



It is indeed a great pleasure to share with you the first issue of the **HAART for Children Newsletter**.

It has been three years since Caritas launched the *HAART for Children Campaign* and while advocacy by Caritas and other NGOs has resulted in more attention to the needs of mothers and children living with HIV and TB, much more action is needed.

Even today children are infected with and die from diseases that are preventable, treatable and curable. It is estimated that there are 3.4 million children living with HIV; 90% of them live in Africa. Worldwide, two thirds of pregnant women are not aware of their HIV status and, as a consequence, well over 90% of HIV-positive children were infected during pregnancy, birth or breastfeeding. A marked increase of TB co-infection among children with HIV has been noted and in settings with high TB prevalence, infants living with HIV are 20 times more likely to develop TB than those who are HIV-negative. In addition, children living with both HIV and TB are often stigmatized and cannot access education.

The Caritas Campaign has enlisted partners

in all continents to raise public awareness about the plight of children living with HIV and TB infections, to demand effective action from governmental health officials, and to call on pharmaceutical companies to put the lives and future of children above the exclusive search for profit during these public health emergencies.

This Newsletter is being shared with Caritas Internationalis (CI) member organizations and its partners to provide information, including United Nations guidelines and documents, on mother-to-child transmission of HIV and pediatric HIV and TB. We also want to inform you about the progress of the *HAART for Children Campaign*; and to encourage additional action to promote the right to health of children and mothers.

This issue, which is being released in observance of World TB Day (24 March 2012), has a major focus on HIV/TB co-infection in children. It also presents information on CI engagement in the *Global Plan Towards the Elimination of new HIV Infections among Children by 2015 and Keeping their mothers alive*.

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## Upcoming Event

World TB DAY  
[www.stoptb.org](http://www.stoptb.org)



## The children and mothers of Mai Tam – Vietnam

Francesca Merico  
Fr. John Toai

Anyone who meets Fr. John Toai is inspired by his passion and dedication to those whom he serves.

With his gentle smile and strong will, he seems capable of achieving the impossible, and the results are truly amazing. In just a few years, he established Mai Tam – *The house of Hope* – for mothers and children living with HIV/AIDS. Mai Tam provides shelter, life-saving medicines, comprehensive health and dental care, education, counseling, and income-generating opportunities, both to its residents and to many other needy people living or affected by HIV and AIDS who simply “walk in” to ask for help. This facility is the first and only of its kind in Ho Chi Minh City (Vietnam) and assists more than 500 women and children.

At Mai Tam many children live with HIV and TB co-infection. Presently, six of the children have active TB infections; the youngest one is only 6 months old. “Pepsi was born prematurely and was not vaccinated against TB,” Fr. John reported some days ago. “Now it is evident that she is suffering from extra-pulmonary TB, which means that the infection has affected other systems in her body, outside her lungs. Recently, she developed infected lymph nodes under her arms that were very painful and full of puss.” Pepsi was hospitalized for two weeks in order to undergo TB treatment. This week, she was discharged and has returned home to Mai Tam”. Fr. John added, “Presently, we have 4 other children undergoing TB treatment: two 8-year-old boys, one 1-year-old boy, and one 2-year-old girl. In addition, one 7-year-old boy remains in the hospital.”

Fr. John continued, “Children living with HIV and TB have the burden of taking several pills everyday several times per day. We do not have child-friendly TB drugs: the medicines for TB treatment available in Vietnam are the adult formulations, which also must be used for children. Of course, it is very difficult for children to swallow them. There is not a wide choice of TB medicines for use with children. Two children currently are taking both TB and ARV drugs: both of them developed anemia as a side effect of the medicines. We tried to switch the HIV anti-retroviral medicine, but the problem persisted. So we had to discontinue the TB treatment, and the doctors are searching for alternative TB



medicines, which so far have been difficult to find.”

He went into more detail about the complexity of providing treatment for HIV/TB co-infection, “Children born to HIV-positive mothers are more vulnerable to TB. In addition, when children develop chest infections, they receive high dosages of antibiotics. This complicates the detection of TB when the child is tested for this disease. Thus many children are left untreated.”

Fr. John also shared some “good news” and a sign of hope emerging from Mai Tam, “Pao is one of our lucky children; he was treated early for TB and today he is going to public school like any other child. ***I hope that, in my lifetime, children and mothers will no longer suffer from TB, and that there will be greater availability of tools to diagnose this infection accurately and a wider range of medicines developed so that children vulnerable to TB could enjoy a brighter and healthier future***”.

Currently, there is a lack of correct and updated information about HIV/TB co-infection in children, diagnosis of TB in babies is very difficult, and there is a lack of integration between HIV and TB programmes and maternal and child health care. Tragically, TB is among the primary causes of death among children living with HIV. Indeed, children under 3 years of age, those with severe malnutrition, and HIV-positive children are at greatest risk for developing TB.

WHO recommends that childhood TB is viewed as a “family” illness since most children who become ill with TB have been infected by an adult who often lives in the same household. WHO further recommends more intensive outreach to identify TB infection among the general population, since, each year, some 3 million people living with TB are not diagnosed or treated in accord with international guidelines. Finally, WHO calls more effective and efficient integration of maternal and child health care, HIV care, and TB care into comprehensive, or so-called “one stop” programming.



## ***A QUICK LOOK AT PMTCT & PEDIATRIC HIV AND TB***

- At the end of 2010, 3.4 million children younger than 15 were living with HIV; 90 % of these children live in Africa;
- 2/3 of pregnant women are not aware of their HIV-status;
- Well over 90% of infections among young children were transmitted vertically, from mother-to-child. The risk of transmission is estimated to be 5%-10% during pregnancy, 10%-20% during labor and delivery, and 5%-20% during breastfeeding;
- In 2010, the global coverage of pregnant women receiving the most effective antiretroviral medications to prevent mother-to-child transmission (PMTCT) was estimated at 48%;
- Early testing and diagnosis of infants born to mothers living with HIV are important measures to identify the HIV status of the baby in order to treat successfully the child;
- 1 in 3 children living with HIV and not receiving treatment will die before her/his first birthday;
- 42% of infants born to mothers living with HIV were reported to receive antiretroviral medicine in 2010;
- At least half a million children become ill with TB each year;
- There is a marked increase of TB co-infection among children with HIV;
- In settings with high TB prevalence, infants living with HIV are 20 times more likely to develop TB;
- Children with both HIV and TB have a higher mortality rate than those who are not HIV-positive;
- Up to 70,000 children die of TB every year;
- The world lacks an accurate diagnostic test for pediatric TB;
- In 2010, some 10 million children were orphaned as a result of TB.



## **Towards Zero TB infections in children and Zero TB Deaths in children living with HIV –**

**Interview with Dr Malgorzata Grzemska**  
 WHO Stop TB Department;  
 Childhood TB Subgroup of the Stop TB Partnership

Francesca Merico

Dr Malgorzata Grzemska is the coordinator of the Technical Support Coordination Team (TSC) of the Stop TB Department of the World Health Organization (WHO). She is also in charge of the Secretariat of the Childhood TB Subgroup, of which Caritas Internationalis is a member. Since Caritas first planned and initiated its *HAART for Children Campaign*, Dr Grzemska has served as an invaluable source of information on childhood TB. She helped us to identify the key challenges related to pediatric TB and to develop advocacy messages on HIV/TB co-infection in children.

My colleague, Andrea Bottini, and I had the pleasure of interviewing her last week.

### **Dr Grzemska could you please give us an overview of the global situation of HIV/TB co-infection in children?**

It is complex to set the scene. We estimate that, in 2010, there were 8.8 million new cases of adult infections of TB and 1.1 million (13%) of these adults were living with the HIV/TB co-infections. Unfortunately we do not have the same information regarding children. TB illness in children is often missed or overlooked due to non-specific symptoms and difficulties in diagnosis, such as obtaining sputum from young children. In addition, TB in children is often not reported even when it is diagnosed. As soon as a child is diagnosed with TB, it is important to inform the TB surveillance/reporting system of the relevant Ministry of Health so that reliable data on childhood TB can become available. Insufficient awareness of the magnitude of the problem results in a lack of public attention and funding. Reporting from the district level is key.

The most recent estimates of the WHO and the Childhood TB Subgroup are that at least one-half million children become ill with tuberculosis each year and that, on an annual basis, up to 70.000 children die of TB. However we still need more complete information about the HIV/TB co-infection in children. We are aware that TB poses a serious threat to HIV-positive women and their children.

The majority of patients with TB in Africa are also HIV-infected, and these overlapping epidemics accelerate illness and death.

### **What should be done to control childhood TB in high burden HIV areas?**

From the perspective of those engaged in HIV care, it is important that all HIV-positive pregnant women are tested for TB. It is easier to detect the illness in adults than in children. In addition, children are usually infected with TB by an adult, often one living in the same household, but the children themselves cannot pass on the infection to another child or to an adult.

If a pregnant woman is diagnosed with TB, treatment should be started immediately; such treatment will not cause any harm to the baby. However, WHO does not recommend the administration of the antibiotic streptomycin to pregnant women. All HIV-positive pregnant women should be examined for signs and symptoms of TB and provided with treatment if needed or at least be given preventive treatment with isoniazid.

If the pregnant woman is co-infected and has not been enrolled in a Prevention of Mother-to-Child Transmission program (PMTCT), her child should receive treatment immediately after birth. In such cases the diagnosis is not easy: neither for TB (because the baby is not coughing), nor for HIV. Therefore, it is important to follow the baby closely. At every visit, babies and children who are malnourished or living with HIV should be checked for signs and symptoms of TB.

BCG vaccine should not be administered to HIV-positive babies; this is the vaccine that prevents the most severe forms of TB. If the HIV status of the baby born from an HIV-positive mother is uncertain, the BCG vaccine is delayed until the HIV status can be determined in the child. If HIV is excluded in the newborn or the mother already underwent PMTCT during pregnancy, the baby can receive the BCG vaccine.



As you can see, it is very complex for a health care worker to know whether or not the BCG vaccine can be administered to children who may be co-infected with HIV.

Finally, if the child is HIV-positive but TB-negative, she/he must receive isoniazid preventive therapy (IPT). This treatment is very inexpensive – \$5 (US) per 6 months but also is very effective in the prevention of TB among HIV-positive adults and children. The same approach should be used with a child whose HIV-status cannot be determined but appears in good health. Regrettably, the isoniazid therapy is not used as much as it should be.

### **Why IPT (Isoniazid Preventive Therapy) is not used more widely if it is so inexpensive and effective?**

A lot of resistance comes from the parents, especially in households that include HIV-positive persons: “Why should I treat my children for an illness they do not have? They are already taking all those HIV medicines!” When the parents and the children are already on Highly Active Antiretroviral Treatment (HAART), parents do not want to add more medicines. In addition, there is a fear that IPT (with 1 medicine only) may trigger development of drug resistance. Finally, IPT is available in TB programmes, but not always in HIV programmes and/or maternal and child health centers. Indeed, we must make TB prevention and care an integral part of prevention of mother-to-child transmission of HIV, prenatal care, and immunization services. This will prevent millions of unnecessary deaths among pregnant women and their children.

### **What are the countries with the highest TB prevalence?**

WHO identified 22 high TB-burden countries, some of which are also high HIV-burden countries. However, in the settings where PMTCT has been successful but IPT is not being implemented, there is a larger number of children living with TB than those living with HIV. WHO also has a list of countries with the highest burden of MDR TB, the form of TB that is resistant to two most powerful anti-TB medications.

### **Children co-infected with HIV/TB face double stigma and discrimination in schools, health facilities, and the larger community. How could we reduce stigma and discrimination toward children living with HIV/TB?**

A woman from India did not want to inform the neighbors and distant family members that her daughter was treated for TB since she was afraid that the daughter eventually would not be able to find a husband.

One of our roles is to inform people that TB is preventable and curable. Moreover, non-pulmonary TB in children is not infectious. TB can be easily transmitted from an adult to other adults and to children. Infants, young children, children whose mothers are co-infected with HIV have an increased risk of TB, but do not transmit TB.

In addition, TB services, such as diagnosis of pediatric TB, preventive therapy and treatment require better interaction between TB programmes and HIV/AIDS, immunization, child and maternal health programmes. Advocacy around TB and HIV also should be more integrated and coordinated.

### **What kind of advocacy is needed?**

Childhood TB is still overlooked by public health authorities, TB control programmes, policy makers and donors. Moreover, this disease is closely related to poverty: 99% of TB cases are found in poor settings. In order to change such a situation, we need more advocacy related to childhood TB. We need to call for better diagnostic tools for children and for child-friendly treatment formulations for TB. Thus children need to be included in clinical trials. In addition, there is an urgent need for more effective and safer TB vaccines for children.

However, advocacy needs to be accompanied by capacity building: health care workers need to be trained on how to promptly detect TB in children and in pregnant women. Field workers need to be able to recognize the problems and the symptoms in order to make sure that children and pregnant women have access to IPT or are evaluated for TB treatment every time it is necessary. TB is curable: if you diagnose it, it can be treated in 6 months. It is also important to rely on the advocacy by other parents and patients: “I made it! ... You can as well!”. Successful stories are strong tools to motivate more people to take the treatment.

This year’s World TB Day theme - *In My lifetime campaign* – focuses on childhood TB and calls for bold and strong actions at country level in order to attain the goal of zero TB deaths among children. In observance of World TB Day, WHO and the Stop TB Partnership will launch new advocacy documents related to childhood TB, including: **“No more crying, no more dying: towards zero TB deaths in children”**, which presents the key messages of a Roadmap to Reduce Childhood TB; and a Fact-Sheet on **“Combating Tuberculosis in Children”**.

For more information on childhood TB:

<http://www.stoptb.org/> and <http://www.who.int/tb/en/>



## Caritas Internationalis: Mobilizing communities for children with HIV/AIDS

Aurorita Mendoza  
Michael Zündel

In solidarity with the *HAART for Children Campaign* of Caritas Internationalis (CI) launched in 2009, **Caritas Vorarlberg** is championing the campaign objectives to increase the access of children and mothers to testing and treatment for HIV and TB.

The response from CI partners at country and community levels has moved forward and aligned with actions of the international community to intensify the global focus on maternal and child-care in the context of the HIV epidemic.

*The Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive* was kicked off by international organizations and partners in 2011 to provide a foundation for community-led movement to eliminate HIV infections among children and provide life-saving treatment for their mothers. Caritas Internationalis was subsequently requested to sit on the Steering Group of the Global Plan.

“The nearly 23,000 signatures of people and active attendance of 1,500 young people in Vorarlberg demonstrate tremendous support for the *HAART for Children Campaign*. We are convinced that *Caritas Vorarlberg* has the opportunity to raise greater visibility to the campaign messages. We are proud to be a part of the Caritas network working with and for people with HIV/AIDS to push international partners on their critical role to achieve our common goals”, says Michael Zündel from *Caritas Vorarlberg*.

He also says: “For a successful realization of the target, we need to reach greater numbers of pregnant women for HIV testing, so that they can receive treatment and support and prevent their babies from getting the virus. But we must fight against the social stigma associated with HIV/AIDS, especially on women when they are found to be HIV-positive. This is one of our major challenges in our partner countries -- Ethiopia, Mozambique and South Africa -- where a stronger effort to support women and children is needed.

But we are ready to accept the challenge!”

Behind the *HAART for Children Campaign* is Msgr. Robert Vitillo, Caritas Internationalis Special Adviser for HIV and AIDS. Based in Geneva, Switzerland, Msgr. Vitillo has been a leading advocate for HIV/AIDS for more than 20 years. He has seen a gradual though positive movement among Caritas members and partners to engage in HIV issues. The *HAART for Children Campaign* is an initiative that highlights the need to respond to the HIV treatment needs of the 1.3 million children living with HIV. Only 28% of them receive anti-retroviral medications (ARVs), due to challenges related to poor HIV diagnosis, inappropriate pediatric drug regimens, and weak health systems. Msgr. Vitillo says: “With our Campaign and the Global Plan, we are in a strong position to advocate with the pharmaceutical industry for greater availability and lower prices of these life-saving pediatric HIV drugs. The needs of children with HIV have long been a neglected issue. The Campaign will keep their needs in the forefront of the AIDS response, both at community and global levels. The response of *Caritas Vorarlberg* shows us that young people are eager to support the *HAART Campaign*, while also learning more about HIV prevention within their own communities.”

This year, Caritas Internationalis will focus the Campaign on the development of appropriate medications to treat infants with HIV, especially for use in poor settings. Together with its local partners, it also will assess the impact of funding cutbacks on HIV care, treatment, and support.

Some quotes:

Msgr. Robert J. Vitillo, Caritas Internationalis in Geneva: “The Caritas network on HIV/AIDS makes it possible to work more effectively and collaboratively on a common objective, especially for the children with HIV/AIDS. Children with HIV can have a future”.

Aurorita Mendoza, volunteer Caritas Internationalis. With 18 years of experience working on HIV/AIDS, “my goal has always been to address the barriers that prevent marginalized groups, like young people and women, from rightful access to social services.”



## **Doing Better for Children and Mothers: The Global Plan for HIV Elimination among Children and Mothers**

Aurorita Mendoza

“The HIV needs of children and their mothers have been on the sidelines of the HIV response far too long. We must bring these to the center of the response and act on them in a sustained and committed way”, says Msgr. Robert Vitillo, Special Adviser on HIV/AIDS for Caritas Internationalis. Indeed, the impressive progress, observed in a growing number of countries, to stop new infections among children and reduce maternal deaths due to HIV has demonstrated that, with political will and leadership, these key components of the Millennium Development Goals are achievable and that success is replicable in many other countries.

At the United Nations General Assembly High Level Meeting on AIDS in June 2011, the UN Secretary General launched *The Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive*, with the committed support of government and civil society stakeholders and thus encouraged the international community to attain a new and historic milestone in the HIV response. The *Global Plan* lays out a roadmap for action from 2011-2015 at country, regional, and global levels. Building on the success of Prevention of Mother-to-Child Prevention (PMTCT) programmes in countries with high HIV burden as well as countries with epidemics that are concentrated in particular segments of the population, the *Global Plan* has set two global targets: i) to reduce the number of new HIV infections among children by 90%, and ii) to reduce the number of AIDS-related maternal deaths by 50%. It aims to make the largest impact in 22 countries\*, where nearly 90% of pregnant women living with HIV are located and are in need of life-saving treatment and care.

The ongoing campaign of Caritas Internationalis, *HAART for Children*, which calls on national and local Caritas members and partners to push for increased access of children to highly active antiretroviral treatment, shares many common elements with *The Global Plan*. The Caritas campaign urges governments to increase resources in order to scale up PMTCT programmes and requests pharmaceutical companies to provide appropriate and more effective and affordable treatment and tools for children living with HIV, particularly for those living in low- and middle-income countries. Msgr. Vitillo serves as a member of the Global Steering Group of this *Plan* and as the Co-lead for its Implementation Work stream, and thus can bring to the global level continued commitment of the Caritas Confederation to promote maternal and child health.

The Global Plan:

[http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609\\_JC2137\\_Global-Plan-Elimination-HIV-Children\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf)

\* Angola, Botswana, Burundi, Cameroon, Chad, Cote d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, Swayiland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe



## Upcoming Events

◆ **World TB Day** – 24 March 2012

World TB Day, falling on March 24th each year, is designed to build public awareness that tuberculosis today remains an epidemic in much of the world, causing the deaths of several million people each year, mostly in developing countries. It commemorates the day in 1882 when Dr Robert Koch astounded the scientific community by announcing that he had discovered the cause of tuberculosis, the TB bacillus. At the time of Koch's announcement in Berlin, TB was raging through Europe and the Americas, causing the death of one out of every seven people. Koch's discovery opened the way towards diagnosing and curing TB.

This global observance will focus on the situation of children living with TB.

[http://www.stoptb.org/events/world\\_tb\\_day/2012/events.html](http://www.stoptb.org/events/world_tb_day/2012/events.html)

◆ **WHO World Health Assembly** – 21-26 May 2012, Geneva

"The World Health Assembly is the decision-making body of the World Health Organization. The Assembly is attended by delegations from all WHO Member States and focuses on a specific health agenda prepared by the Executive Board. The main functions of the World Health Assembly are to determine the policies of the Organization, appoint the Director-General, supervise financial policies, and review and approve the proposed programme budget. The Health Assembly is held annually in Geneva, Switzerland."

<http://www.who.int/mediacentre/events/governance/wha/en/>

◆ **WHO Executive Board** – 28-29 May 2012, Geneva

"The main functions of the Executive Board are to give effect to the decisions and policies of the Health Assembly, to advise it and generally to facilitate its work."

<http://www.who.int/governance/eb/en/>



We're on the Web!  
[www.caritas.org](http://www.caritas.org)

*Pope Benedict XVI has appealed to health care workers worldwide "... to undertake, or continue, a decisive action aimed at preventing illnesses as far as possible and, when they are present, at curing the small patients by means of the most modern discoveries of medical science as well as by promoting better standards of hygiene and sanitation, especially in the less fortunate countries. The challenge today is to ward off the onset of many pathologies once characteristic of childhood and, overall, to encourage the growth, development and maintenance of good health for all children"*

[http://www.vatican.va/holy\\_father/benedict\\_xvi/speeches/2008/november/documents/hf\\_ben-xvi\\_spe\\_20081115\\_hlthwork\\_en.html](http://www.vatican.va/holy_father/benedict_xvi/speeches/2008/november/documents/hf_ben-xvi_spe_20081115_hlthwork_en.html)

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The Caritas network includes 164 national member organizations, operating in more than 200 countries and territories of the world. In addition, in each country, there may be several local (diocesan) Caritas agencies. This network is participates in and benefits from ongoing exchange between national, and local Caritas organizations. This is facilitated by the 7 regional Caritas structures and by the Caritas Internationalis General Secretariat and International Delegations, which assist members to advocate at regional and global levels (UN agencies and Regional Economic and Parliamentary structures, among others).

The overall network is highly engaged in providing a person-centred response to HIV/AIDS and TB and other global health challenges and dedicates significant resources to advocacy, awareness campaigns and provision of social, economic, development and humanitarian actions in the field.

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