

That they may have life and have it to the full
John 10:10

**Millennium
Development Goal 6:
How can religious congregations
help achieve its targets?**

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Please allow me to begin with sincere thanks to Sr. Donna, Fr. Prakash, and all who organised this session for the gracious invitation to address your membership. I feel obliged to state, at the outset, that I will concentrate mainly on the global situation of the HIV pandemic, since this is the major focus of my present ministry. I also will mention two other serious pandemics – that of tuberculosis and malaria and will try to make the connection between the three pandemics as well as the connection with the need for integral human development. All of this will be done through the lens of the Church's mission to serve and to advocate for and with the sick and the vulnerable, and particular attention will be paid to the specific contribution of religious in this regard.

Millennium Development Goal #6 is articulated as follows: **Combat HIV/AIDS, malaria, and other diseases.** One of its targets is to have halted and begun to reverse the spread of HIV/AIDS by 2015. The following indicators will help to monitor progress: HIV prevalence among pregnant women aged 15-24 years; ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years. The other target is to have halted and begun to reverse the incidence of malaria and other major diseases by 2015. The following indicators will help to monitor progress: prevalence and death rates associated with malaria; proportion of population in malaria-risk areas using effective malaria prevention and treatment measures; prevalence of death rates associated with tuberculosis; proportion of tuberculosis cases detected and cured under DOTS (Directly Observed Treatment Short Course).¹

Let us now begin to review the impact of the three major pandemics to which this Millennium Goal refers.

Tuberculosis - The latest estimates of the global burden of tuberculosis refer to cases arising in 2005. During that year, of the 8.8 million estimated cases, of whom 639,000 were adults infected with HIV; 1.6 million people died of tuberculosis, including

¹ Source: *Health and Millennium Development Goals*, World Health Organisation, 2005, p. 11.

199,000 people co-infected with HIV. The estimated total number of multi-drug-resistant cases worldwide is put at 424,000. During 2006 reports began to emerge of extensively drug-resistant tuberculosis (XDR-TB) with significantly worse treatment outcomes than multidrug-resistant tuberculosis. To date, 20 countries have reported such cases, including South Africa, where the XDR-TB has been reported in association with HIV infection with extremely high mortality (98%).² While there is no direct connection between TB and HIV, it should be noted that most TB-infected people never develop active disease, whereas people co-infected by both diseases, due to the suppression of the immune system that is caused by HIV, are much more likely to develop active TB disease. Of course, since TB is spread through air-borne means, its means of transmission is much more facile than that of HIV.

Malaria - Each year, more than 3000 million people are at risk of contracting malaria and more than 500 million people suffer from acute disease resulting in more than one million deaths. Also, more than 125 million non-immune travelers visit malaria-endemic countries annually, with between 10,000 and 30,000 contracting the disease. Malaria is a major cause of anaemia in children and pregnant women and of low birth weight, premature births and infant mortality. Until very recently, it was thought that there was no direct relationship between malaria and HIV. During the past few years, a number of studies have suggested that those who are infected with HIV are more susceptible to malaria, and that the response of the immune system to the malarial parasite produces proteins called cytokines, which have the perverse effect of encouraging HIV to replicate.³

In 1998, the Roll Back Malaria movement was established and a global partnership was launched by WHO, UNICEF, UNDP, and World Bank; this partnership now comprises a wide range of partners, including governments, non-governmental organisations, foundations and research and academic institutions. Funding for work on malaria also has been increasing, especially through mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Malaria Initiative of the President of the United States of America, the World Bank Booster Programme for Malaria Control, and the Bill & Melinda Gates Foundation.⁴

HIV/AIDS - When opening the 2006 United Nations High Level Meeting to assess the global response to the pandemic of HIV, held in June 2006, then-Secretary General Kofi-Annan said:

² Tuberculosis control: progress and long-term planning. Report by the Secretariat. World Health Organisation Executive Board, 120th Session. EB 120/8, 21 December 2006.

³ "A Vicious Circle", *The Economist UK*, 12 August 2006, reporting on a study published in *Science* by Laith Abu-Raddad of the University of Washington.

⁴ Malaria, including a proposal for establishment of World Malaria Day. World Health Organisation Executive Board, 120th Session. EB 120/5, 14 December 2006.

It is 25 years ago ... that the world first heard of HIV/AIDS. Looking back, that age of innocence -- if I may put it that way -- seems to belong not only in a different time, but in a different world.

Since then, HIV/AIDS has unfolded along a pattern we tend to see only in nightmares. It has spread further, faster and with more catastrophic long-term effects than any other disease. Its impact has become a devastating obstacle to the progress of humankind. In 25 short years, HIV/AIDS has gone from local obscurity to global emergency.

It took the world far too long to wake up. Denial dogged the response to AIDS. Millions paid with their lives.⁵

Let us now review in summary fashion the frightening dimensions and impact of the HIV pandemic on the human family:

- According to estimates released by UNAIDS, the Joint Co-Sponsored Programme of the United Nations mandated to coordinate the global response to the HIV pandemic, some 39.5 million people worldwide were living with the virus at the end of 2006, some 4.3 million people became newly infected during that year, and some 2.9 million people lost their lives to AIDS-related illnesses during that same year.⁶
- With some 11,000 new infections each day in 2006, the greatest burden of HIV was felt in developing countries. This illness strikes most at younger people, with women carrying at least (and sometimes more than) 50% of the HIV burden in many parts of the world.
- Sub-Saharan Africa remains the worst-affected region in the world. A little more than one-tenth of the world's population lives in this area, yet it is "home" to almost 64% of all people living with HIV. Three-quarters of all HIV-positive women (15 years of age and older) live in sub-Saharan Africa. When compared with men, women in this region are disproportionately affected by AIDS; this seems to be living – and dying – proof of the highly unequal socioeconomic status of women in many of the concerned countries.⁷
- The major impact of the epidemic seems to be arriving later in Asia and the Pacific Islands. However, public health experts are deeply concerned about some emerging trends there. HIV prevalence is increasing in China, Indonesia, Papua New Guinea, and Vietnam, and there are signs of new outbreaks in Bangladesh and Pakistan.⁸

⁵ [1] UN Secretary-General Kofi Annan, Opening Address to U.N. General Assembly High-level Meeting on AIDS, on 31 May 2006.

⁶ *Report on the Global AIDS epidemic: A UNAIDS 10th Anniversary Special Edition*, Geneva: UNAIDS, 2006, p.8.

⁷ *Ibid.*, p. 9

⁸ *Ibid.*, p. 9.

- Eastern and Central Europe also give cause for serious concern. The majority of people living with HIV in this region can be found in two countries: the Ukraine, where the number of new HIV diagnoses increases each year, and the Russian Federation, which has the largest HIV epidemic in all of Europe. More recent epidemics are emerging in Kazakhstan, Tajikistan, and Uzbekistan.⁹
- The HIV situation in the Caribbean has made this region the second most affected in the world. In Latin America and the Caribbean, as in many other places, this epidemic is strongly related to deep poverty and gender inequality.¹⁰
- In the Middle East and North Africa, except for Sudan, national HIV prevalence is quite low and does not exceed 0.2%. However, available data indicate that epidemics are growing in several countries, including Algeria, Islamic Republic of Iran, Libya, and Morocco.¹¹
- In high income countries, such as the United States of America, Canada, and some countries of Europe and Oceania, HIV-infected people are living longer, and many are able to maintain a higher quality of life due to the availability and use of combination anti-retroviral medications. However, more women are becoming infected in these countries, as are people of colour and other marginalized and poor people. Moreover, there seems to a resurgent epidemic among men who engage in homosexual activities.¹²

Let us move beyond numbers, however, in order to get a glimpse of the impact of HIV on social life and development. In order to do so, it might be helpful to envision, in the form of a tree, both this pandemic and the damage it causes. Despite the massive effects of HIV, including premature loss of life and skills, disruption of family harmony, exacerbation of poverty, and disrespect for human rights, it surely would be a mistake to focus solely on the external or visible results of the epidemic – those which might be depicted as the branches and leaves.

Unless we look down to the roots of disease transmission – the social, economic, cultural, and gender issues which cause people be vulnerable to contracting this virus, or prone to infecting others, we can never hope to halt the dissemination of this global emergency.

While the roots of transmission are different for TB and Malaria, many similar structural and social causes could be identified.

If we look for a moment at the roots of the problem, we note that this pandemic is intimately linked with situations that affront human dignity, including structural injustice, prejudice, the lack of distributive justice, gender inequity, human trafficking, sexual abuse and sexual commerce.

⁹ *Ibid.*, p. 34.

¹⁰ *Ibid.*, p. 38.

¹¹ *Ibid.*, pp. 48f and presentation by UNAIDS representative to Caritas MONA Workshop, Alexandria, Egypt, 6 February 2007.

¹² *Ibid.*, pp. 45-47.

In his excellent report entitled, *HIV and AIDS: A Justice Perspective*, Jesuit Father Michael J. Kelly, S.J., offers more details on the dynamics which underlie the destructive interaction between the pandemic and poverty as it makes its impact on poor people and families:

- Since time is their greatest economic asset, those who are poor may not be able to afford either the cash or opportunity costs of medical treatment. Hence they may carry untreated sexually transmitted infections (STIs) and other conditions that increase the likelihood of HIV infection.
- The poor are susceptible to other health conditions, such as malnutrition, micronutrient deficiencies, malaria, tuberculosis, and worm infestation, all of which can depress the immune system in a way that makes them more likely to contract HIV upon contact with the blood or sexual fluids of an infected individual.
- Poor people, especially women and girls, cannot afford protective gloves and disinfectants, to prevent HIV transmission during home care being provided to relatives suffering from AIDS-related illnesses.
- Poor people, especially women and girls, frequently are deprived access to education, including basic HIV prevention information.
- Migration in order to find employment often forces poor people into situations that foster sexual activity outside marriage and proliferation of STIs.
- Lack of access to water can result in poor personal hygiene, a factor that increases the possibility of ulcerative STIs and thereby the risk of HIV infection.
- Under pressure to meet immediate needs, many poor people live for the present. Unable to envision a future for themselves, they may fail to appreciate the need to protect themselves against the possibility of HIV infection.¹³

Now let us see whether any progress has been made to date on achieving the targets set for 2015. Currently, there are not enough data available for HIV prevalence among young pregnant women (15-24 years of age) to permit a full trend analysis for this indicator. Even in countries where the HIV epidemic has a very high impact, however, such as in Swaziland and South Africa, a large proportion of women first learn about their HIV infection when they present themselves at ante-natal clinics. Although infection rates seem to be stabilizing among the very young women, less than 20 years of age, significant increases of infection rates are noted among the older pregnant women.¹⁴

In countries that are highly affected by HIV, the proportion of orphans under 15 years of age due to all causes can be as high as 17% of all children. The number of double orphans (both mother and father have died) is increased as the epidemic matures. MDG indicator 20 measures the ratio of current school attendance among orphans and non-orphans between 10 and 14 years of age. On average, in sub-Saharan Africa, children

¹³ Michael J. Kelly, S.J., *HIV and AIDS: A Justice Perspective*, Lusaka, Zambia: Jesuit Centre for Theological Reflection, April 2006, pp. 24f.

¹⁴ Source: *Health and Millennium Development Goals*, World Health Organisation, 2005, p. 20.

who are double orphans are 17% less likely to attend school than children whose parents are both alive and who are living with at least one of those parents.¹⁵

During this year 2007, approximately US\$20 billion will be needed in order to meet a range of needs in the response to HIV.¹⁶ Not infrequently, AIDS advocates are questioned about how the global community can even hope to generate the funds to provide such medications and services to so many people. Let us not forget that an estimated \$52 billion per year is spent in the United States alone in order to cope with the medical consequences of obesity.¹⁷ Perhaps even more startling is the fact that, during 2004, military spending worldwide amounted to more than one trillion U.S. dollars.¹⁸

The issue of adequate funding to address the depth and breadth of needs posed by AIDS, for example, is far above the capability of non-profit structures such as those maintained by churches and other faith-based organisations. Global funding for HIV programmes increased significantly, 28-fold in fact, from \$300 million in 1996, to \$8.3 billion in 2005¹⁹, much of that due to the formation of and support for the Global Fund to Fight AIDS, Tuberculosis, and Malaria, as well as bi-lateral efforts such as the U.S. President's Emergency Programme for AIDS Relief (PEPFAR), and multi-lateral efforts such as UNITAID.

Governmental leaders at the September 2005 World Summit committed to a massive scaling up of HIV prevention, treatment and care.²⁰ This promise was affirmed when the Heads of State of the G-8 countries shared the following vision at their Gleneagles meeting in July 2005:

... with the aim of an AIDS-free generation in Africa, significantly reducing HIV infections and working with WHO, UNAIDS and other international bodies to develop and implement a package of HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010".²¹

These dynamic commitments "raised the bar" for the global response to HIV and brought it to another historic juncture, which was launched at the High Level Meeting on AIDS convened by the United Nations General Assembly in June 2006. In their Political Declaration passed unanimously at the close of this meeting, leaders with responsibility for public health, development, and overall common good in their respective nations committed themselves to:

¹⁵ *Ibid.*, pp. 21-22.

¹⁶ Yvette Collymore, Population Reference Bureau, July 2004.

¹⁷ UNAIDS, Report on the Global Situation of AIDS, December 2000.

¹⁸ *SIPRI Yearbook 2005: Armaments, Disarmament and International Security*. Stockholm International Peace Research Institute (SIPRI), Press Release, 7 June 2004, p. 13.

¹⁹ *Report on the Global AIDS epidemic: A UNAIDS 10th Anniversary Special Edition*, Geneva: UNAIDS, 2006, p. 224.

²⁰ [1] 2005 World Summit Outcome document, A/RES/60/1.

²¹ Gleneagles G-8 Communiqué, July 2005.

... pursu[e] ... all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multi-sectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society, and the private sector, towards achieving the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010.²²

The Southern Africa Catholic Bishops Conference, in cooperation with various Catholic funding agencies, as well as with its local programme partners, prepared itself to participate in the Universal Access Initiative by serving as a “pioneer” in launching anti-retroviral treatment in this region and then in building capacity among its partners so that these medications would be administered in the most responsible manner. Sr. Regina, Missionary Sister of the Most Precious Blood, of Mariannhill, South Africa, passionately summarised the dilemma felt by helping persons before their entry into anti-retroviral treatment services: “Nurses today say, ‘we are just nursing for the cemetery.’”²³ With the help of the U.S. President’s Emergency Plan for AIDS Relief, SACBC now serves as the second largest provider of anti-retroviral treatment in South Africa.

Efforts to reach other targets designed to reduce the impact of the HIV pandemic show mixed results. As mentioned earlier, significant progress was made toward raising funds for these efforts. However, only 33% of male youth and 20% of female youth were able to correctly identify ways of preventing HIV transmission; only 9% of HIV-positive pregnant women received medication to prevent the transmission of HIV during the birth process; and only 20% of people with advanced HIV infection received antiretroviral therapy. It was estimated that 1.4% of young men and 3.8% of young women are HIV-infected; and 26% of infants born to HIV-infected mothers were found to be HIV-infected themselves.²⁴

As I mentioned earlier, major funding partnerships, such as the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria, have attracted some \$8.1 billion in the past five years and awarded grants totaling \$3.6 billion. These efforts can have dramatic results. In Niger, for instance, the Global Fund helped distribute more than two million insecticide-treated bed nets to all mothers with children under age five. The Global Fund estimates that this effort will protect some three and a half million children against malaria. Likewise, from 2000 to 2005, the vaccination efforts of GAVI and its partners are thought to have

²² *Political Declaration on HIV/AIDS*, UN General Assembly 60th Session, Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS, A/60/L.57, 2 June 2006.

²³ From video about St. Mary’s Hospital, Mariannhill, South Africa.

²⁴ Source: 2006 Report on the Global AIDS Epidemic, UNAIDS, December 2006

prevented nearly two million deaths from bacterial meningitis, caused by *Haemophilus influenzae* type B (Hib disease).²⁵

However, at the current time, only some 15% of children under five years of age sleep under a net, and only 2% sleep under an insecticide-treated net. The challenge of sufficiently reducing the burden of tuberculosis in order to reach the respective MDG target for 2015 depends on how rapidly TB treatment programmes can be implemented by a diversity of health-care providers, and how effectively they can be adapted to meet the challenges presented by HIV co-infection (especially in Africa) and drug resistance (especially in eastern Europe).

In February 2007, the World Health Organisation released a report, undertaken with public health researchers based in United States and in Africa, and entitled *Appreciating assets: mapping, understanding, translating and engaging religious health assets in Zambia and Lesotho*. The report estimated that between 30% and 70% of the health infrastructure in Africa is currently owned by faith-based organizations but also concluded that there is often little cooperation between these organizations and mainstream public health programmes. Dr Kevin De Cock, Director of the WHO Department of HIV/AIDS commented on these findings as follows :

Faith-based organizations are a vital part of civil society. Since they provide a substantial portion of care in developing countries, often reaching vulnerable populations living under adverse conditions, FBOs must be recognized as essential contributors towards universal access efforts.²⁶

An analysis of the funding patterns by the Global Fund to Fight AIDS, Tuberculosis and Malaria, however, shows a serious imbalance between the funds made available to support FBO programming and the burden of care for which they assume responsibility. Global Fund officials explain that decisions on funding allocations are made within the recipient countries; however, FBOs often report frustration and exclusion in response to their attempts at participation in such decision-making processes. Recently, civil society activists have proposed a dual track system for Global Fund applications – one that would allow direct application to the Global Fund by civil society actors, including FBOs. It is the sincere hope of this speaker that donor governments and all Global Fund Board members will consider this proposal in a favourable manner.

Support for HIV services and for health infrastructure in general must be integrated, however, into a much larger package of human development support and global solidarity between high-income and low-income countries. The United Nations Millennium Project estimates that approximately U.S. \$135 billion of official development assistance were needed in 2006 and approximately U.S. \$195 billion will be

²⁵ Michael D. Conway, Srishti Gupta, and Srividya Prakash, “Building Better Partnerships for Global Health”, *The McKinsey Quarterly*, January 2007)

²⁶ “Faith-based organizations play a major role in HIV/AIDS care and treatment in sub-Saharan Africa,” press release by the World Health Organisation, 9 February 2007, Washington, D.C.

needed by 2015. Let us note that the cost estimates are well within the target that higher-income countries should dedicate as development aid, that is, 0.7% of Gross National Product (GNP), as was adopted by the United Nations General Assembly in 1970 and renewed at the 2002 U.N. International Conference on Financing Development held in Monterrey, Mexico.²⁷ It was at the latter conference, in fact, that Renato Cardinal Martino, head of the Holy See delegation, raised the urgent plea:

... the Family of Nations cannot allow one more day to pass wherein a real attempt to meet goals and make measurable progress toward the eradication of poverty is not pursued with all of the energy and resolve that [it] can muster.²⁸

The observations of a Key Informant study by the Global Health Council and Catholic Medical Mission Board include the following:

- FBOs have long been leaders in delivering social, educational and health services in many countries;
- WHO estimates that one in five organizations engaged in HIV programming is faith-based;
- Up to 40% of health care in poor countries is delivered by private religious organizations;
- The global community is urgently seeking to identify all relevant partners
- But the evidence-based body of knowledge on the role of FBOs in addressing HIV and AIDS has been limited.²⁹

Neither faith-based organisations, nor governments, nor civil society-at-large could claim to have harnessed or reversed the destructive impact of HIV on the human family. Despite the laudable efforts of FBOs in this field, they confront some haunting questions or challenges about necessary future actions. Such questions were aptly summarized by the *Faith in Action* report which I mentioned earlier; they include the following:

How Can FBOs ...

- Leverage vast assets to strengthen and scale up in-country response?
- Monitor, evaluate, document and disseminate best practices systematically?
- Contribute collectively and individually toward enhancing evidence-based knowledge through scientific studies?
- Increase their funding at all levels to reflect the scale of their work?

²⁷ U.S. \$135 billion is currently equivalent to 0.44% of the combined GNP of the countries in question, as reported by R. Dodd and A. Cassels, "Health, Development, and the Millennium Development Goals," *Annals of Tropical Medicine & Parasitology*, Vol. 100, Nos. 5 and 6, p. 382 (2006).

²⁸ Archbishop Renato R. Martino "Development Is First and Foremost a Question of People", Holy See's delegation at the U.N. International Conference on Financing Development, Monterrey, Mexico, (MARCH 24, 2002, www.ZENIT.org).

²⁹ Faith in Action: Examining the Role of Faith-Based Organizations in Addressing HIV/AIDS: Report by Catholic Medical Mission Board and Global Health Council, 2005.

- Increase and strengthen collaboration with other secular organizations in mounting a scale-up of the HIV/AIDS response?
- Help religious leadership and other clergy to increase their knowledge about HIV/AIDS prevention, care, support and treatment?³⁰

What can religious do to advance progress toward Millennium Goal #6?

Share the Church's "Best Kept Secret" – its Social Teaching

In my somewhat unique global ministry, I frequently am asked why the Church is keeping silent on AIDS. The fact is that our Church leaders have spoken frequently, strongly, and passionately about HIV and the other pandemics we have analysed today. However, it my respectful belief that we members of the clergy and of religious congregations, who have more direct and daily contact with both the Catholic faithful and people of other faiths and without faith do not disseminate such teaching widely enough.

Popes John Paul II and Benedict XVI, as well as the entire college of bishops throughout the world, took very seriously their responsibility to teach that appropriate education, service, and pastoral attention must be extended to those affected by this pandemic. Between 1987 and the present time, for example, some sixty letters, messages, communiqués, and statements about HIV and AIDS were prepared by various Episcopal conferences in Africa. The vast majority of these declarations urgently admonish clergy as well as religious and lay pastoral workers to open the doors of our spiritual communities and most especially the sacramental life of the Church to those living with this virus and those whose families have been devastated by it. In conjunction with the Symposium of Episcopal Conferences of Africa and Madagascar (SECAM) Plenary Assembly, held in Dakar, in October 2003, a collection of these statements was issued under the title, *Our Prayer is Always Full of Hope*.

In their pastoral statement, the Southern Africa Catholic Bishops' Conference left no room for any possibility of stigmatisation or marginalization based on the false premise that God has "willed" AIDS for sinful individuals:

AIDS must never be considered as a punishment from God. He wants us to be healthy and not to die from AIDS. It is for us a sign of the times challenging all people to inner transformation and to ... [a] ministry of healing, mercy and love.³¹

At their Plenary Assembly in 2003, the bishop members of the Symposium of Episcopal Conferences of Africa and Madagascar developed an Action Plan to enable the Church in Africa to react more quickly, more comprehensively, and more compassionately to the pandemic. That plan contained the following commitments:

³⁰ *Ibid.*

³¹ A Message of Hope to the People of God from the Catholic Bishops of South Africa, Botswana, and Swaziland. July 30, 2001.

- Provide access to care and treatment, and advocate vigorously for access for those excluded through poverty and structural injustices
- Make sure that Church institutions and services respond appropriately to the needs of people living with HIV and AIDS
- Advocate for policies that support them adequately and assure a life of dignity
- Focus on the particular vulnerability of girls and the heavy burden borne by women
- Advocate for the implementation of governmental commitments³²

The bishops of India make it quite clear – no Catholic institution can or should reject people affected by HIV. But they also advise Church workers to learn more about how to “fight” this disease and to avoid any stigmatizing or discriminatory behaviour toward such persons and their families.

All the Catholic healthcare institutions, as we are serving the Lord in the abandoned and afflicted, will admit and care for the people living with HIV or AIDS. As Blessed Teresa of Calcutta used to say, ‘a person affected by HIV and AIDS is Jesus among us. How can we say no to Him!’ Every baptised [person] is invited to show compassion and love to those already infected. The family members of the person infected play a major role in the home-based care, which is palliative in nature. Families and caregivers at home need to be trained in day-to-day care of the patient. We need to know how to fight this disease, while taking care not to discriminate and stigmatize the infected.³³

It might be argued that the most urgent ethical issue arising from the pandemic of HIV and AIDS is the lack of distributive justice. The poorest, most marginalized and oppressed members of society are also most vulnerable to the threat of HIV and the tragic consequences of AIDS. They are deprived of access to the preventive education, care, treatment, and support which they urgently need. Thus the Head of Delegation for the Holy See to the Special United Nations Session on AIDS, held in 2001, argued:

An important factor contributing to the rapid spread of AIDS is the situation of extreme poverty experienced by a great part of humanity. Certainly a decisive factor in combating the disease is the promotion of social justice, in order to bring about a situation in which economic consideration would no longer serve as the sole criterion in an uncontrolled globalization.³⁴

³² *The Church in Africa in Face of HIV/AIDS: Our Prayer is Always Full of Hope*, SECAM, Dakar, 2003.

³³ Bishop Bernard Moras, Chariman, CBCI Health Commission, *The Challenge to be His Light Today: A Message for the World AIDS Day 2003*, October 18, 2002, Feast of St. Luke.

³⁴ Cardinal Javier Lozano Barragán, UN Special Session on AIDS, June 2001

During the 2005 Meeting of the United Nations Commission on Human Rights, the Permanent Observer of the Holy See to the United Nations and Specialized Agencies in Geneva exercised the advocacy role of the Church by insisting that the poor and vulnerable people of the world be accorded, as a universally recognized human right, access to care and treatment, not just for HIV, but also for the other two global “killer” pandemics, tuberculosis and malaria. He linked this advocacy to the Church’s teaching about the sacredness of human life and to the already-recognized rights to health and development, which many countries have affirmed and which the Commission on Human Rights is expected to guard.³⁵

What can religious do to advance progress toward Millennium Goal #6?

Share information and network with other religious congregations and other Catholic Church-sponsored organisations responding to these pandemics – integrate attention to these pandemics into your regular and ongoing ministries.

It is my sincere belief that religious congregations are the “back-bone” of the Church’s mission of service among the most vulnerable in our human family. With all due respect, however, I have observed that there seems to be little inter-congregational sharing or collaboration and even less collaboration with other Catholic organisations. Such collaboration does not mean that you are required to develop huge programmes – or even new programmes - but you can integrate the lessons learned and the expertise of other Catholic efforts into your ongoing ministries which may be posed with new challenges as a result of the growing impact of all three of the pandemics which we have examined today.

A good example of such networking can be found in a Best Practice study focusing on the engagement of the Catholic Church to HIV programming in Southern Africa.³⁶ I had the great privilege of authoring this report which was published by UNAIDS in December 2006. This study describes the work of the Choose to Care initiative which began in 2000. It shows that effective scaling-up of programmes in response to HIV does not necessarily have to involve the expansion of a single central service. Working through the diocesan and parish system, coordinated by the AIDS Office of the Southern African Catholic Bishops’ Conference, and originally funded by the pharmaceutical company, Bristol-Myers Squibb, the Catholic Medical Mission Board and other Catholic funding agencies, the Catholic Church in this five-country area scaled up service provision by the replication of small programmes, many of which are sponsored by religious congregations and are rooted in and responsive to the needs expressed by local communities. The range of services developed under this initiative include the following:

³⁵ Cf., Intervention of H.E. Archbishop Silvano M. Tomasi, Apostolic Nuncio, Permanent Observer of the Holy See to the United Nations at Geneva at the 61st Session of the Commission on Human Rights, Item 10: Economic, social and cultural rights, March 30, 2005

³⁶ *A Faith-Based Response to HIV in Southern Africa: the Choose to Care Initiative*. UNAIDS Best Practice Collection, UNAIDS, December 2006.

Prevention, Care, Treatment, Services for Orphans and Vulnerable Children, Advocacy, Capacity Building, Interfaith Involvement, Theological Reflection.

Another excellent example of networking among religious can be found in Vietnam. A request was made by the Vietnamese government to the Archbishop of Ho Chi Minh City for the Church to provide medical care to persons in advanced stage of AIDS who are resident in a drug “rehabilitation” centre in rural area. Father, John Toai, of the Order of St. Camillus, organised a team of some 40 religious (women and men) from 17 different religious congregations. Even without access to anti-retroviral medications, many patients under their care have improved, and some even have been able to finish their term at the “centre” and be reintegrated into the community. Some of these patients were trained by the religious as health care aides and now are assisting at the HIV clinics sponsored by the Church in Ho Chi Minh Archdiocese. Some government officials claim that the project is a failure because the religious were supposed to help the patients die and, in fact, “too many are surviving”!

African Jesuit AIDS Network is working in 29 countries of the continent to animate the response of Jesuits to this disease, to educate all those served by Jesuits about the need for a holistic and caring ministry to those in need, and promote changes in society that will eliminate factors that make people more vulnerable to HIV infection or cause undue deprivation, rejection, and suffering once they, or their loved ones, have contracted the virus.

Another example of networking can be found in a collaborative project of the Unions of Superiors General. In 2005, the Unions of Superiors General established a Joint Commission on Health (with special focus on the HIV pandemic). They recommended that the Unions launch a survey of all HIV-related activities sponsored or staffed by religious communities. They were assisted by UNAIDS and Caritas Internationalis to convene key stakeholders and to design a survey instrument. At the present time, they are awaiting more responses to the survey. Georgetown University, a Jesuit university based in the United States, is assisting the Unions to record, analyse, and eventually report on the data. This information should help religious congregations to represent the work in response to the HIV pandemic that is being done by their members and to strategically plan additional responses that might be needed.³⁷

Advocate to eliminate stigma and discrimination, for solution to the structural roots of vulnerability, and for better access to education, care, support, and treatment:

Progress in attaining access to services and provision of the full range of prevention education, care, support, and treatment that is needed to achieve Millennium Goal #6 does not come without vigorous advocacy. Many religious congregations have established advocacy efforts at the level of the United Nations Organisation and at national and local levels.

³⁷ AJAN website: <http://www.jesuitaids.net>

Advocates' voices are best heard when they are raised in concert with others, so once again it is important to network in advocacy efforts. Since the year 2000, the capability of faith-based organisations engaged in advocacy on HIV-related issues has been enhanced greatly by the work of the Ecumenical Advocacy Alliance, based in Geneva, Switzerland. Some accomplishments of this organisation include the following:

- It builds a close working relationship among Christian faith-based organisations within a comprehensive campaign to decrease AIDS-related stigma and discrimination, to promote “full funding” for the Global Fund to Fight AIDS, TB and Malaria, to participate in the 2006 UNGASS review meeting, to hold governments, FBOS, and civil society accountable for promises of action on AIDS, and to convene Christian and other faith-based organisations during the International AIDS Conferences;
- It is planning a specific Action Campaign to advance access to pediatric treatment
- It has prepared a “Faith Literacy” document for use by decision-makers and staff of governmental and inter-governmental structures.

Three organisations related to religious orders already are members of the Ecumenical Advocacy Alliance – they are: Franciscans International, Africa Jesuit AIDS Network, and the Maryknoll AIDS Task Force. Others would be most welcome to join; but, at the very least, take advantage of the excellent website made available by EAA; its address is: www.e-alliance.ch .

In conclusion, we might do well to recall the urgent appeal of Pope Benedict XVI given on the eve of World AIDS Day 2005, when he singled out the “truly alarming” statistics related to the pandemic and then affirmed:

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.³⁸

In a similar manner, the Holy Father offered a message on the occasion of World TB Day 2006:

[World TB Day] which is promoted by the United Nations is an appropriate occasion to call for renewed commitment at the global level, that the necessary resources may be made available to cure our sick brothers and sisters, who often also live in situations of great poverty. I encourage the initiatives of assistance and solidarity towards them, hoping that they may always be guaranteed dignified conditions of life.³⁹

³⁸ “Pope Assures Sufferers of his support”, Vatican Information Service, VIS 051130 (150).

³⁹ Vatican Information Service 22 March 2006