UNAIDS-Caritas Internationalis Joint Consultation with Catholic Church-related and other FBOs on Expansion of Anti-Retroviral Treatment

Rome (Italy) – February 25-26, 2014

More than 100 representatives of diverse Christian faith traditions, UNAIDS, WHO Stop-TB and HIV/AIDS Departments, UNITAID, the Global Fund, Vatican offices, governments, the medical and scientific community, and the diplomatic corps accredited to the Holy See gathered in Rome, on 25-26 February 2014. Their aim was to identify opportunities and challenges in expanding access to HIV treatment globally and strengthening the role of faith-based organisations (FBOs) in the provision of such services.

Speakers included:

Dr Luiz Loures, Deputy Executive Director Programme, UNAIDS

Rev Phumzile Mabizela, Executive Director of the International Network of Religious Leaders Living with or Personally Affected by HIV or AIDS (INERELA+)

Cardinal John Onaiyekan, Catholic Archbishop of Abuja, Nigeria

His Excellency Kenneth Hackett, Ambassador of the USA to the Holy See

Dr Stefano Vella, MD, Director, Department of Pharmacology and Therapeutic Research, Istituto Superiore di Sanità

Dr Julio Montaner, Director, British Columbia Centre for Excellence in HIV/AIDS, Providence Health Care

Dr Chewe Luo, Senior Advisor, UNICEF

"Ensuring 15 million people have access to high quality antiretroviral medicine and care by 2015 will be a critical milestone in reaching everyone in need," said Dr Luiz Loures, Assistant Secretary General of the United Nations and Deputy Executive Director Programme, UNAIDS.

"But we cannot do it alone. Historically, the services provided by the faith-based community have been a critical contribution to the millions of lives saved and they must be fully involved and engaged in efforts to expand access to HIV services. They

have the capacity, the networks, the expertise and the experience. They will be one of our greatest allies in reaching people most in need."

The consultation was related to the UNAIDS Initiative called *Treatment 2015* ; this Joint United Nations Programme estimated that, at the end of 2012, 9.7 million people were accessing antiretroviral therapy in resource-limited settings.

Participants recognised that churches and other FBOs are the largest single group providing health care services for HIV, contributing up to 50% of facility-based and community care in some countries, particularly serving marginalised and vulnerable people in resource limited settings.

Setting the Stage for Progress to Reach "Treatment 2015"

In welcoming the participants, Archbishop Zygmunt Zimowski, President of the Vatican's Pontifical Council for Health Pastoral Care, acknowledged that we are very far from universal coverage in access to HIV treatment but also highlighted the long and untiring involvement of the Catholic Church in response to HIV and in caring for people affected by it. He noted some of the Pontifical Council's work, including a Test and Treat project about to take off in Tanzania to guarantee ARVs to 100,000 people for 5 years.

He asked the participants to resist becoming discouraged and always be inspired by Jesus, the Good Samaritan, who invites us every day to care for our neighbour. St. John Paul II always encouraged everyone to work together, using their specific skills to care

The Archbishop noted that recognition of and collaboration with other agencies is essential, and should be practiced while respecting each one's specific contribution. HIV is a pandemic that can be overcome by a true alliance of men and women of good will, guided by principles and ethical values with the ultimate aim to act in the service of life for every person. In all cases, we should place at the centre of all our health care interventions, the people living with HIV, their dignity, their needs and rights, their family and social and relationships, and their rightful place in society.

Dr Luiz Loures, Assistant Secretary General of the United Nations and Deputy Executive Director of UNAIDS, stated that we are entering a new phase in response to AIDS, and its main aspect is hope. He recognised the churches' strong position against discrimination and for dignity that made the response to AIDS so different. Science, and then funds, followed. He delineated certain "non-negotiables" for expansion of treatment:

- Integral right of everyone to enjoy highest attainable standard of physical and mental health;
- First and foremost for safeguarding health of people living with HIV;
- HIV testing and ART initiation – voluntary and non-coercive;
- Ensuring best interests of people living with HIV;
- Highest quality of medicines and care;

Dr. Loures urged that four principles be kept in mind:
1. We have to mind the country context;
2. No one left behind – particularly not the children;
3. We need to be ambitious in scaling up;
4. Communities at the centre.

He acknowledged that we cannot scale up without money. More than 50% of the money today is coming from national budgets. That is good news. We need this amount to be increased in order to reach the end goal. Potentially we can have a lot of efficiency gains and less money can do more. If we take an investment approach we can do more with less money. But we need new money now for this approach. To expand Anti-Retroviral Treatment ART to 27-28 million people by 2020, the international community will need US$26.5 billion. With significant increases in funding now, we will save more money in the future.

Dr. Loures told the faith-based organisations that they have the scale and the means to move forward. "You care about dignity, and that can make even more of a difference. Dignity has the same value as providing the drugs. It is the combination of access to drugs and dignity that can bring us forward. Nobody can do this better than you."

Mr Michel Roy, Secretary General, Caritas Internationalis conveyed a special welcome to participants on behalf of the Caritas Internationalis confederation. All the members of this confederation are engaged in promoting integrated human development that confronts injustice, inequity, marginalisation and oppression. Members deliver services to all in need, and have made particular efforts to care for women and children who are more vulnerable to violence and other social problems. For over 25 years, Caritas Internationalis has addressed HIV and AIDS and its related issues as a priority issue for response and action. They have connected with many others to promote non-judgmental compassion and acceptance, effective prevention education in line with the values and teaching of the Catholic Church, and comprehensive care and treatment. These organisations are gathered in the Catholic HIV and AIDS Network (CHAN), whose work is fundamental to the effort. They have had open and honest discussion when Catholic Church positions and strategies differ from those of others in the response.

"This event recognizes the extensive HIV treatment services as well as care and support programmes offered by Caritas, other Catholic Church-based organizations, and many other Christian faith traditions, particularly in areas with limited resources," said Caritas Internationalis Secretary General Michel Roy. "We have a common goal to provide treatment to all people living with HIV who need it."

His Excellency Kenneth Hackett, Ambassador of the United States of American to the Holy See said, "This consultation brought key partners together to look at current efforts, the new financial architecture of the HIV response through the Global Fund, PEPFAR and UNITAID, and how we can be strategic, practical and collaborative in reaching our vision of millions more receiving the treatment and services they need for full and productive lives."

Ms Jane Gondwe, DREAM project, Malawi, expressed gratitude for the opportunity of this consultation to expand treatment in Africa for those living with HIV. She recalled her own personal experience ten years ago when her husband died and she discovered she was HIV positive. She was fired from her job as a teacher, she was sick, still with the responsibility of taking care of her children. She thought she would die. One day, a neighbour took her to the DREAM Centre. She still remembers the warm welcome. She had never seen a hospital giving ARVs free of charge. After 10 years, she can say she has a new family. DREAM saved her life physically and emotionally. She is able to work again. Now she serves others, speaking about what is possible and that we can have a new generation that is HIV negative. In DREAM, she noted, they take care of each other and love each other. To be HIV+ is not a death sentence, it is new life. Her country is doing quite well against HIV, but can do more. By working together, with resources and capacity, we will get results. In Malawi, although they are starting to see the end of the epidemic, many organisations are stepping back, talking about exit strategies. We can restore the gift of many women, children, families and countries. We can change the history of the nation. We can change Africa. Our challenge is to keep the patient in treatment. As the voice of all mothers, and for the children who have no one: Help us, help our children. Find an answer for their future.

Dr Stefano Vella, MD, Director, Department of Phamacology and Therapeutic Research, Istituto Superiorie di Sanità noted that AIDS has been in his life since the beginning of the pandemic. His organisation has also worked with FBOs since the beginning of the epidemic. He presented an overview of the progress in treatment since 2003 but emphasised we have a gap to fill. We work for universal access to ARVs, but there is something more that this work can do for health and equity. In Africa, we see the double burden of disease – where HIV is, there are also diseases from chronic inequities. This is a global problem. Inequalities are everywhere. What we have done for HIV (and are doing) could be seen as a global health model. We can build a more equitable world.

Review of Objectives for the Consultation

Msgr Robert J. Vitillo, Special Adviser for HIV and AIDS, Caritas Internationalis, drew attention to the background for this consultation, much of which is described in the concept paper. UNAIDS has taken a leadership role in scaling up access to treatment and in the Global Plan to eliminate mother to child transmission as well as ensuring that children have access to treatment. Caritas Internationalis has been privileged to be part of the steering groups for these initiatives, and has tried to remind governments and others that we have to work together. This gave birth to the idea of this consultation to develop a roadmap of how to work together better. Msgr Vitillo reflected on the challenges he has heard in his visits in the field – without resources, medicines cannot be provided and services cannot be offered in the way FBOs do, treating the whole person. No one can do this alone in the field, and we cannot afford to duplicate work in the field. We need to find ways to work together, and most of all with people living with HIV. FBOs should maintain the values of their institutions but we can and should work together.

Dr Reuben Granich, Special Adviser for Care and Treatment, UNAIDS, recognised that all of the participants work very hard in different aspects of HIV. He walked through the six objectives of the consultation:

1) Review of Treatment 2015 and current treatment expansion efforts;
2) Presentation of the ongoing and planned contribution by faith-based organisations to treatment and HIV services expansion;
3) Review of opportunities and obstacles for faith-based organisations to maintain and further expand HIV services including treatment;
4) Expansion of participants' knowledge base about the progress made in efforts to attain Universal Access to antiretroviral treatment for all who need it and about the impact of such treatment on preventing the further spread of HIV;
5) Refinement of advocacy skills to promote treatment expansion within church-related structures and in the wider global community;
6) Development of a collaborative action plan and joint statement on ways to further accelerate treatment expansion.

He concluded that working alone, we can do what we can. But, working together, we can achieve much more. On the current trajectory, millions will not have access to treatment, and that is not acceptable.

Ms. Sally Smith, Chief AI Community Mobilisation, UNAIDS, reviewed the agenda. She concluded the review by noting that Jesus would challenge us in our own faith community about our own prejudices. She expressed the hope that we can all listen, and be honest while we grapple with our own respective issues.

Updates from the Experts:

Dr Julio Montaner, Director, British Columbia Centre for Excellence in HIV/AIDS, Providence Health Care, described the experience of responding to HIV in Vancouver, which demonstrates the effectiveness of aggressive treatment in preventing new infections.

Early on when treatment therapy was discovered, clinicians and researchers in British Columbia saw that, by deploying triple therapy aggressively, it stopped the development of the virus, and could put people in "remission", stopping HIV replication. So today, a 20-year-old diagnosed with HIV has a life expectancy of over 50 years. This can also protect, up to 90%, the possibility of transmission. British Columbia has expanded the treatment programme, which has dramatically decreased incidence of mortality since 1996 - from one death a day to today in which there is perhaps one death a month. The virtual elimination of AIDS cases and deaths is now foreseen. Expansion of therapy is good for both people living with HIV and in preventing further cases. The more we treat, the less we diagnose new infections.

Moreover, evidence from clinical trials recently has demonstrated treatment as prevention among sero-discordant couples, with positive results of greater than 95% through immediate ART. This can be as much as 100% - and it doesn't get any better than that!

Dr. Montaner maintained that this is not just a Vancouver phenomenon. Similar trends have been seen in Kwazulu-Natal – for every 1% increase in treatment, you see a 1% decrease in transmission. He welcomed the development of the new WHO guidelines. The status quo will lead to increased new infections. With the 2013 guidelines, we can drive down new infections. Our opportunity to end the epidemic is here and now.

What about the money? If we move from status quo to more aggressive treatment now we will save many lives. It will cost money upfront, but very quickly, there will be a significant decrease and billions will be saved by going to a test and treat methodology. If we don't do this, it will cost us more – the epidemic will grow and the needs will as well. This is potentially the beginning of the end of HIV and AIDS. We need to rally our troops.

Dr Marco Antonio De Avila Vitória, Medical Officer WHO/HIV and AIDS Department, explained the new WHO guidelines with an update on current HIV trends. The WHO vision consists of:

1. Treatment for all eligible. The science of treatment is evolving considerably.
2. Pushing for safer, optimised drug regimens.
3. Affordable treatment and care. There is a lot of progress, but we have a ways to go.
4. Effective, accessible and quality assured services. Can we reach patients in a sustainable way?
5. Retention across the cascade – keeping people on treatment.

Key new recommendations are both clinical and operational. On the clinical side is the earlier initiation of treatment, including immediate ART for children under 5 and for all pregnant and breastfeeding women (Option B/B+). There is a change in the drug regimen, to reduce as much as possible the number of tablets, which has a big impact in terms of adherence. Operationally, they recommend fixed dosed combinations and improved patient monitoring. They recommend task shifting – which is complex. And they recommend community involvement in testing and treatment.

Dr Chewe Luo, Special Advisor on HIV and AIDS, UNICEF, welcomed the opportunity for UNICEF to be present to be a voice for children – it doesn't always happen, but it is getting better. Why is it so important to focus on children? People don't know that children are so left behind.

We can see the impact of the Global Plan, starting in 2009 that accelerated the decrease in new infections in children – but we need a far more intense decline by 2015 to meet the Global Plan target. Where we are and where we are going is mixed when you look at the country context.

Dr. Luo urged the following future actions:
- put women and girls at the centre;
- highlight paediatric HIV care and treatment through the launch of the Double Dividend';

- address adolescents.

Ms Hannah Monica Yesudian Dias, Technical and Information Officer, WHO/TB Department, identified key challenges to TB eradication, which are comparable to HIV:

- Case detection (a third of cases not diagnosed or reported
- TB/HIV co-infection (which is a special challenge in Africa)
- Multidrug-resistant TB (especially in Eastern Europe)
- Weak health policies, systems, financing, and services
- Under-engaged communities and providers
- Still need to support research and innovation, for instance, for rapid diagnostic test

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She noted that TB and HIV are inextricably linked. All must take action and invest in solutions to save lives.

The "New Financial Architecture" of HIV and AIDS Funding:

Dr Christoph Benn, Director of External Affairs, Global Fund to Fight AIDS, Tuberculosis and Malaria, maintained that the role of faith-based organisations has always been important to the Global Fund, which recognises their provision of health care, particularly where it matters most and with the hardest to reach populations. We have supported faith-based organisations since the Global Fund was created in 2002. Cumulatively, almost 1 billion USD has been disbursed to FBOs. He maintained that, in the end, it is not important whether a faith-based organisation, a government, or a civil society organisation is providing the service – what matters is who can make resources most available, and most effectively, to people in need. It is a question of how can we can best implement these programmes.

Mr Mauricio Cysne, Director of External Affairs, UNITAID, presented his organization's clear focus to address market shortcomings to improve access to health products. It works through implementers (not directly through countries). Formed in 2006 with five founding countries, UNITAID would like to have the multiplier effect with its smaller resources to leverage the Global Fund and domestic spending so that it is most effective. UNITAID works with a variety of implementers internationally and nationally. It tries to intervene on intellectual property and market issues, issues of quality, availability, price, research, delivery – to bridge the research and development of the product with country implementation.

Fr Edward Phillips, President of Board of Directors, HIV and AIDS Programme, Eastern Deanery – Nairobi Archdiocese, noted that he was speaking from the experience of a large on-the-ground operation (20,000 patients in Nairobi) with a long-term relationship with PEPFAR.
He reviewed three phases of PEPFAR, stating that if you don't understand the process, it is difficult to understand where it is going. In the first phase of five years, PEPFAR funds were readily available. International non-governmental organisations (NGOs), notably Catholic Relief Services (CRS) and World Vision, received funding. Then the recession hit, which reduced funds available on the ground and the term "indigenisation" was raised, meaning the ownership of the country is central. It is an

important principle, and also an attempt to reduce costs by cutting out the intermediary.

In the second phase of PEPFAR, local organisations received contracts. Some international NGOs created local organisations in order to access funds. Some international agencies were funded to provide administrative support. Towards the end of this phase though, budgets became frozen. A frozen budget over several years is in reality a budget cut. The new slogan "do more with less" appears, but at what point in time will the increased targets cross with the reduced resources and become a self-destructive process? Delays in issuing new contracts, or making only partial payments, has led to staff and programme insecurity and even raises questions about the viability of the organisation. At the same time, there is the new expense of chronic care – people are living much longer on the medicines and developing other side effects. The new mantra becomes country ownership of programmes, which is again an important principle but means huge battles in national budgets.

What will the third phase of PEPFAR be? Fr Edward made several future projections, while at the same time expressing the hope that he will be proven wrong:

- PEPFAR funds will be cut back.
- More funds will be directed to governments and not service delivery organisations.
- FBOs and other groups will lose funding (depending on their contacts within the country).
- Programmes will shut down or transfer to governments.
- The poor, whom the FBOs reach, will be marginalised again.

Dr Amy Ellis, Health Policy Adviser, Catholic Relief Services (CRS) – USA, reported that
CRS works with over 1,000 partner organisations in health services, half of which are Catholic. Their largest PEPFAR grant was called AIDSRelief, which began in 2004 and continues in some countries today. Enormous numbers of people reached, trained, and lives saved. CRS also receives Global Fund grants, for example, for Catholic partners in Pakistan reaching the poorest and most marginalised people.

Their dramatic achievements are only possible by working with FBOs who reach the hard to reach population and demonstrate service and compassion. FBOs are critical to global health but specifically to HIV. FBOs are part of communities and have long-term commitment to communities, not just for a five-year funded programme. FBOs work in hard to reach areas. They provide holistic care – not just treatment, but also psyco-social support, spiritual support, etc. They care for the whole human being. FBOs fill a gap. It will be difficult to reach the new targets without FBOs. It's easy to have donor fatigue, to say, "do more with less". It's easy to say, not easy to do. We have, however, done the groundwork and we need to push now to build on that and be able to see the end of the epidemic.

CRS sees two challenges in the changing funding environment:

- CRS is particularly excited about the Global Fund's new funding model and country-led participatory approach. The key though is, How do you get FBOs to the table and participating in these dialogues? Sometimes FBOs are

geographically distant; it is hard to get to the capital for these discussions. Sometimes they don't have the right contacts to get involved.

- Country ownership and handover of country-based organisations: We want to foster capacity of country organisations. In a funding environment where funds are going directly, how can we as an international NGO help to ensure they are able to manage the funding in this transition phase? How do you hand over the reins so that they can maintain the same level of care without smothering them and enable them to receive further funding?

Learning from the experience of faith-based organizations already engaged in prevention, treatment and comprehensive care and support of those living with or affected by HIV:

Ms. Aurorita Mendoza, retired UNAIDS staffer who now volunteers with Caritas Internationalis, presented a preliminary report on a survey that was conducted among organizations partincipating in the consultation. With regard to resource mobilization, all respondents indicated good to excellent support from church-based funders. Less than half were successful in accessing support from Global Fund or other selected bilateral funders; very few indicated that they had no knowledge or little success with regard to accessing support from other bilateral or multi-lateral organizations, including UN agencies.

Implementation of HIV activities (N= 15)	% of organizations offering services	% of budget (range)
Gen. HIV education	**73%**	2-15
Pediatric ART	**60%**	2-10
Home-based care	**60%**	**1-45**
ART	53%	**24-50**
Counselling & testing	53%	2-11
OVC	53%	**2-80**
PMTCT	40%	1-7
Others*	40%	1-22

*Palliative care, OI, pastoral care, stigma reduction, income generating, advocacy

Both the range and the volume of health care delivered by Catholic Church-related and other FBO providers is quite evident – they have the structure to deliver both facility-based and community-based services efficiently, effectively and often at lower-cost that governmental and some other providers. However, a recurrent theme in the survey responses and during the Consultation is that they are constantly be asked to do more with less and that they do not perceive the possibility of scaling up without increased funding. Moreover, he following challenges in service implementation and delivery were identified:

- Maintaining high adherence rates to ARVs
- Managing implications of reduced financial support: service quality; staff retention; handover transition

- Producing and using quality strategic information
- Providing holistic/comprehensive care

A significant number of "good case" examples were presented during the consultation. For purposes of brevity, only a few will be mentioned in this report:

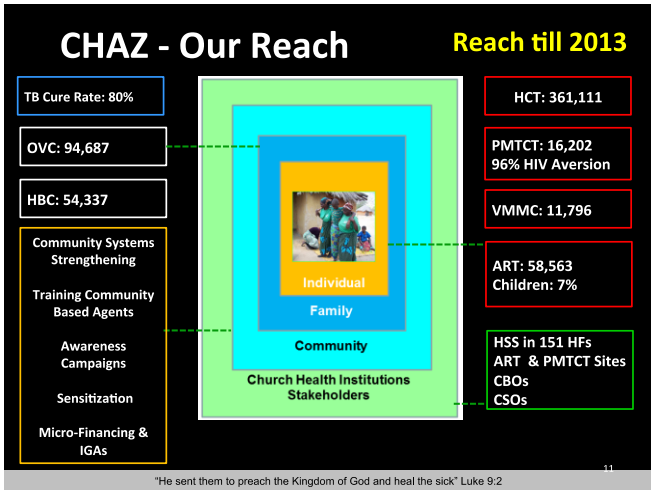
Catholic Relief Services' "AIDSRelief Project", was in operation in 10 countries between 2004 and 2013, and received US$740million in PEPFAR support. Over 713,000 people were served and over 395,000 enrolled in ART. Strong community-based treatment services were created, and 30,000 staff trained. CRS worked in a consortium with four other organisations that brought together the right experts to build the system and provide the skills for high quality HIV care. CRS built on an extensive reach of faith-based health networks, including Christian and Muslim organisations to assist the most underserved populations with HIV care and treatment. These networks enabled AIDSRelief to leverage community linkages, develop highlight effective community supports, and reach patients at the household level.

Here are just a few of the accomplishments of the AIDSRelief programme:

- Excellent clinical outcomes
- Lost to Follow-up rate was **5.2**/1000 patient months, or **10.6%.**
- Mortality rate is 3**.2**/1000 patient months, or **7.8%.** [1]
- Between 2006 and 2012, the programmes attained a virus suppression rate of 85.8%.

During the past 28 years, the Churches Health Association of Zambia (CHAZ) has worked with Mission Health Facilities (68) and their Communities in the implementation of HIV/AIDS Programme. With the support of local and international partners, it provides a full range of HIV and AIDS services including the following:

[1] These estimates were calculated by the Futures Group.



CHAZ reported using the **Tanahashi Model** as a tool to measure HIV and AIDS Service Coverage, using the:

1. <u>First, the client looks at the HIV and AIDS service in his area, that is relevant to his problem:</u>

Availability coverage:

- Manpower, Facilities, Drugs, etc. … are required in order to provide a service.
- The lack of such resources limits the maximum capacity of the service.
- The ratio between this capacity and the size of the target population gives the measurement of coverage for this stage.

2. <u>When he has found an appropriate and available service , he can use it only if has the means to reach it:</u>

Accessibility Coverage:

- Even if all the necessary resources are available, the service must be located within reasonable reach of the people who should benefit from it.
- Here, the capacity of the service is limited by the number of people who can reach and use it.

3. <u>Whether he can afford it:</u>

Acceptability Coverage:

- Once the service is accessible, it still needs to be acceptable to the population, otherwise people may not come for it and may even seek alternative care.
- The acceptability may be influenced by factors such as: the cost of the service to the user, the form of religion he follows, the cultures and believes, etc…
- Here, service capacity is limited by the number of people who are willing to use the acceptable service.

4. <u>Decides to use the services. If he does, then, he receives the service:</u>

Contact Coverage:

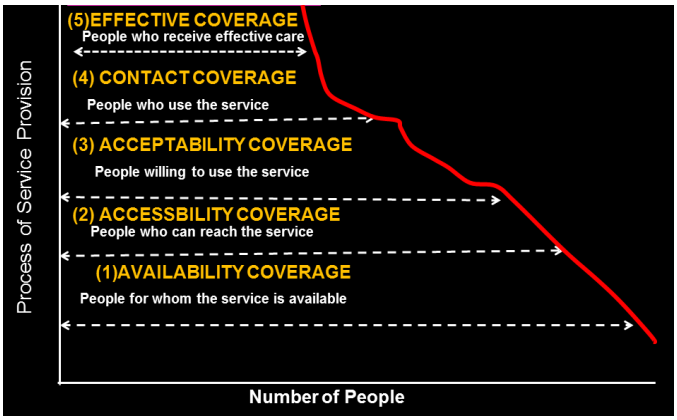
- This is the contact between the service provider and the user.
- The number of people who have contacted the service is a measurement of service output.
- The ratio between this and the size of the target population gives the contact coverage.

5. <u>But the service may or may not solve his problem, depending on the quality of the service as well as the nature of his condition:</u>

Effective Coverage:

- The contact between the service provider and the user does not always guarantee a successful intervention related to the user's health problem or effective service.
- The service performance is appraised as satisfactory when the specific criteria is achieved.

The relationships between the different measurements of coverage are the key factors in the evaluation of the HIV and AIDS Services Coverage.



The Comuintà Sant' Egidio presented its DREAM (Drug Resource Enhancement against AIDS and Malnutrition) Project":

- ❖ Program was initiated by the Community of Sant'Egidio to support African countries to provide a holistic model of care for people living with HIV/AIDS. Sant'Egidio implements, manages and expands DREAM in collaboration with a vaste network of public and private partners, governments, religious orders.
- ❖ The organization refused to accept a double standard with therapy accessible only to patients of the North and «prevention» for the South of the planet; thus set up a quality-oriented system of care.
- ❖ DREAM started in Mozambique in 2002 and is one of the very first and oldest programs aiming to treat people living with HIV/AIDS in Sub-Saharan Africa.
- ❖ DREAM pioneered new models of intervention in PMTCT, breastfeeding treatment, viral load monitoring and adherence, retention, ART as a novel method to prevent, maternal mortality reduction and modelling.

DREAM was cited in WHO's 2011 Retetion meeting report for the following strategy:

°°Comprehensive health education
°°Full immunologic and virologic monitoring
°°Electronic medical records (DREAM software)
°°Nutritional support
°°Strong linkage system between pharmacy, laboratory, PMTCT centre etc
°°Shorten the delay between assessment and commencement of PMTCT/ lifelong ART
°°Commencing ART for all HIV positive pregnant women regardless of CD4 count (the option B approach) has been adopted in DREAM programmes and may offset (Lost to Follow-Up) LTFU post-ANC (ante-natal care) and delays in lifelong ART initiation post-PMTCT. This may result in reduced maternal mortality, and may be cost-effective .

Doctors with Africa – CUAMM - sends missionary doctors to Africa (Currently in 7 countries – Angola, Ethiopia, Mozambique, South Sudan, Tanzania, Uganda and Sierra Leone). Most relate to Catholic hospitals and centres but also to others. They also support training through nursing schools and universities.

They use the continuum of care approach: from communities and families (awareness raising, some services); to first referral to health centre, then second referral to a hospital. Systems need to work as a whole.

CUAMM makes a distinction between what health centres and hospitals provide and what their challenges are. Each has both geographical considerations and areas of expertise. You need to make sure that you have connections between the community, health centre and hospital.
They also have clear experience and expertise in what they aim for in community and families. They work in community mobilisation, education, support and home-based care, coordinating with existing networks and organisations. Other challenges include urban vs. rural provision of services. The urban population is rising, along with the related problems such as slums. CUAMM is considering transitioning from rural areas to urban areas.

In addition, the additional burden of chronic diseases is placing additional challenges on health services particularly in developing countries. The double burden scenario where you have to provide services for both infectious diseases and rising chronic disease burden needs to be considered as we continue to try to meet the needs of people in communities.

Other panelists from Papua New Guinea, Brazil, India, Vietnam, Ukraine, Poland, Kenya, Uganda, Ethiopia, and Nigeria identified challenges to scale up ART, including :

- stigma and discrimination in health care settings
- staff attitudes and lack of knowledge and skills
- waiting times at facilities
- economic reasons
- long distance to facilities

- side effects and lack of treatment education/misconceptions.

Working Groups identified major strengths of faith-based organizations engaged in treatment programming, including their ability:

- to reach down to local communities and mobilise them. We can reach far-flung posts, the most vulnerable people and those in greatest difficulty. But we need to continue to pursue resources to be able to accomplish this. And for those who live in countries where it seems that HIV is not a problem, it is in fact a hidden problem;
- to deliver free services to all – the challenge is to go on doing that, and to continue to give the best possible treatment.
- to transfer competence and passion to even those lay people who form part of our organisation.

Reflections on Catholic Church and other Religious Teachings on Engagement in HIV Response, with Special Regard for Treatment Services

Cardinal John Onaiyekan, Archbisop of Abuja, Nigeria, pointed out that this is an emerging new era in HIV and AIDS. Without suggesting that there is no problem, we must agree that a lot has changed. This era has moved from despair to hope. We can dare to hope. We are now better informed. We are working seriously against stigma and discrimination. Yet we have not succeeded; it is still around. We can say that HIV is no longer a death sentence. This is an era of treatment – not palliative care for people waiting to die. We should remember that all of us are living our lives in relatively – not perfect – good health. All of us are vulnerable. We share in the vulnerability of human nature.
This is also an era of collaboration between the church and other agencies involved in the response. Not too long ago, much precious time was wasted on long debates – like on the Catholic Church and condoms. Such debates prevented people from seeing the great work the Church is doing. This consultation is a sign of the new era of collaboration, which focuses on the people in need. This collaboration is not a sign of victory of one side or the other. Helping people in need should be the full focus. Where we manage to link hands (including with other faiths) the impact far exceeds the sum of our individual efforts.

We have seen in the work of the Ecumenical Advocacy Alliance (EAA) but also in the experience of interfaith projects in Africa (e.g. in Uganda). That work is so much more effective than if we tried to work on our own. In Nigeria, in which we hear so much of Boko Haram, we have not imploded - we, Christians and Muslims, have done so much together. Not that we don't have challenges. But every effort should be made to continue in this direction. One advantage of interfaith collaboration is that many of the international agencies find it easier to deal with an interfaith group rather than individual religious bodies.

One of the fruits of this collaboration is to make Catholic teaching better known. It is well known that the Catholic Church has a set of principles that are non-negotiable. These are based on our understanding of the Gospel of Jesus, demands which are also convictions on what is best for humanity. The Church is aware that these are not accepted by even perhaps a majority of people. She does not impose. Some try to prevent the Church from expressing its position, particularly in condoms and

abstinence. Scientific evidence has shown that the position of the Church is not as unrealistic as some people have tried to claim. He gave the example of talking to young university men about responsible sex, after which the young men formed peer groups to live responsible lives.

Teachings are not only a list of prohibitions. They teach us also how to live, like taking care of your neighbour. This is the basis for services to people of all creeds and colour. High-level policies have been issued by church to guide the faithful – including the councils in Africa – to serve all and overcome stigma and discrimination. The action plan of SECAM is still guiding many councils and churches. The Archbishop said that he himself also has issued many messages of hope on World AIDS Day.

Church teaching must be the basis of action. The Church is asked to model Jesus in compassion as well as condemn evil. People need to know their status so that people can make informed decisions. He himself publicly announced that he has gone for testing. This scandalises some, but the majority got the message that they also should be tested. Pastors who demand HIV negative certificates before a wedding are certainly not respecting confidentiality, but couples need to be encouraged to inform each other and make responsible decisions.

The Church has abundant resources of love and compassion. Combined with adequate funding – and a lot can be done by local fundraising – much can be achieved for all in need.

Rev. Phumzile Mabizela, Executive Director, International Network of Religious Leaders Living with or Personally Affected by HIV (INERELA+), noted that she would speak about Protestant churches, and about treatment vs. healing. She shared a story from a few years back, in which she spoke about her experience of living with HIV with a group of Christians. One brother, deeply touched, asked if she believed in God, and if she believed, why did she take drugs and not trust in God who made the lame walk? This came from an informed leader.

The issue of ART remains controversial among some traditions, and she often has to compare her taking of medication with drugs for high blood pressure or diabetes that other leaders take.

There are different Protestant churches, and she said that she would focus on the most popular – mainline, Pentecostal and African Initiated Churches. They differ on approaches to treatment, and she planned to focus on practice, not teachings. "Healing" goes hand in hand with treatment and has created much confusion among churches in the HIV context. The church is still struggling to understand the epidemic and its role in advocating for holistic care of those living with HIV. Issues like gender inequality, poverty and apathy are our worst enemies.

Most mainline churches have incorporated HIV discourse into their curricula, and have developed a lot of academic work. The challenge is getting the many resources out to all who need it. National Councils of Churches have worked hard at demystifying HIV-related issues, including treatment.

Pentecostal churches have a different view – faith in God and miracles takes centre stage. They have not understood that HIV is a virus and rather consider it a curse from God. They think one is are only healthy or healed on the basis of the strength of her/his faith. Pentecostal churches are more interested in deliverance than development, and believe that faith healing can cure HIV. Some Pentecostal churches are praying for ARVs - to make them more effective. We need to promote that healing in the name of Jesus means using all the resources available, including ARVs. African-Initiated Churches understand disease as a manifestation of a breakdown of communication between the living and the dead. Not connected to sin, it is a sign of breakdown of community and family. While not necessarily rejecting ART, they often use herbal concoctions that reduce the efficacy of ARVs. They have certain rituals that aim to contribute to spiritual, emotional and physical healing.

Healing in African cultures is very important, but it is unfortunate that some of the traditional community practices and rituals that can help have been lost. Due to a lack of understanding, many in the churches propagated destructive attitudes that contributed to fear and silence among those living with HIV. Recognition of these negative and judgmental attitudes has led to new efforts against stigma and discrimination. But there still is room for improvement. In addition, ensuring access to treatment depends on political will and the church has raised its voice with people living with HIV and advocated with government.

Treatment is a gift from God. Rev. Phumzile expressed the hope that one day we will develop a theology of life that particularly highlights the role of medicines and particularly ARTs in HIV. Science has shown us that treatment is a prevention tool. Scaling up will save more lives. Treatment is a justice issue and the church should be in the forefront of advocating for universal of access. What is also required is proper nutrition; food sovereignty is a related justice issue.

The church has also played a role in helping parents understand the importance of protecting mothers and babies, and progress in the elimination of Mother to child transmission is vital. However, men are still dying because of traditional notions of masculinity.

She offered three proposals for further involvement by faith communities:

1. Provide services and space for dispensing medication.
2. Advocacy and service involvement to help reach 30 million by 2020.
3. Improved adherence with support from churches. Many people stop taking medication because of its side effects; the church can understand this better in order to support people living with HIV more effectively.

She commended churches that have transcended the barriers of church tradition in order to save lives. We need to continue to work together and ensure that people living with HIV are empowered in making decisions and being agents of life.

The Way Forward to attain the goals and aims of "Treatment 2015"

The following "Road Map" was developed by the co-organizers and participants of the Conference:

- **Drugs, dignity and decentralization**

Catholic and other FBO service providers will promote a holistic approach to health care, by prioritizing access to services and provision of care to the most marginalized, remote and vulnerable populations, protecting service delivery, confidentiality, client and staff safety in situations of conflict and difficulty.

- **Data, document and disseminate**

UNAIDS will partner with Catholic partners to gather accurate data, through more systematic methods, document and disseminate and showcase good practice to support applications for funding .

- **Coordinate, collaborate and communicate**

UNAIDS will convene meetings at national and regional level between UNAIDS staff, Church and other counterparts to discuss concrete areas for collaboration

- **Community of practice**

Catholic Church partners will convene ecumenical collaboration at national level to facilitate a broad partnership base for national Governments in the HIV response

UNAIDS to send quarterly updates/or hold webinars with FBO technical partners on key technical issues

Concluding Remarks:

Dr Luis Lourez thanked all those who have organised and supported this meeting. He reflected that it was by accident that he became involved in AIDS. In the beginning, there was no science, no hope. Together, we have managed to change this hopeless situation to the hope we have today. There is no reason we could not end this epidemic by 2015.

But this perspective is not there for everybody. There is not the equal hope, for instance, for children, for people who belong to vulnerable groups. The work that FBOs do is the key to moving forward. Attitudes like stigma and discrimination are stronger than the virus. We know how to deal with the virus. But the stigma is still there. We need to deal with violence against women, sexual discrimination. We need to bring minorities with us.

The way to go forward is to combine the drugs and the dignity. From the United Nations, we should be learning from FBOs and providing an environment for you to be part of the mainstream in responding to the epidemic. There is no reason to be shy of the work you are doing. Bring the evidence and get the communication strategy and tell the story of what you have done and what you are doing. Document, communicate, and count on us to support you. This is the moment to mainstream your work, to take you out of the periphery. We are prepared to bring this debate, to be with you in making this dialogue happen with countries and partners. This is an historical opportunity in your hands, to be the engine for a breakthrough in the near future.

Ambassador Kenneth Hackett thanked the organisers for allowing the USA embassy of the Holy See to be part of this support mechanism to launch this special effort. For the US government this is a critical issue. He thanked all the participants for what they do. He thanked them for being bold: For this situation, you must be bold.

He emphasised that we must recognise our strengths and get them better known. The Catholic Church and its people do wonderful things, powerful things that change people's lives – but they do not bother documenting it. He worked with an American university that decided to enter into global development with no experience but great fundraising skills, so he got them into documenting results and evidence. He suggests putting our work with Catholic universities together to finance and bring these studies to the fore. We can prove our good work.
We also must raise our voice. The voice of those living with or affected by HIV seems to have grown quieter, and we need to make it louder. In the US, you have to get mad and demand money. He concluded with a "six-week challenge": Ask yourself in six weeks, what have I done since this conference?

Mr Michel Roy added his appreciation to all the co-sponsors of this consultation, including the support from the high levels of the Pontifical Councils and General Superiors of the Religious Orders. This meeting has given us responsibility; this is not the end – this is a new beginning. We need to work together more because all together we can change the current reality. We have realised that we can eliminate HIV. But we need to work still on treatment for all to the elimination of the pandemic itself. It really is a matter now of money. Together we can reach those who are financially able to support this work.

Networking is so important. From now onwards, we need to increase this. We need to continue combining our expertise and experiences, while preserving our identities, principles and teachings. It is all of this that will make the response to HIV and AIDS so much more.

Archbishop Silvano Tomasi, Apostolic Nuncio and Permanent Observer of the Holy See to the UN in Geneva, concluded that this kind of effort facilitates a convergence between the forces of civil society and international institutions. This is a process that we need to strengthen so that international institutions do not become abstracted from reality. We need international institutions in a globalised world, but they need to be reminded they are serving real human beings.

The key factor is the sense of love and solidarity with the people who are suffering. This is what links all of us beyond confessional and cultural differences. This is the strength that makes the activity of such conferences like this viable and important. We must take time to inform each other and such institutions of what is being done. In the long run, this will multiply the effectiveness of the actions we are carrying out.

Every effective action is local. So renewed effort is needed at the national level to link UN teams, civil society, voluntary groups and other types of FBOs because the effectiveness of large policies only comes when it is translated into local service. Children remain a priority. We need to learn from those who are suffering that there are other dimensions of life that go beyond our own concerns.

Finally, the Archbishop declared that we must maintain the universality of love that comes from the Gospel. It is up to God to judge. Our calling is to help all.

Book launch: Catholic Responses to AIDS in Southern Africa

During the Consultation, an opportunity was taken to launch the book, *Catholic Responses to AIDS in Southern Africa*, edited by Fr. Stuart C. Bate, OMI and Sr. Alison Munro OP. The book shares an important story of one of the earliest response of the Catholic Church in Africa. The book is a combination of research, experiences and statements. Undergirding the effective work demonstrated through these essays is the added benefit of doing this work through the Church.

Fr Michael Czerny, in describing his article, noted that 95% of patients that use Catholic AIDS services in Senegal are Muslim, and the reasons they gave for coming is first confidentiality and second, that we treat the whole person. He quoted Bishop Kevin Dowling, "How can I understand a figure or a statistic unless I've held the hand of the person it represents?"