%	0 ,0%	1 100,0%	1 100,0%	0 0,0%
Great Britain	0 ,0%	0 ,0%	1 25,0%	0 0,0%	1 33,3%
Italy	2 15,4%	1 7,7%	7 53,8%	11 100,0%	6 46,2%
Poland	1 100,0%	0 ,0%	0 ,0%	1 100,0%	0 0,0%
Russian Federation	0 ,0%	0 ,0%	0 ,0%	0 0,0%	0 0,0%
Spain	5 15,1%	2 6,0%	19 57,6%	23 69,7%	12 36,4

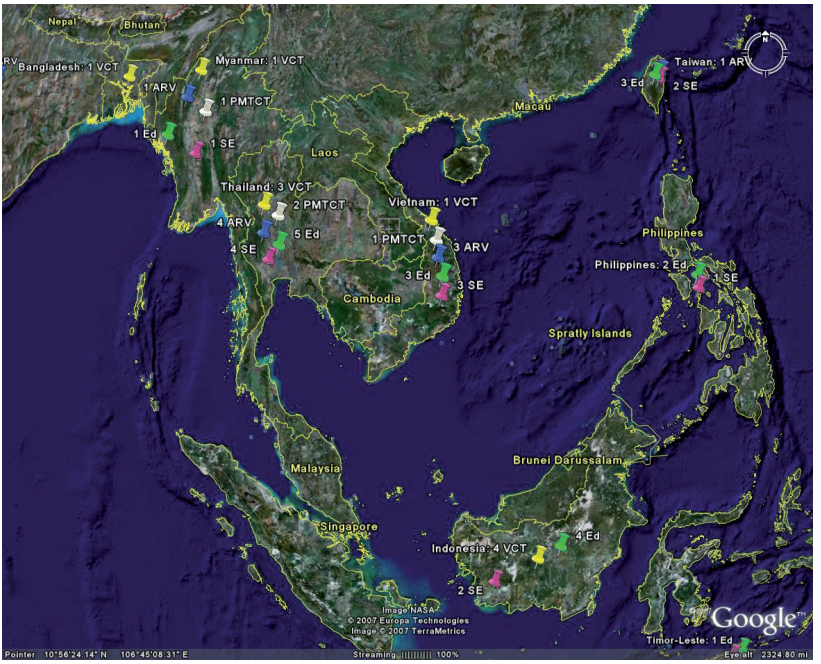
COUNTRY	VCT	PMTCT	ARV	EDUCATION	STIGMA ERADICATION
North America	**4** **1,4%**	**3** **1,1%**	**12** **42,9%**	**22** **78,6%**	**17** **60,7%**
United States	3 13,6%	3 13,6%	7 31,2%	16 72,7%	12 54,5
Oceania	**3** **27,3%**	**4** **36,4%**	**6** **54,5%**	**8** **72,7%**	**6** **54,5%**
Australia	0 ,0%	1 33,3%	2 66,7%	1 33,3%	1 33,3%
New Zeland	0 ,0%	0 ,0%	0 ,0%	0 0,0%	1 100,0%
Papua New Guinea	3 42,9%	3 42,9%	4 57,1%	7 100,0%	5 71,4%
TOTAL	**180** **39,3%**	**104** **22,8%**	**190** **41,9%**	**398** **91,1%**	**302** **67,3%**

Appendix 3.
Maps Depicting Distribution of HIV and AIDS Services Provided by Catholic Institutes of Men and Women, by Geographical Region as Reported by Survey Respondents

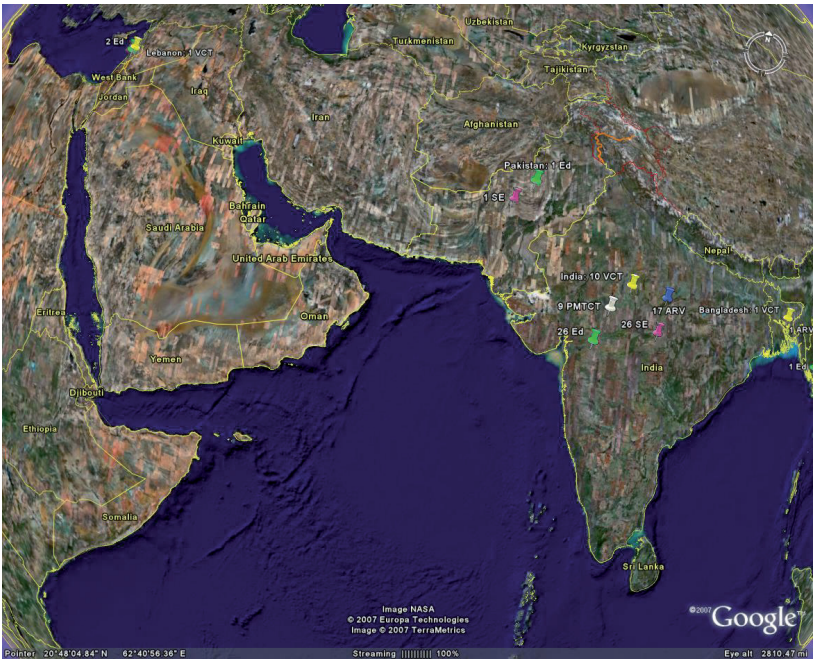
DISTRIBUTION OF HIV AND AIDS SERVICES IN AFRICA

(Legend: VCT, Voluntary counselling and testing; PMTCT, Prevention of mother-to child transmission; ARV, Amtiretroviral)



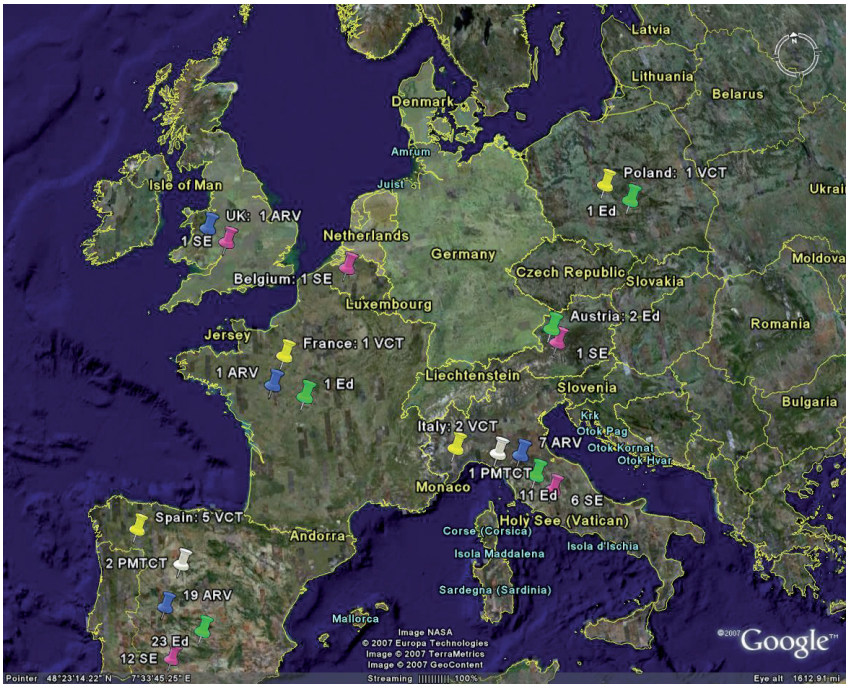


DISTRIBUTION OF HIV AND AIDS SERVICES IN ASIA, IN THE MIDDLE EAST AND NORTH AFRICA



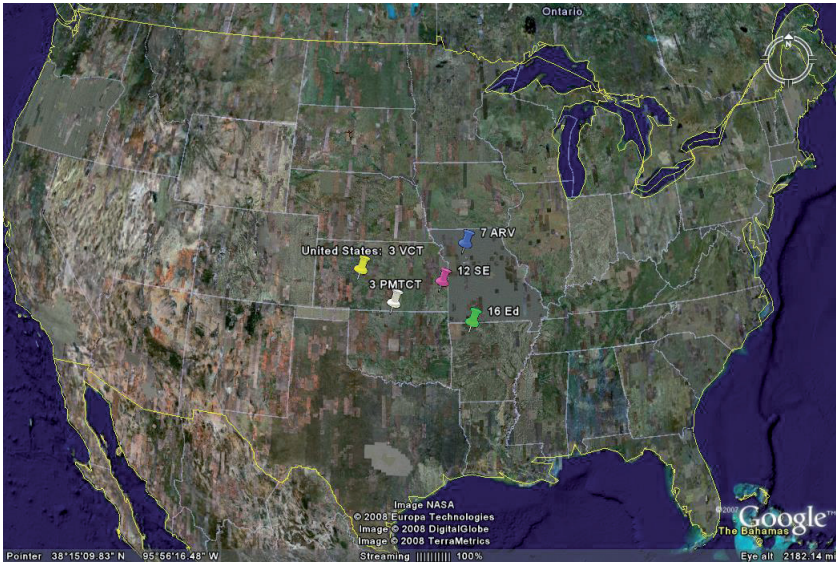
DISTRIBUTION OF HIV AND AIDS SERVICES IN EUROPE

(Legend: VCT, Voluntary counselling and testing; PMTCT, Prevention of mother-to child transmission; ARV, Amtiretroviral)



DISTRIBUTION OF HIV AND AIDS SERVICES
IN NORTH AMERICA

(Legend: VCT, Voluntary counselling and testing; PMTCT, Prevention of mother-to child transmission; ARV, Amtiretroviral)

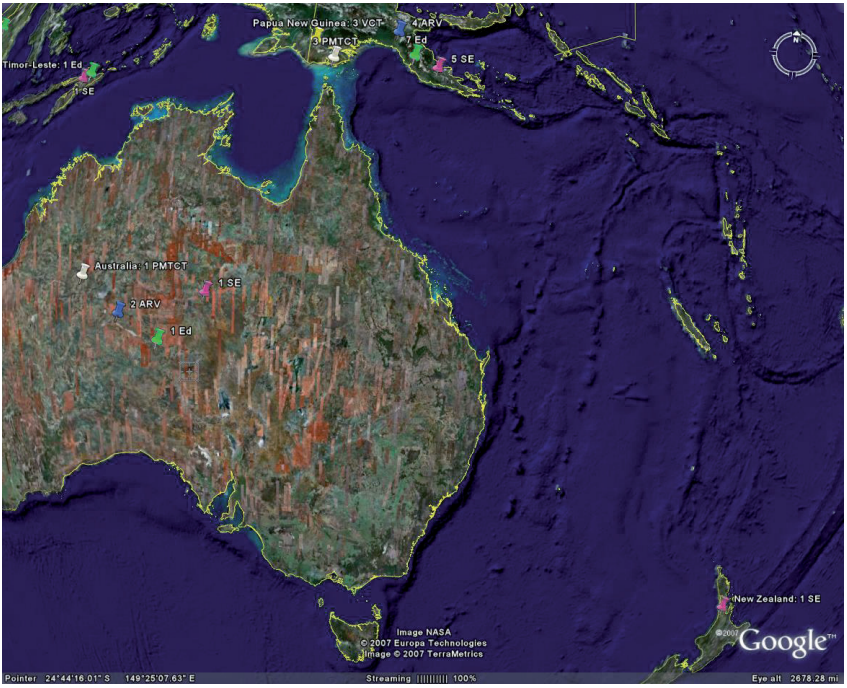


DISTRIBUTION OF HIV AND AIDS SERVICES
IN CENTRAL AND SOUTH AMERICA

(Legend: VCT, Voluntary counselling and testing; PMTCT, Prevention of mother-to child transmission; ARV, Amtiretroviral)

DISTRIBUTION OF HIV AND AIDS SERVICES IN OCEANIA

(Legend: VCT, Voluntary counselling and testing; PMTCT, Prevention of mother-to child transmission; ARV, Amtiretroviral)



Appendix 4.
Description of Religious Institutes Generally and of the International Unions of Superiors General

Religious Institutes

For sake of simplicity and to avoid possible confusion, we utilize this term to define all the religious societies of men or women: Orders and Congregations. In these associations, members, according to proper law, pronounce public vows, either perpetual or temporary, of chastity, poverty and obedience, and live together in fraternal life.

In the Catholic Church there are many Institutes of consecrated life which have different gifts, according to the grace which has been given them trough their Founders, to follow Christ more closely. So there are Institutes exclusively or mostly dedicated to prayer, while others dedicate themselves in a special way to the service of God and of the Church in announcing the kingdom of God, performing good works for people, sharing their life with them in the world with special attention and care to the poor and most abandoned, teaching, caring for the sick, etc.

An Institute is said to be of pontifical right if it has been erected or recognized by the Apostolic See (the Pope); it is said to be of diocesan right if it has been erected or recognized by a diocesan Bishop and has not yet obtained approval by the Apostolic See. [1]

In our study, we will consider all Institutes in the same way, irrespective of being Order or Congregation, of pontifical or diocesan right.

According to the official statistics of the Catholic Church, there are about 2000 Institutes counting a total of about 1 million members, between priests, brothers and sisters, many of them working in most remote and poor areas.

[1] Adapted from: Code of Canon Law Latin-English edition. Canon Law Society of America; Part III Institutes of Consacrated Life and Societies of Apostolic Life.

International Unions of Superiors General: UISG/USG

Superiors General are those who govern a whole Institute.

The ***International Union of Superiors General (UISG)*** is a worldwide, canonically approved membership organization for superiors general of institutes of Catholic women religious. Established in 1965, the Union has its headquarters in Rome.

The purpose of UISG is to promote an understanding of the religious life of Catholic women religious throughout the world and to foster its development in the Church and in society.

All superiors general of institutes of Catholic women religious dedicated to apostolic works and societies of apostolic life, whether of pontifical or diocesan right, are entitled to membership.

The ***Union of Superiors General (USG)*** is an organization according to pontifical law created by the Sacred Congregation of Religious as a public juridical personality (c. 709).

The aim of the USG is as follows: "To promote the life and mission of the individual institutes that serve the Church in order to facilitate more effective co-operation between them and achieve more fruitful contacts with the Holy See and the Hierarchy of the Church".

Membership of the USG. All Superiors General of the Religious Institutes or Societies of Apostolic Life recognized by pontifical law are members. Superiors General of Institutes recognized by diocesan law may become associate members.

The USG's governing body is the General Assembly, which must be convened at least once a year. It is the Assembly's responsibility to elect the *USG Council, which acts as its executive organ*. The Council consists of a President, Vice President and ten Councillors.

The Superiors General who belong to the USG meet twice a year to deal with problems and issues of common interest.

The USG offers a service by various *Commissions,* some *permanent,* others "*ad hoc"* to study a particular matter (www.vidimusdominum.org).

The two Unions are joined in membership for a better coordination between Religious Institutes, and to carry out reflections on special subjects of common interest. There are special Commissions dedicated to specific areas, such as Health Commission, Justice & Peace Commission, Education Committee, Inter-religious dialogue.

Appendix 5
Common Delcaration. Religious in the World and the AIDS Pandemic: Commitment, Challenge and Prophecy

Introduction

> *A Samaritan traveller who came upon him was moved with compassion* (Lk 10:33)

The third millennium has reawakened a need in us; a need to come together, to join forces, to share expectations and hopes in order to reflect on a theme which for us is life. We are talking about that life which we encounter daily and which we seek to serve: that life which has been wounded in so many ways and in diverse circumstances by the HIV/AIDS pandemic. This desire to serve became a reality when a group of 40 male and female religious from many different countries and various Religious Congregations met in Rome from 12th – 14th December 2005. The theme of the meeting was, "***Religious in the world and the AIDS pandemic: commitment, challenge and prophecy***". The event was organised by the Health Commission of the two Unions of Superiors General UISG and USG to which about 2000 religious institutes and their approximately one million members involved in many and diverse fields in the various continents belong.

Representatives of Caritas Internationalis and UNAIDS, organisations with whom we are working to establish dialogue, were also present at our meeting.

The meeting brought us to the heart of the world. During these days together we heard the cry of many brothers and sisters; we shared our experiences, hopes and concerns and, even more, we rediscovered the two icons which seem most significant for our present reality, the Good Samaritan and the Samaritan Woman. These two icons were presented to us in the Congress on Religious Life last year one of the fruits of which was this meeting.

We feel that this moment is a call to be prophetic, to speak out courageously about a reality which questions us even while we try to

deny it or run away from it. The pandemic challenges us to find new forms of radical poverty in sharing in the suffering and the tragedy of a great part of humanity, and it also invites us to unconditional love.

From the beginnings of this enormous tragedy of our time, just like the Good Samaritan and led by our shared passion for Christ and for humanity, we have stopped to help the many people left on the side of the road. At the same time we recognise we are among the wounded; we are vulnerable people marked by our fragility and limitations. AIDS is not just outside of us but is found within our very communities.

Like the Samaritan we are aware that it is faith, the living water, which offers a response to the many questions on the meaning of life, death and illness. It frees our capacity for love and forgiveness while it reminds us of the people we have met who have given us so much and have shared their great human and spiritual richness with us. Our service has been an exchange of gifts.

We have been reconfirmed in our commitment and in our conviction of the need to mobilise our energies and outline new strategies for future collaboration among ourselves, overcoming division and individualism. In the fight against HIV/AIDS, which presents us with extremely vast and diverse challenges, each Institute has something to contribute from its own charisma.

The reality

Give me a drink (Jn 4:7)

AIDS is considered by the WHO to be among the three principal dangers for our planet together with nuclear risk and climate change. The situation of HIV/AIDS infection in the world (as given in the UNAIDS Report 2005), is that of an epidemic currently in expansion with an increase in the number of infected people in Eastern Europe and in Asia. There are also alarming signs in the Pacific. The increased number of people at risk in these areas makes our commitment to programmes of prevention and care, which will bring about a change in behaviour, even more urgent.

In December 2005 the estimated number of people with HIV was 40 million. Almost 5 million new cases were reported in 2005. AIDS has

already killed 25 million people since it was first recognised in 1981. In spite of the great number of new cases and the fact that the number of people who are HIV positive has greatly increased, there is ample evidence that the efforts at prevention have lessened in many groups and especially among young people. Although there are new cases all over the world, sub-Saharan Africa is still the most strongly affected and has about 26 million people who are HIV positive, which means that two thirds of all people living with AIDS are living there. The growing number of AIDS orphans, of families headed by children, of grandparents who take on the burden of a large number of orphans and the tremendous weight of suffering carried by children in Africa is a growing concern for us. We are challenged by the growing number of women affected by this pandemic; 50% of those who live with the virus are women and they pay the highest price in this situation.

The prevention of the disease among the youth and those who are most at risk needs to concentrate on education for life and on sexuality. It needs to be carried out clearly and thoroughly particularly in areas in which neglect and poverty makes those who work in the sex industry and those who seek "escape" through drugs more vulnerable to HIV infection. Though the responses to HIV/AIDS have increased and improved notably in the last ten years, they have still not kept pace with an epidemic which is constantly worsening. Access to anti-retroviral drugs has increased and these are available in the richer countries, but the situation is different in the poorer countries of Eastern Europe, Latin America, the greater part of Asia and virtually in the whole of sub-Saharan Africa.

Responses and challenges

> *He went up and bandaged his wounds, pouring oil and wine on them (Lk 10:34)*

Effective prevention is still undermined by stigma and discrimination that create a climate in which the pandemic continues to advance. These challenges require competent co-operation from all men and women of good will, from international agencies, with NGOs and Faith-based groups, cross cultural co-operation and the sharing of

resources which can guarantee the best care, education and prevention which our human creativity can put together.

In this collaboration, we religious can offer the richness of our experience inspired by evangelical values. We would like to point out what is specific to religious life and which brings us to:

a) Be and create bridges of mutual dialogue:

• Inside Congregations, local Churches, Social Organisations, Governments …

• With people: proximity, nearness, vital relationships, listening in order to understand the problem, care (cfr. Icon of the Good Samaritan)

• With cultures, in order to discover their values and bring them out rather than importing everything from outside (cfr. Icon of the Samaritan Woman)

b) *Harmonise the response to the urgency of the pandemic with an integral approach that considers all the various sides of the problem, which takes time*.

c) Recognise the challenge to conversion for us as religious in the face of a problem which touches the way we interpret the illness, overcoming ignorance and the tendency to "moralise", and to recognise, with humility, the presence of the illness even within our communities.

d) To be prophetic in recognising the demands that this illness brings into the pastoral environment and to deepen the theological and pastoral reflection brought about by HIV/AIDS.

Action points

• Bring about awareness in all the Congregations and in the Church that the AIDS problem is a complex reality that goes beyond the medical aspect; that it includes education, social, economic and political conditions; that it is about justice and that it is the responsibility of all of us. For this reason HIV/AIDS should become a part of our pastoral programmes, of our teaching, preaching, care, social development programmes and justice education programmes.

• Continue the plan of mapping and bringing about awareness in religious communities to facilitate subsequent interventions in this area according to the various charismas.

• Collaborate and network among ourselves and with other groups

continuing along the lines of this initial event with the formation of a larger forum in order to bring about the recommended resolutions.

• Learn from one another which are the best strategies, such as those we have heard in these days. These will include preventive care programmes, sexual education for life, the formation of youth, care of the sick, integration of children with HIV/AIDS into society, particular attention to orphans and children in the counselling field, the setting up of research in this area, support programmes for women, for the sick and their families etc.

• Involve ourselves in advocacy. The aim of this will be to seek funds, to facilitate treatment of the most vulnerable groups so that all might have access to anti-retroviral treatment and other necessary care, and for prevention.

• Make use of the Justice and Peace website (UISG-USG) and establish links with the websites of the various congregations and of other Catholic organisations, which are committed to combating the pandemic.

• Pay attention to the call for the pastoral and humane care of those caught up in the pandemic; the care of the sick and dying of AIDS, solicitude for those who care for them, for those who are HIV positive and for those who lose their relatives. Organise days of support and of healing prayer and create family support groups.

• Specific formation in the training of health workers and those working in pastoral care. Set up programmes in our houses of formation which should include courses on HIV/AIDS, as well as personal and religious development. Create models of formation that others can follow.

• Circumscription superiors should establish guidelines that offer support to priests, brothers and sisters who live with the virus.

• Face the problem of stigmatisation and discrimination by means of a series of theological and pastoral reflection and offer our witness of involvement with people living with HIV.

• Work in collaboration with those who live with HIV/AIDS, with other Catholic organisations who are involved in the fight against the pandemic, with people and organisations of other denominations and faith groups, governments, international agencies (such as UNAIDS, WHO and the Global Fund for the fight against AIDS, TB and Malaria), and civil society.

Conclusion

Last November Pope Benedict XVI, referring to World AIDS day, declared that the statistics of those who suffer from AIDS were "*truly alarming*". He went on to say, "*Following the example of Christ, the Church has always considered the care of the sick an integral part of its mission. Therefore, I encourage the many initiatives being carried out, especially by the Christian communities, for the eradication of this disease, and I am close to those who suffer from AIDS along with their families, as I invoke the help and comfort of the Lord upon them*."

We have a steadfast hope that this initiative is only the first step on a long journey that we have to take and along which we can proceed together. We hope that other Congregations that are not specifically involved in health ministry might also respond to this call according to their charismas. We are also aware that the response of the Congregations which are already involved needs to move to greater unity as we work to overcome the present fragmentation of our various commitments.

Forty million people who suffer from AIDS are looking to us with hope!

Rome 15th December 2005

For the participants:

Fr. Frank Monks MI
President of the Health Commission
UISG/USG

Sr. Maria Martinelli CMS
AIDS Group Co-ordinator
UISG/USG

Martha's Way: Income Generation through Cooperation

Martha had lost everything because of AIDS: her husband, her son, and she herself was in bad conditions. A day came when she sat in front of my door and said: "Sister, now I am too sick to be able to labour as I always did. But I do not want do die before the time. I know how to embroider and I could do this work and teach it to other women." Thanks to her determination we have today in our village a cooperative of 150 women working, maintaining their families, developing creativity and talents, finding new dignity and hope. Martha continued to work for eight years, coming first in the morning and going away as the last one in the evening. It was impossible to understand how she could do it, as she was by this time quite ill. Working gave her new energies and life. She used to say that like Martha in the Gospel, she was finding Jesus in working. (*Sister Dorina, Uganda*)