The major focus of this *HAART for Children Newsletter* includes prevention of mother-to-child transmission (MTCT) of HIV and access to HIV treatment for all who need it.

The editors held a very interesting e-discussion on Progress toward achieving the *Global Plan to eliminate new HIV infections among children by 2015 and to keep their mothers alive*, with Dr. Nicholas Muraguri, Executive Director of the Secretariat for the Global Plan, based in Nairobi, Kenya, and Dr. Karusa Kiragu, Senior Advisor, Maternal and Child Health, UNAIDS, based in Geneva. The *Global Plan* has the goal to improve maternal, newborn and child survival and health in the context of HIV.

The Newsletter also presents the work of Catholic Church-related institutions to eliminate MTCT, particularly the efforts of the national Caritas and other local Church structures in the Democratic Republic of Congo.

Finally, we present some advocacy activities of the Caritas Internationalis (CI) delegation to the United Nations (UN) in Geneva such as: the side event on “*Children, HIV and Health Rights*”, held during the 22nd regular session of the United Nations Human Rights Council; an exhibit, *HAART in ART*, which appealed for an urgent response by the global human family to fulfill commitments towards building a world where children can be born HIV-free; and a side event on Access to Treatment organized during the 23rd Session of the UN Human Rights Council (May 2013) appealing for the need to eliminate numerous obstacles to ensuring access to health care and medicines for all.

Also, we share an article from AJANews on the TRIPS (Trade-Related Aspects of Intellectual Property Rights) agreement and the decision to extend, by eight years, the transition period for least developed countries (LDCs) to comply with the TRIPS agreement. The transition deadline was 1 July 2013 and is now 1 July 2021. The Permanent Mission of the Holy See to the United Nations in Geneva strongly advocated for this extension.

Rev. Msgr. Robert J. Vitillo, Special Advisor on HIV and AIDS, Caritas Internationalis
Ms. Francesca Merico
“What did Jesus do when he found a child crying? What did he do? He stopped. Why? Because children are those whom Jesus loves the most. That’s the way Jesus is. And Jesus is here, with us.” These were the words of Pope Francis when, on 31 May 2013, he received 22 children, patients at the Policlinico Gemelli, suffering from cancer. The children gave the Pope some small gifts. After praying the “Hail Mary” together with the children, the Pope gave them his blessing, which he said is “like a hug from God” because “when the priest blesses God hugs us” and “at this moment, Jesus comes to you and hugs you.”

Pope Francis (Adapted from http://www.piccolenote.it/10528/papa-francesco-i-bambini-son-qui-elle-lo-ama-di-plu and translated by R. Vitillo)

For this issue of the HAART for Children Newsletter, the editors held a very interesting e-discussion with Dr. Nicholas Muraguri, Executive Director of the Secretariat for the Global Plan to Eliminate New HIV Infections among Children by 2015 and to Keep their Mothers Healthy, based in Nairobi, Kenya, and Dr. Karusa Kiragu, Senior Advisor, Maternal and Child Health, UNAIDS, based in Geneva. Here is their update on Progress toward Achieving this Global Plan.

The Global Plan for elimination of new HIV infections among children and keeping their mothers alive by 2015 sets two broad targets and 10 interrelated minor targets (See table 1). Data from the 2013 UNAIDS progress report on the Global Plan has been used to assess the progress towards these targets.

Q1. Reduction of new pediatric infections – Among the 22 focus countries, which country has significantly moved towards achieving its targets? In which areas are they making the most evident progress, e.g., enrolling women in PMTCT programs?

Several countries are progressing well towards achieving the Global Plan eMTCT targets. According to the UNAIDS, there was a 38% reduction in the number of new HIV infections among children in the 22 Global Plan priority countries. Overall, there were 210,000 new infections among children in 2012 and 4 out of 10 pregnant women living with HIV did not receive antiretroviral medicines for preventing mother to child transmission of HIV.

By end of 2012, Botswana and South Africa had achieved the universal <5% eMTCT 2015 target, while Ghana, Namibia, Zambia, Swaziland, Kenya, Mozambique and Tanzania had MTCT rates of ≤15%. It is noteworthy that Angola had a 12% increase in the number of new HIV infections among children and a 14% increase in the number of new HIV infections among women of reproductive age (WRA).

Among the 22 focus countries, Ghana and South Africa have made the most significant progress in reducing new HIV infections among children with a reduction of 76% and 63% respectively, between 2009 and 2012. Other high-performing countries include Botswana, Ethiopia, Malawi, Namibia and Zambia, all of which have reduced the numbers of new pediatric HIV infections by at least 50% since 2009. However this performance is still below the 90% Global Plan target. These high-performing countries have a history of strong political commitment focused on achieving eMTCT by 2015. They have scaled up services, decentralized PMTCT services to primary healthcare facilities, strengthened service integration, efficient data management systems that give them a comprehensive understanding of country needs, and strong community mobilization activities with extensive efforts to educate and dialogue with women and men.
In addition, reduction in new HIV infections among women of reproductive age, the high uptake of maternal prophylaxis and provision of ART to breastfeeding Mother-Infant Pairs could also explain their outstanding performance. (See table 2)

A second set of countries is making moderate progress, having achieved a 30-49% reduction in new HIV infections since 2009. They include Burundi, Cameroon, Kenya, Mozambique, Swaziland, Tanzania and Zimbabwe. These are countries where accelerated efforts will put them confidently on track to achieve the requisite reduction in new HIV infections among children. However, a last set of countries are in danger of missing the target. They include Angola, Chad, Cote d’Ivoire, DRC, Lesotho and Nigeria; countries that had less than 30% decline in new HIV infections since 2009.

Q2. What factors have contributed towards progress in these areas? Please give an example of an approach that was effective in addressing a specific challenge or barrier.

The enabling factors for the observed progress are not homogeneous. Every country has unique opportunities and challenges. Countries like Botswana, Namibia and South Africa have strong economies and can fund the bulk of their programs, while others like Malawi innovated into Option B+ to address their resource shortages in the context of high fertility. The latter is an example of how a country has addressed a specific barrier as illustrated by the March 2013 CDC article.

ARVs can be used to improve a patient’s own health, prevent vertical HIV transmission from mother to infant, and/or prevent horizontal transmission through sexual contact with an uninfected partner. In most resource-limited settings, ART eligibility is based on CD4 cell count or WHO clinical staging. For eligible pregnant women (CD4 ≤350 or at WHO clinical stage 3 or 4), the 2010 WHO PMTCT recommendations include lifelong ART, and either Option A (single drug) or Option B (triple drug) for the ineligible pregnant women. This decision requires CD4 testing.

In Malawi, the health sector did not have sufficient lab capacity and infrastructure to provide universal access to CD4 testing needed to implement either of the two options. The government modified Option B (called “Option B+”) whereby all pregnant and breastfeeding women living with HIV are offered life-long ART regardless of CD4 count or WHO clinical stage. This policy streamlined the process of ART initiation and has the potential to improve maternal and child health. Implementation of Option B+ required integration of ART into all antenatal care settings, training of nearly all health-care workers in a new integrated curriculum, facilitated by existing task-shifting policies that allow clinical officers, medical assistants, and nurses to initiate ART.

The results were evident - there was a seven-fold increase in the number of pregnant and breastfeeding women started on ART just within 12 months of implementing Option B+. This has multiple potential benefits to mothers, their partners, and their children. Option B+ is an important innovation that could accelerate progress in Malawi and other countries toward the goal of eliminating mother-to-child transmission of HIV worldwide. A study by CDC showed that adoption of Option B+ in Malawi led to a 748% increase in the number of pregnant and breastfeeding women started on ART.

Q3. Access to ART for children living with HIV.
Access of children living with HIV to ART continues to be a key challenge. In implementing the Global Plan, what effective approaches are we learning to reduce the inequities in their access to ART?

Access to ART continues to be a key challenge for children living with HIV. Inequities in ART among children remain, and the progress in 2012 is discouraging, only 4 out of the 22 priority countries were able to provide ART to at least 5 out of 10 children living with HIV. Only 33% of eligible children in the 22 highest-burden countries received ART in 2012. While this is double what it was in 2009, the rate of progress is much slower than the rate of progress among adults. Only 2 countries (Botswana and Namibia) have universal coverage for pediatric treatment (i.e. ≥ 80% coverage), with South Africa (67%) and Swaziland (54%) not far behind. In all the other countries, less than half the children in need of ART received it. Coverage in Côte d’Ivoire, Cameroon, Angola, Nigeria and the DRC was ≤20%.

The complexities of pediatric treatment are well understood, including poor regimen choice, fragmented pediatric market, provider proficiency in managing pediatric AIDS, limited access to EID, and community barriers. It is notable that countries that have higher coverage of pediatric ART are those that have extensive early infant diagnosis programs in place, such as Botswana. Countries are now linking pediatric HIV testing in immunization clinics and pediatric wards in order to identify children that were missed at either at birth or at the first clinic visit.
Among the approaches being explored for increasing pediatric access to ART include decentralization of services to primary healthcare facilities, strategies to increase retention of children in program, scaling up Early Infant Diagnosis through point of care diagnosis, and integration of ART services in postnatal clinics.

Q4. Has progress been made with the goal to reduce the number of AIDS-related maternal deaths?

In reducing AIDS related maternal deaths (by 50%), two countries (Botswana and Ethiopia) have achieved the target while 8 are midway (i.e. ≥ 25%) to achieving the target1. (See Table 3) Increased proportions of pregnant women in need of ART who were actually put on ART is a key factor in the reduction of HIV-related maternal deaths.

Conclusion

Among the factors that have significantly contributed to the observed progress in the top countries are improved access to health services, demand creation, good leadership and governance structures.

Improving access by removing barriers: Financial barriers include fee-for-service, which prohibits access especially to persons living below the poverty line, which is where majority of the most affected are. Abolishing fee-for-service charges significantly increases access. Decentralization of services to primary health care facilities and involvement of the private sector and mission hospitals in service delivery has also been instrumental in reducing the geographical barriers as this increases the number of service delivery points in any geographical region. Improved quality of services and ensuring availability of services through sustained and predictable financing is also a critical component of improving access to health services. The adoption of Option B+ strategy, which requires that all HIV infected pregnant women be put on ART for life, ensures that all pregnant women living with HIV have access to the essential lifesaving medicines they require to live healthy lives. Integration of PMTCT into broader prevention agenda for HIV, sufficient staffing, community engagement creating awareness on the benefits of PMTCT program, advocacy for early diagnosis and treatment initiation, also contribute to favorable outcomes3,4,5.

Demand creation: Sustained demand for services through multiple strategies including the use of social media, networks of women living with HIV and the civil society is important in achieving the Global Plan targets.

Leadership and governance: Broader engagement of all stakeholders at political and technical level sustains the funding flow to meet the targets, particularly in performance based funding. This is critical for sustained demand creation and uninterrupted delivery of services. It is no doubt that the renewed focus on the Millennium Development Goals has also contributed towards the Global Plan targets.

## Table 1: Global Plan Targets, including

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing new pediatric HIV infections by 90%</td>
<td>90</td>
</tr>
<tr>
<td>Reduce MTC rates to less than 5%</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Reducing AIDS related pediatric deaths by 50%</td>
<td>50</td>
</tr>
<tr>
<td>Provide ARV for all HIV infected children</td>
<td>100</td>
</tr>
<tr>
<td>Reduce AIDS related maternal deaths by 50%</td>
<td>50</td>
</tr>
<tr>
<td>Reduce HIV incidence in women of reproductive age (WRA) by 50%</td>
<td>50</td>
</tr>
<tr>
<td>Provide perinatal ART to 90% mothers</td>
<td></td>
</tr>
<tr>
<td>Provide ART to breastfeeding infant mother pairs</td>
<td>90</td>
</tr>
<tr>
<td>Provide ART to pregnant women in need of ART</td>
<td>90</td>
</tr>
</tbody>
</table>

## Table 2: Reduction in pediatric infections

<table>
<thead>
<tr>
<th>Country</th>
<th>MTCT rates (%)</th>
<th>Reduction of new Peds infections (%)</th>
<th>% Reduction in HIV infection among WRA</th>
<th>Maternal prophylaxis for PMTCT (%)</th>
<th>ART to breastfeeding MIP (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>3</td>
<td>52</td>
<td>14</td>
<td>&gt;95</td>
<td>69</td>
</tr>
<tr>
<td>South Africa</td>
<td>5</td>
<td>63</td>
<td>29</td>
<td>87</td>
<td>87</td>
</tr>
<tr>
<td>Namibia</td>
<td>9</td>
<td>59</td>
<td>9</td>
<td>94</td>
<td>56</td>
</tr>
<tr>
<td>Ghana</td>
<td>9</td>
<td>76</td>
<td>43</td>
<td>95</td>
<td>95</td>
</tr>
<tr>
<td>Zambia</td>
<td>12</td>
<td>50</td>
<td>15</td>
<td>95</td>
<td>54</td>
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<tr>
<td>Swaziland</td>
<td>13</td>
<td>38</td>
<td>15</td>
<td>83</td>
<td>34</td>
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<tr>
<td>Kenya</td>
<td>15</td>
<td>43</td>
<td>8</td>
<td>53</td>
<td>22</td>
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<tr>
<td>Tanzania</td>
<td>15</td>
<td>48</td>
<td>5</td>
<td>77</td>
<td>77</td>
</tr>
<tr>
<td>Mozambique</td>
<td>15</td>
<td>46</td>
<td>0</td>
<td>86</td>
<td>86</td>
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<tr>
<td>Ethiopia</td>
<td>25</td>
<td>50</td>
<td>5</td>
<td>41</td>
<td>21</td>
</tr>
<tr>
<td>Malawi</td>
<td>16</td>
<td>52</td>
<td>3</td>
<td>60</td>
<td>57</td>
</tr>
</tbody>
</table>

## Table 3: Reduction of AIDS-related maternal deaths

<table>
<thead>
<tr>
<th>Country</th>
<th>% reduction of HIV related maternal deaths (2005 vs 2010)</th>
<th>% of pregnant women on ARV (for their own health) 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>64</td>
<td>95</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>56</td>
<td>38</td>
</tr>
<tr>
<td>Zimbabwe</td>
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<td>56</td>
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<tr>
<td>Namibia</td>
<td>36</td>
<td>94</td>
</tr>
<tr>
<td>Kenya</td>
<td>35</td>
<td>58</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>33</td>
<td>32</td>
</tr>
<tr>
<td>Swaziland</td>
<td>32</td>
<td>79</td>
</tr>
<tr>
<td>Malawi</td>
<td>31</td>
<td>86</td>
</tr>
<tr>
<td>Zambia</td>
<td>27</td>
<td>89</td>
</tr>
<tr>
<td>Tanzania</td>
<td>25</td>
<td>53</td>
</tr>
</tbody>
</table>
Faith Based Services in Democratic Republic of Congo: Working To Eliminate Mother to Child Transmission of HIV – The Need of Sustainable Support

Aurorita Mendoza

Catholic Church-related institutions, together with Protestant organizations, provide more than half of all health services in DRC. They extend to rural, isolated areas and conflict settings, which overstretched government health facilities are unable to reach.

Msgr. Robert J. Vitillo, of Caritas Internationalis provided a case study on such activities in DRC at the Annual Meeting of the Inter-Agency Task Team on Preventing Mother-to-Child Transmission, held in Addis Ababa, Ethiopia, on 17-18 April 2013. Much of his presentation was based on extensive interviews with Dr. Bruno Miteyo, Director of Caritas, Democratic Republic of Congo (DRC), and Dr. Bernard Bossiki, focal point for the prevention of mother to child transmission of the DRC Government.

In a country with a generalized HIV prevalence and 37% transmission of HIV from mother to child, HIV prevention and treatment services offered by faith-based organizations are critical in reaching thousands of vulnerable men, women and children in need. Caritas DRC itself provides 40% of health services in the country. As one of three Principal Recipients of the Global Fund support to the national HIV program, Caritas DRC HIV places particular emphasis on PMTCT services.

The approach is holistic, as the needs of women, particularly of women living with HIV, go beyond the health domain. In addition, since significant numbers of women are unable to access other health services, an integrated approach is taken to respond to overall health needs, including maternal and child-care. Thus, PMTCT services are integrated into community-based development programs, such as formal and non-formal education, provision of nutrition education and supplements, and self-help/livelihood development, with special attention given to women who are not able to read or write. The involvement of is an important aspect of the program, since it provides opportunities for couples counseling and helping both spouses to be concerned with each other’s health and welfare.

Challenges persist in scaling up the PMTCT services in DRC. Current coverage stands at only 13%, which is far below the national target. Improvement in data collection and reporting on PMTCT service delivery is urgently needed to help determine where priority attention and resources should be placed. Annual cost for the PMTCT program amounts to some US$ 25 million; support is provided by the Global Fund, PEPFAR, and several UN agencies. Direct and timely availability of these resources to faith-based organization partners needs to be ensured so that stock-outs and other gaps in service delivery could be avoided. In addition, technical assistance to FBO partners is needed for capacity-building and expansion of present services.

Since DRC is one of six countries showing only a slow decline in new infections among children between the period of 2009-2012, the President of the country has launched a national initiative in order to intensify the implementation of the PMTCT program. With this high-level support to the implementing partners, including faith-based organizations, there still is hope that the country will reach its Global Plan targets by 2015.
The decision to give the world’s poorest countries more time to fall in line with an international agreement regulating intellectual property rights has been welcomed as a positive step… but not as positive as it could have been. In early June, the TRIPS (Trade-Related Aspects of Intellectual Property Rights) Council of the World Trade Organization (WTO) decided to extend by eight years the transition period for least developed countries (LDCs) to comply with the TRIPS agreement. The transition deadline was 1 July 2013 and is now 1 July 2021.

The TRIPS agreement was introduced in 1995 to protect intellectual property rights on a global scale. Patent protection, however, pushes up the costs of medicines, placing essential treatment such as antiretroviral therapy (ART) for people with HIV outside the reach of LDCs. This is why flexibilities were introduced in the TRIPS agreement. The flexibilities offer LDCs a renewable exemption from TRIPS obligations, giving them the space to manufacture affordable drugs locally or to import them more easily, and to build up their sorely needed technological, human, financial and other capacities.

“The extension granted by the TRIPS Council is essential if ART is to continue being available to those who need it in most sub-Saharan African countries,” said Fr. Paterne Mombe SJ, director of the African Jesuit AIDS Network (AJAN). “However the extension simply doesn’t give these countries enough time to implement TRIPS flexibilities to the fullest and to set up systems that guarantee a reliable supply of low-cost treatment.”

What’s more, the extension alone is not sufficient. “Other measures are needed, such as technology transfer, improvement and clarity on safeguard measures, their adaptability to African settings, and much more,” continued Fr. Mombe. “Otherwise, in the long run, people with HIV in the world’s poorest countries could see access to the medicine they need to survive threatened.”

In his response to the WTO decision, Archbishop Silvano M. Tomasi, Representative of the Holy See to the UN in Geneva, echoed the need to remember the bigger picture: “…bear in mind that the main goal of the of the international community in developing a fair regime of intellectual property rights should aim toward the good of all and the pursuit of more equitable international relations, especially with regard to poorer and more vulnerable people.”
Interview with Rev. Msgr. Robert J. Vitillo – based on his input to the Training Session for Portfolio Managers at the Global Fund to Fight AIDS, TB, and Malaria

On 24 June 2013

What do you see as the main challenges in sustainably engaging Key Affected Populations (KAPs), Civil Society Organizations (CSOs), Faith Based Organizations (FBOs), human rights experts, and/or groups advocating for equitable access for both women and men, to achieve impact against the 3 diseases?

With regard to FBOs, most of these organizations, especially those based and indigenous to the countries of local areas where they work, already were responding to other health, development, and humanitarian needs, even before the onset of the HIV pandemic and certainly before the creation of the Global Fund. Thus I see the present issue not so much as one of sustainable engagement but as one of providing capacity-building and resources for these organization to scale up their programmes in order to address current needs and to make even more significant contributions to achievement of universal access to prevention, treatment, care and support for these diseases. These organizations already are engaged in advocacy with governments, at national, provincial, district, local levels, for more just and equitable policies and practices; but again they could benefit from additional resources and capacity-building to increase such activities and to develop them in a more strategic manner.

What role could the Global Fund play in helping networks to engage?

In addition to providing funds, and especially to facilitating a more simple, direct, and objective, and transparent manner to obtain such funds, the Global Fund can use its influence with governments to include FBOs, not only in a formal manner in the CCMs, but to facilitate real access to funding and to technical assistance. In the past, FBOs were told by staff of the Fund that they needed to become members of the CCMs: this would get them access to resources. In fact, we have evidence to show that this has not become a reality. We have many FBO leaders serving as members of CCMs and some even as chair or vice chair of the CCMs, but overall the record of FBO access to Global Fund money has been extremely low: only about 5%. while as we

Another point to be remembered is that government health care services often do not reach the entire country and that often FBOs provide those services in the most isolated and rural areas of the country or to the most marginalized and excluded populations throughout the country, even in urban areas. Again, the Global Fund can encourage governments to include those isolated areas and populations in their plans OR the Fund needs to develop realistic plans for direct funding of such programmes.

That brings me to a final point on this issue: I congratulate the Fund for providing access to funds civil society organizations so that they could participate in planning processes. However, please be aware that many of these organizations working in rural areas do not even have access to information about these planning processes and certainly do not have access to government policy-makers.

What role could local, regional, and global networks play?

These networks can play an important role, and some do already. For example, since 1987, my own organization, Caritas Internationalis, has played a capacity-building, information-sharing, and representational role for our 164 national member organizations and for other Catholic Church-related organizations engaged in the response to HIV, TB, and malaria. However, please keep in mind that not all networks are connected to national and local programming. Some have been created as a response to funding opportunities, especially in response to HIV. Some have been created by governments themselves and really operate as a type of “para-statal” organization and thus do not always represent, safeguard, or advance the real interests of the people in need. Others have been promoted by foreign governments and are seen as acceptable because they advance the agenda of such governments. Moreover, many truly community-based organizations have not been invited become part of some of the networks.
Upcoming Events

CHAN annual meeting – Geneva, 16-17 October 2013
The Catholic HIV/AIDS Network (CHAN) annual meeting is taking place in Geneva on 16-17 October 2013.

High Level United Nations Session on progress toward achieving the Millennium Development Goals by 2015 – New York; 23 September 2013
This will include progress toward realizing goal 6, which focuses on combating HIV/AIDS and other diseases, such as Malaria; and aims to halt and reverse the spread of such diseases by 2015.

World AIDs Day – 1 December 2013
“World AIDs Day on 1 December brings together people from around the world to raise awareness about HIV/AIDS and demonstrate international solidarity in the face of the pandemic. The day is an opportunity for people to spread awareness about the status of the pandemic and encourage progress in responding to the pandemic that already has taken the lives of some 30 million people since it was first identified in the early 1980s. Between 2011-2015, World AIDs Days will have the theme of “Getting to zero: zero new HIV infections. Zero discrimination. Zero AIDs related deaths”. This focus includes advocacy to achieve greater access to life-saving antiretroviral treatment for all people living with HIV, early diagnosis and treatment, and a larger variety of “child-friendly” medicines for children living with HIV (only some 30% of HIV-positive children have access to appropriate treatment).

International Conference on AIDs and STIs in Africa – Cape Town, South Africa; 7 -11 December 2013
“The United Nations’ (UN) Human Rights Day is annually observed December 10 to mark the anniversary of the Universal Declaration of Human Rights. It is an occasion to raise awareness on human rights.

Speakers1 and participants focused on the disparity between children and adults living with HIV in relation to access to anti-retroviral treatment (ARVs); what donors can do to help try to overcome the barriers to HIV treatment among children and the reasons why HIV-positive children continue to have a high rate of death when present-day science and medicine could prevent nearly all HIV infections. Indeed, in 2011, ARVs were available to 57 percent of adults who required them, but only to 28 percent of children in need. As a consequence, thirty years into the HIV epidemic, every hour, approximately 30 children die as a result of AIDS-related diseases.

The main purpose of the event was to draw attention to the particular challenges facing children living with or affected by HIV in the context of the discussion on children’s health rights. Other objectives included: to sensitize governments and other international stakeholders to the needs of children when it comes to preventing and treating HIV/AIDS; to promote maternal health strategies that effectively prevent the transmission of the virus from an HIV-positive mother to her child and serve as an entry-point for mothers, children and their families to access other HIV services; to recommend steps that governments and other international stakeholders can take to promote and advance children’s right to health in the context of the HIV epidemic.

Participants committed themselves to engage more actively in the Global Plan to Eliminate New HIV infections among children by 2015 and to keep their mothers healthy, an initiative launched in 2011 by UNAIDS, WHO, and UNICEF. Msgr. Robert J. Vitillo, of Caritas Internationalis, serves on the Global Steering Group to implement this plan in the 22 focus countries (21 in Africa + India) where 90% of all mother-to-child transmission of HIV takes place.

Complementing the panel event was an exhibit, HAART in ART, which featured the works of various artists from all over the world portraying fairy tales from some high impact for HIV infection among children. Together with the art work, posters displayed strategic information on the situation of pediatric HIV in these priority countries. Particular attention was called to how HIV presents an obstacle to the achievement of the hopes among such children for a better life, free of pain and suffering. The exhibit appealed for an urgent response by the global human family to fulfill commitments towards building a world where children can be born HIV-free.

The exhibit was organized in collaboration with the International School and Permanent Collection of Art Illustrations for Children located in Sarmede, Italy, with support from the Permanent Mission of Italy and the International Federation of Pharmaceutical Manufacturers and Associations.

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1 Ms. Karusa Kiragu, Senior Prevention Advisor, UNAIDS; Ms. Josephine Nabukenya, Ambassador, Elizabeth Glaser Pediatric AIDS Foundation; Mr. Moses Rugema, First Counselor, Permanent Mission of the Republic of Rwanda to the UN; Ms. Finola Finnan, Chair of the Catholic HIV/AIDS Network; Dr. Michael Johnson, Global Fund Attaché to the Office of the Global AIDS Coordinator. Moderator: Philip O’Brien, EGPAF.
The Caritas Confederation 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 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 to the UN, which assist members to advocate at regional and global levels (UN agencies and Regional Economic and Parliamentary structures, among others).

The Confederation 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.

Broader structural factors impede access to treatment and must be addressed as part of an integrated health response. Panelists in the side event on Access to Treatment organized by Caritas Internationalis and several other non-governmental organizations during the 23rd Session of the UN Human Rights Council (May 2013) insisted on the need to eliminate numerous obstacles to ensuring access to health care and medicines for all. They highlighted, in particular, the negative impact of stigma and discrimination, poverty, high costs for healthcare and medicines, and restrictive research and development frameworks imposed by some components of the pharmaceutical industry.

UNAIDS Human Rights and Law Senior Adviser, Helena Nygren-Krug, and the National HIV/AIDS Coordinator of Caritas Ukraine, Dr. Dzvenyslava Chaykivska, emphasized the need for women living with HIV to receive non-discriminatory and non-judgmental care from health providers to increase the uptake of ART services for themselves and for their HIV-positive children. In an effort to strengthen and preserve intact families, the Heart to Heart program of Caritas Ukraine extends holistic health and social care to mothers and their children, including pediatric consultation, humanitarian aid, cultural activities, special training and education for children. This approach differs from traditional adult-oriented ART services that typically focus on medical services alone. Because HIV infection among one or more members often creates a crisis for the entire family, the provision of social protection, psychosocial support, and other help can successfully strengthen the family’s capacity to deal with the many challenges posed by HIV.

Taking a broader perspective, Dr. Emmanuel Kabengele, from the University of Geneva, underlined the links between social determinants and attainment of the right to health. Conditions such as poverty, malnutrition, and unemployment create health inequities that worsen already existing vulnerabilities to poor health. Such social determinants limit the enjoyment of the right to health, and access to health care can be improved only if broader actions on these determinants are taken at local, national, and global levels.

Mr. Pascale Boulet, from the Drugs for Neglected Diseases Initiative (DNDi), a non-profit organization working on increasing access to medicines for neglected diseases, focused on the need to develop new paediatric medicines much more quickly. Much progress has been made with the development of ART medicines for use among adults. However, far fewer medicines are available for pediatric use. HIV-positive children need formulaeations that are simple, easy to administer, and better tasting. DNDi, through collaboration with a drug manufacturer in India (CIPLA), has brought forward to the development phase a fixed-dose combination (4 drugs in one) delivered as a sprinkle sachet that will be more easily administered to and taken by children.

Mr. Boulet mentioned some of the obstacles to faster development of new and much-needed drugs, including restrictive patent ownership, unaffordable product prices because they are linked to costs of research and development,
Lack of funding for manufacturing of pipeline candidates. These obstacles block effective treatment for pediatric HIV and other neglected diseases, such as chagas disease, malaria, and leishmaniasis. Solutions to these barriers will require increasing incentives to private sector, easing regulatory frameworks, and mobilizing the leadership of affected countries. Ms. Boulet pointed out the need for coordinated actions among stakeholders that include the pharmaceutical industry, research institutes, Ministries of Health, and civil society.

As a global health agency, the World Health Organization can play an important role in coordinating and accelerating the initiatives already in place. A rich discussion followed the presentations, and all concluded that the fulfillment of the right to health is a responsibility that is not confined only to the Ministries of Health. Social and economic barriers to access to treatment can be removed only through a comprehensive and integrated response that engages other sectors of government, industry, and non-government organizations.

For further information on the HAART FOR CHILDREN Campaign & your feedback, Please contact:

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