The Contribution of Catholic Church-Related Organisations to the Global Plan towards the Elimination of New HIV Infections in Children by 2015 and Keeping their Mothers Alive

A Report from the Catholic HIV and AIDS Network (CHAN)[1]

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Key Findings

1. 95% of Catholic Church-related organisations participating in the research are **involved with their National AIDS Programmes**, and follow national guidelines for HIV and AIDS, prevention of mother to child transmission (PMTCT) and maternal-child health (MCH). While 67.5% were **aware of the Global Plan** prior to their involvement in the survey, only 17.5% had **previously been involved in its implementation**. However, 92.5% of survey respondents indicated that **they would like to be involved in Global Plan implementation in the future.**

2. At the community level, there is a need for **community mobilisation** in order to facilitate "buy in" by communities to PMTCT programming. Media, radio, churches, religious leaders and community elders were identified as possible channels for increasing community awareness of, and involvement in, PMTCT.

3. Catholic Church-related organisations tend to focus on a **family-centred approach** to HIV mitigation and PMTCT. Women often identify the lack of support from their husbands or partners as a major barrier to accessing antenatal or other forms of health care. A number of Catholic Church-related organisations are piloting projects to **engage men in PMTCT** and to increase uptake of joint counselling for couples.

4. **Lack of funding** continues to be a major challenge. As a result, many Catholic Church-related organisations are unable to scale up programmes and procure essential supplies. **Lack of nutritional support** is another common challenge. **In rural areas in particular, pregnant women and people living with HIV are less likely to access health clinics, hospitals and antenatal clinics**. Lack of transport remains a major barrier, with some people having to walk an entire day to access health care. The majority of women deliver their children at home, and utilise traditional birth attendants or no attendants at all; additional training is needed for those who assist with home deliveries.

5. In order to enable the full implementation of the Global Plan, a number of **social and cultural barriers** need to be addressed. There is a need for a **localised approach** to implementation, which includes addressing issues such as harmful gender norms, stigma and discrimination, sensitivity around HIV, women's fear of discussing the need for PMTCT with their husbands and lack of prioritisation of HIV at the local level.

1 The Catholic HIV and AIDS Network (CHAN) is a network of Catholic Church-related partnership organisations from Europe, North America and Oceania that support HIV programmes throughout the world.

Background

In 2010, 390,000 children were born with HIV and more than 700 children died each day — almost all of them in low- and middle-income countries, mainly in sub-Saharan Africa. The level of new infections brings into focus the continuing failure to address unmet needs of mothers and children, especially with regard to prevention of mother to child transmission (PMTCT).

In June 2011, the Joint United Nations Programme on HIV/AIDS (UNAIDS) launched *The Global Plan towards the Elimination of New Infections among Children by 2015 and Keeping their Mothers Alive* in response to this failure. Focusing on 22 priority countries with the highest rates of mother to child transmission of HIV, the Plan includes a detailed timetable for action at community, national, regional and global levels, with a goal to reduce the number of children acquiring HIV by 90% by 2015.

Research conducted by the Catholic HIV and AIDS Network (CHAN) in 2012 examined the contribution of Catholic Church-related organisations to the Global Plan. Specifically, the research sought to:

(1) Identify Catholic organisations in the 22 Global Plan priority countries and assess their current involvement in the Global Plan

(2) Assess opportunities for their engagement in the Plan

(3) Identify and document challenges faced by Catholic Church-related organisations at the local level to participate and contribute to country targets in the surveyed countries.

The Catholic Response to HIV and AIDS

"The Catholic Church is disseminated all over the country." Mwemezi Ngemera, Catholic Relief Services, Tanzania

Catholic organisations have been involved in a comprehensive HIV and AIDS response since the early 1980s, and currently have active programmes in at least 114 countries. For example, during 2010, ten of the largest organisations within CHAN collectively channelled US $241,244,145 to HIV and AIDS activities in low- and middle-income countries worldwide.[2] These international Catholic partnership organisations provide both funding and technical assistance to community-based and Catholic organisations responding to HIV and AIDS in low- and middle-income countries.

The research findings confirmed that most Catholic Church-related organisations are engaged more broadly in health and development programming, and many already have established maternal-child health programmes. Most are based in, or have been working in, communities for at least 10 years - and some for over 60 years, and communities trust them because of this long-term presence. These organisations have an established infrastructure and many own and operate health centres, especially in rural and hard to reach areas. There is also an added pastoral/spiritual care component to their work, which is not typically found in secular organisations.

2 Report by CHAN members to Caritas Internationalis.

Methodology

The research was commissioned by CHAN. It involved a written survey for Catholic Church-related organisations working in the 22 Global Plan priority countries. Potential respondents were identified by CHAN members and included both Catholic organisations who participate in the network and Catholic partners of CHAN members. An invitation to complete the survey was sent via e-mail to approximately 50 Catholic Church-related organisations in the 22 Global Plan priority countries, and circulated via e-mail to several list-serves. Those invited to respond to the survey included Catholic Church-related organisations working at global, regional and national levels, and engaged in a wide range of HIV-related care programmes, including ART, PMTCT, care, support, advocacy, education and community-based initiatives.

The survey yielded 40 responses from international, regional, national and grassroots organisations; they collectively represent work in all 22 of the Global Plan priority countries. Following the survey analysis, semi-structured telephone interviews were conducted with 13 of the survey respondents to elicit additional country-level and community-specific qualitative data on PMTCT work by the organisations and on the challenges faced in terms of implementation of the Global Plan. The interviewees were selected from a pool of survey respondents who had previously indicated their willingness to participate in the qualitative phase of research/interviews. Care was taken to ensure that a balance of geographic location, gender of interviewee and size of organisation was achieved in the overall demographic of interviewees. The sample of interviewees represented persons working in both small and large organisations and rural and urban organisations, based in seven of the Global Plan priority countries, together with four Catholic Church-related organisations based in the Global North that cumulatively operate HIV-related programmes in all 22 Global Plan priority countries.

Involvement in National AIDS Plans and the Global Plan

95% of responding organisations are involved with their National AIDS Programmes, and follow national guidelines for HIV and AIDS, PMTCT and maternal-child health (MCH). Their level of involvement ranged from receiving funding from Government or National AIDS Programme (22.5%); receiving anti-retroviral drugs (ARVs), lab equipment and/or other supplies (57.5%); representation of the respective organisation on the National AIDS Programme advisory committee (22.5%); and participation in workshops, trainings and seminars provided by the National AIDS Programme (77.5%).

67.5% of the respondents reported previous awareness of the Global Plan, however only 17.5% of the organisations had previously been involved in its development or implementation. Only one organisation reported being consulted in the Global Plan's development (Comunità di Sant'Egidio), 5% had previously participated in a survey on the Global Plan, and 12.5% had previously participated in a workshop on the Global Plan.

When asked about the greatest unmet needs to be addressed in order to facilitate better support for their engagement in implementing the Global Plan, respondents identified the following: advocacy for future funding and supplies, technical assistance, capacity building, promotion of strategies for male involvement in PMTCT programmes, and facilitation of access by regional and national organisations and their subsidiaries in the implementation of the Global Plan.

Progress in Global Plan Implementation

Participants in the research survey were also asked to rate their country's progress in achieving the three prongs of the Global Plan in which Catholic Church-related organisations are most engaged:

Global Plan Objective	Percentage of respondents reporting ***very little progress***	Percentage of respondents reporting ***some progress***	Percentage of respondents reporting ***most needs being met***	Percentage of respondents reporting ***all needs being met***
Prevent HIV among women of reproductive age (Prong 1)	10%	67.5%	17.5%	0
Prevent HIV transmission to infants — during pregnancy, delivery and breastfeeding (Prong 3)	10%	57.5%	27.5%	0
Provide HIV care, treatment and support for women children and their families (Prong 4)	15%	65%	12.5%	2.5%

Organisations based in Burundi, Ethiopia, Kenya, Malawi, South Africa, Zambia and Zimbabwe tended to have a more favourable opinion of their country's progress in meeting the objectives of the Global Plan, especially in relation to Prongs 3 and 4. Organisations based in the Democratic Republic of the Congo were more likely to cite "very little progress" than organisations based in the other Global Plan priority countries. Moreover, while Niger is not included in the 22 Global Plan priority countries, a respondent from that country indicated very little progress in Prongs 1, 3 and 4.

Community Mobilisation

"We have not done much to mobilise communities. This has led to very few families accessing these services." Shouts M. Galang'anda Simeza, Mzuzu Diocese Catholic Health Commission, Malawi

According to a health advisor with the German-based organisation Misereor, in relation to community engagement around PMTCT programming, one needs to look at the general demand for health care and community priorities. Perception of health-related needs by local communities may differ from the priorities set by international donors. For example, at present, many communities attach more importance to accessibility of immunisations than to that of PMTCT. A community must first understand the benefits and see the results before "buying in," and HIV is still a sensitive subject in many of the most affected communities. Women go through PMTCT without informing their partners, and many fear the reactions of their husbands.[3]

Media, radio, churches, religious leaders and community elders were all identified as possible channels for increasing community awareness and buy-in of PMTCT programming. Churches and political leaders could also be utilised, since they are respected within the community. Leaflets could also be employed to educate community members about PMTCT.

A Family-Centred Approach

"In order for anything to move forward, the men must be involved." Khadija Karama, Catholic Relief Services, Kenya

A major barrier towards women accessing antenatal care and health care services is the lack of support from their husbands or partners. The name "prevention of mother to child transmission" itself may serve as a barrier, because it places the responsibility entirely on the mother. A number of Catholic Church-related organisations studied are piloting projects to engage men in PMTCT and increase uptake of couple counselling.

The Role of Men

Catholic Relief Services (CRS) in Kenya received funding from the United States Agency for International Development (USAID)/Centers for Disease Control (CDC) to implement a "men as partners" programme at the community level. The programme supported by CRS and the Ministry of Health, is based on a community-based, primary health care strategy. Implementation of the programme includes mobilisation of community volunteers, who educate the communities on the roles of men in PMTCT and other health issues.

The programme also includes support groups for men, couples living with HIV, and discordant couples. Such programmes enlist men to serve as mentors; they encourage other men to join the support groups and thus function as "role models." Education is done in barazas, where men give testimonies.

As a pilot project operating in three provinces within Kenya — Rift Valley (Narok District), Nairobi (Ngata and Karen Districts) and Central (Kirinyaga District), the programme creates male-friendly spaces in antenatal clinics and health centres in order to increase the accompaniment of women by males to health facilities. Most health centres currently focus on serving women and children. If husbands accompany their wives to the clinics, there is an added incentive that such women are seen first by the health care workers.[4]

Encouragement of male involvement in HIV-related services is a key component of CRS' approach worldwide. CRS international headquarters in the United States has issued two publications that expound on this work — *Getting to Zero: Diverse Methods for Male Involvement in HIV Care and Treatment*[5] and *The Faithful House: Building Families to Affirm Life and Avoid Risk*.[6] The latter publication also has a PMTCT supplement, compiled and published by CRS partners in Uganda.[7]

3 Dr Piet Reijer, personal communication, 14 March 2012

4 Khadija Karama, personal communication, 20 March 2012

5 Catholic Relief Services (CRS) and AIDS Relief (2012). *Getting to Zero: Diverse Methods for Male Involvement in HIV Care and Treatment* Baltimore, United States of America.

6 Catholic Relief Services (CRS). 2005. *The Faithful House: Affirming Life, Avoiding Risk*. Baltimore, United States of America.

Poverty and Nutrition

"The international [community] needs to put their minds together to focus on the needy ones and families." Abba Teum Berhe Danne, Adrigat Diocesan Catholic Secretariat, Ethiopia

The most common challenges and obstacles to achievement of the Global Plan objectives include lack of nutritional support for pregnant women and new mothers (75%), lack of early infant HIV diagnostic tests (65%), lack of funding (60%) and drug stock-outs (57.5%).

Further qualitative data revealed that pregnant women and people living with HIV are less likely to access health clinics, hospitals and antenatal clinics, particularly in rural areas. Lack of transport remains a major barrier, with some people having to walk an entire day to reach health care services. The majority of women deliver their babies at home, and utilise traditional birth attendants or no attendant at all. Mobile clinics that provide education, PMTCT services and anti-retroviral therapy (ART) are one solution to addressing this challenge. Another is training traditional birth attendants in education, HIV counselling and PMTCT services.

AIDS Relief Kenya, which was formed by a Consortium of Catholic and Christian organisations, follows the highly successful National AIDS Plan for PMTCT that was developed by the Government of Kenya. Some of AIDS Relief's major challenges in implementing the Plan are that mothers are in denial about their HIV status and consequently do not enrol in PMTCT programmes. There also are childbirth and delivery challenges, especially when deliveries occur at night. Additional challenges are associated with transport and poverty, and, as a result, women often are unable to take advantage of ongoing antenatal care. Breastfeeding is discouraged in cases of mothers with mastitis or children with oral thrush, and there are also shortages of formula to facilitate artificial feeding in infants.[8]

A recent study by Doctors with Africa (CUAMM) focused on access to health care in Ethiopia. The study revealed that the lowest income-related quintile of the population was not accessing basic health services. Additional barriers to health care may be found in rural areas such as the long distances between home and health clinic. In both urban and rural areas, challenges include financial and cultural barriers.[9]

In Tanzania, it is much easier to access health care in urban areas than in rural areas. In rural areas, people must walk a long way to dispensaries, are less likely to receive information, and have less access to the media. Poor road conditions, cultural barriers and limited communication infrastructure also pose challenges. In certain tribes, women must seek permission and financial resources from their husbands in order to access health services. This is especially true in rural areas, where women are dependent on agriculture for their livelihoods. Women in urban areas have greater economic potential.[10]

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7 Catholic Relief Services (CRS), Maternal Life Uganda and Maternal Life International. (2009). *The Faithful House: Affirming Life, Avoiding Risk. PMTCT Supplement*. Kampala, Uganda: Maternal Life International.

8 George Ogillo, personal communication, 13 March 2012

9 Dr Andrea Atzori, personal communication, 8 March 2012

10 Mwemezi Ngemera, personal communication, 16 March 2012

Need for a Localised Approach

Access to health, maternal and child health, HIV-related and PMTCT services varies significantly between the 22 Global Plan priority countries, as well as within the countries themselves. In addition, each community experiences its own unique social and cultural barriers to provision of HIV-related and PMTCT services. There is a need for a localised approach to implementation, which includes addressing issues such as harmful gender norms, stigma and discrimination, sensitivity around HIV, women's fear of discussing the need for PMTCT with their husbands and lack of prioritisation of HIV at the local level.

In India, the Catholic Health Association of India (CHAI) follows WHO and national guidelines for PMTCT. Only single dose Nevirapine is currently available for HIV-positive pregnant women who are not currently enrolled in ART. There is a noticeable gap in putting pregnant women on ART, and a lack of delivery services especially for pregnant women. Most women are also lost to services and provision of follow-up to HIV-positive new mothers is needed, at least until the child is 18 months of age.[11]

Although HIV prevalence in India is one percent, because of their total population the number of people living with HIV is quite high. In implementing the Global Plan within India, the programme needs to be state-specific and culturally aware. Health care service and prevalence vary significantly from state to state.[12]

Governmental and Civil Society Collaboration

Most faith-based organisations (FBOs) follow national and governmental plans for HIV, PMTCT and MCH. Catholic Church-related organisations also hold membership in Christian health associations, interfaith networks and broader civil society networks. In terms of advocacy activities in high-income countries, many Catholic Church-related organisations are active participants in civil society networks, such as Osservatorio AIDS in Italy and Action against AIDS in Germany.

Adrigat Diocesan Catholic Secretariat (ADCS) in Ethiopia works at the community level especially through religious leaders and is involved in interfaith collaboration. They are part of the interfaith organisation OMCA, through which Orthodox Christians, Muslims and Catholics work together on HIV-related activities — emphasizing attention to mothers, pregnant women, orphans and vulnerable children, and through income-generating activities. They also conduct wellness workshops.[13]

Conclusion

On the basis of the engagement of respondent organisations to date in National AIDS Plans, the research findings indicate that Catholic Church-related organisations are well poised and ready to participate in the implementation of the Global Plan with the right support. An overarching conclusion is that these organisations present strategic advantages that the Global Plan can

11 Mohammed Mateen, personal communication, 16 March 2012

12 Mohammed Mateen, personal communication, 16 March 2012

13 Abba Teum Berhe Danne, personal communication, 13 March 2012

build on, especially as the implementation stage of the Global Plan advances into its second year. The scope of their outreach to mothers and children, acceptance by communities, reputation of quality services, and a holistic approach to health are positive features that can be harnessed to scale up Global Plan activities at the community level.

Numerous studies have shown that faith-based organisations (FBOs) are critical providers of health care in many parts of the developing world, especially in rural areas. Mapping research by the African Religious Health Assets Programme (ARHAP) in 2008 revealed that the contribution of FBOs to health care at the country level in Africa varies from 2% in Mali to about 30% in both Uganda and Zambia, with an even higher percentage in rural areas.[14] An initial study by ARHAP determined this figure to be as high as 70% in rural Zambia.[15]

Despite the well-developed infrastructure of Catholic Church-related organisations, funding challenges still exist. FBOs are not immune to the flat-lining and funding cuts that have been prevalent across HIV-related work since 2009.[16] [17] Furthermore, FBOs often find it challenging to access resources from their governmental structures and multi-lateral funding organisations. In order for the Global Plan to be fully achieved, it must be adequately financed, with commitment from both high-income donor countries and implementing countries. Catholic Church-related organisations, especially those based in donor countries, can play a role in advocacy related to resource mobilisation.

Broader health system strengthening must be achieved in order for the Global Plan to be effectively implemented. Challenges in accessing maternal-child health care, antenatal clinics and obstetric care serve as barriers to women accessing PMTCT services. HIV/TB co-infection also represents a challenge that must be addressed in high prevalence communities. Stigma and discrimination and lack of nutritional support for women living with HIV and their families are ongoing challenges to the effective implementation of the Global Plan. Catholic Church-related organisations may serve as partners in raising awareness and delivering comprehensive care, treatment and support to address these issues.

The research findings affirm that Catholic Church-related organisations may best engage in the Global Plan in collaboration with governmental plans. FBOs engage in government-sponsored workshops and information sharing, and many receive essential medicines and other supplies from their respective governments. However, access to the most effective antiretroviral (ART) and PMTCT regimens still remains a challenge in many countries, and in order to get to zero new HIV infections among children and keep their mothers alive, universal access to prevention of vertical transmission, treatment, care and support must be realised in each of the 22 priority countries.

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14 Schmid B, Thomas E, Olivier J, and Cochrane JR. 2008. *The contribution of religious entities to health in sub-Saharan Africa. Study funded by Bill & Melinda Gates Foundation*. Unpublished report. Cape Town: African Religious Health Assets Programme.

15 African Religious Health Assets Programme (ARHAP). 2006. *Appreciating Assets: The Contribution of Religion to Universal Access in Africa*. Report for the World Health Organisation. Cape Town: African Religious Health Assets Programme.

16 Ecumenical Advocacy Alliance (EAA). 2010. *Assessing the Impact of the Flat-Lining of Treatment Funding on HIV-related Services Delivered by Faith-Based Organisations*. Geneva, Switzerland.

17 Catholic HIV and AIDS Network (CHAN). 2011. *Keeping Commitments for HIV and AIDS: Access for All to Prevention, Treatment, Care and Support. A Position Paper from the Catholic HIV and AIDS Network (CHAN).*