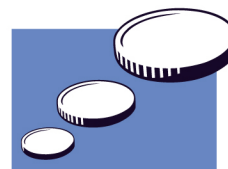


# Out of the shadows



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## **HIV/AIDS in Burundi, Democratic Republic of the Congo and Rwanda**

a guide for donors and funders

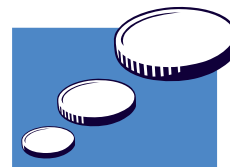


March 2005

Justin Alexander  
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King Baudouin  
Foundation



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**New Philanthropy Capital** is a charity that develops and encourages more effective charitable giving. Its aim is to increase the quantity and quality of resources to the charitable sector.

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Following a call for action from the United Nations Secretary General, the Board of Governors of the King Baudouin Foundation confirmed its agreement on 20 March 2002 to provide support amounting to 1 million euro to support AIDS projects in Rwanda, Burundi and the Democratic Republic of Congo. In this way the Foundation wants to make a contribution towards the global fight against AIDS and encourage other foundations in Europe to follow its example. With the help of the UN programme to fight HIV/AIDS (UNAIDS), the Foundation has identified projects in these three countries.

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# Out of the shadows: HIV/AIDS in Burundi, Democratic Republic of Congo and Rwanda

## Executive summary

- **HIV and AIDS have caused a global catastrophe. Thirty eight million people are infected with HIV, and the social and economic costs are huge.** The pandemic has spawned a worldwide response and an international pool of expertise is now emerging. However, the funding available to take advantage of increasing knowledge and growing initiatives is inadequate, and private individuals can play a helpful role on many levels.
- **The spread and effects of HIV/AIDS are made worse by a vicious circle of infection and poverty.** This can only be broken if the epidemic is tackled on several fronts.
  - Prevention works best when its messages are conveyed in tandem with care and treatment programmes.
  - As those affected (be they infected adults or orphaned children) become poorer, so the risks of contracting or transmitting the virus increase – efforts to address poverty and vulnerability are vital in order to protect those at risk.
  - Medical infrastructure that could deliver care and treatment to those infected with HIV is increasingly stretched by the epidemic. Capacity building is essential to maintain and expand medical infrastructure, but not at the expense of other life-threatening diseases.
  - National efforts involving local governments, communities and people directly affected should be encouraged and supported while duplication by outsiders avoided. Collaboration between donors and service providers is key to success.
  - International and regional efforts to find solutions (treatment trials, effective protection measures) should be supported, as well as national efforts.
- Burundi, the Democratic Republic of Congo and Rwanda are extremely challenging places; **all three are experiencing conflict or have recently witnessed it.** Although they all struggle with its effects on infrastructure and society, each country is very different and has particular needs, not all of which are covered by the large multi-national and bi-lateral donors.
- Funding and implementing projects in these countries is difficult, but not impossible. Donors outside the region can take a number of approaches: either support local NGOs in these countries via donors and implementing agencies already on the ground, or fund international NGOs that operate there.

## Contents

Introduction .....	3
Section 1: A global perspective on the epidemic.....	5
International response to the epidemic .....	6
Methods of tackling HIV/AIDS .....	7
Outcomes from interventions .....	15
Section 2: Burundi .....	17
History.....	17
Prevalence and effects of HIV/AIDS .....	18
Existing provision.....	19
Gaps in provision.....	21
Options for funders .....	23
Section 3: DRC .....	27
History.....	27
Prevalence and effects of HIV/AIDS .....	28
Existing provision.....	30
Gaps in provision.....	31
Options for funders .....	32
Section 4: Rwanda.....	35
History.....	35
Prevalence and effects of HIV/AIDS .....	36
Existing provision.....	37
Gaps in provision.....	39
Options for funders .....	39
Section 5: Funding recommendations.....	44
Brief profiles of recommendations.....	49
Section 6: Conclusion .....	55
Acknowledgements.....	56
Further reading .....	58
Glossary .....	59
Footnotes .....	61



**NPC met with 68 organisations in the region, as well as many in Europe**

## Introduction

### The purpose of this report

This report is a guide for donors who wish to fund projects to help those affected by HIV/AIDS in Central Africa. It provides detailed contextual information and analysis about the extent of the pandemic, resulting social needs, types of response, and the outcomes of such interventions.

The report addresses a spectrum of donors, including private individuals, companies and grant-makers. Parts have been written for the benefit of newcomers to the subject. Experienced funders, however, can view the guide as a starting point for debate and further research.

This guide puts the case for combating the effects of the pandemic, analyses the delivery mechanisms, and advises how donors can target their resources most effectively. King Baudouin Foundation (KBF) and King Baudouin Foundation US (KBFUS) are in a position to help donors provide grants to these recommended organisations.

This report does not contain all the answers to the challenge of funding in these countries, but it may help point donors into some interesting funding directions.

### The content of this report

The report was compiled after extensive meetings with organisations, researchers, and policy makers. NPC analysed charity accounts, activities and research materials.

NPC's researchers visited many projects in Central Africa and interviewed experts, project workers and beneficiaries. NPC met 26 organisations in Burundi and 17 in Rwanda. Unfortunately, because of the deteriorating security situation in parts of the Democratic Republic of Congo (DRC), travel outside the capital was impossible, but it met 25 organisations in Kinshasa. In addition, NPC interviewed 20 of the major international agencies and donors in Europe, and various HIV experts.

The report is divided into six sections. Section 1 explores the global context of the HIV/AIDS epidemic, the role of international bodies and funders, and what lessons are being learnt in other parts of sub-Saharan Africa. Sections 2-4 cover the vastly different situations in each of the selected countries: Burundi, the DRC, and Rwanda.

Section 5 summarises in tabular form various projects, funding options and their outcomes, while Section 6 draws together the conclusions with some general recommendations.

### Supporting initiatives

NPC and other intermediaries are able to assist donors based in a variety of jurisdictions who would like to provide financial support to organisations working in Africa. In most cases this can be done in a tax effective manner.

If you would like further information, please contact one of the following organisations:

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Individuals, corporations and foundations in the United States who wish to support local initiatives and organizations listed in this report can do so through a grant to the King Baudouin Foundation United States (KBFUS). KBFUS will help you overcome the obstacles associated with international giving. Drawing on the extensive expertise of its parent, the King Baudouin Foundation (Belgium), KBFUS can also help you to develop solid and rewarding partnerships in the Democratic Republic of Congo, Rwanda and/or Burundi.

KBFUS is a public charity, within the meaning of Sections 501(c)(3) and 509(a)(1) of the IRC. Donors may thus claim the maximum tax benefits allowed by law for their contributions. Please contact:

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KBF in Belgium is trying to be an example for other foundations in Europe and the US. It may not have presence on the ground, but it is able to form partnerships with people who are. It can also receive funds for onward donation to projects. Please contact:

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## Section 1: A global perspective on the epidemic

**HIV and AIDS have caused a global catastrophe. Thirty eight million people are infected, and the social and economic costs are huge. A global response and an international pool of expertise is finally emerging.**

### The Effects of HIV/AIDS

The Human ImmunoDeficiency Virus (**HIV**) destroys the immune system. An individual can live a normal healthy life while HIV positive, until the destruction is so far advanced that the immune system can no longer fight off infections. At this stage, often ten years after infection with HIV and depending on the person's health, he or she is diagnosed with Acquired ImmunoDeficiency Syndrome (**AIDS**). The individual becomes vulnerable to 'opportunistic infections' ranging from tuberculosis (TB) to the common flu, and needs a combination of antiretroviral therapy (ART) and normal medicines to maintain reasonable health. When AIDS reaches its final stages the symptoms are very unpleasant: chronic diarrhoea, flaky skin, sores, and Candida (thrush) in the mouth and gut, which makes swallowing and digestion difficult.

Obtaining reliable and consistent data on HIV infection is difficult. The key indicator used to measure the epidemic is **prevalence**, ie, the number of people infected with HIV as a percentage of the population. However, prevalence is a flawed measurement tool: death rates will affect prevalence trends and may mask the underlying direction of an epidemic. **Incidence** – the number of additional cases of infection over a time period – is a much better indicator, but more difficult to measure. Nevertheless the data which is available is useful in determining needs relating to treatment, care and numbers of future orphans.

Stark statistics are emerging from the pandemic:

- Of the 38 million people infected with HIV, the majority (25 million) live in sub-Saharan Africa (a prevalence of 7.5%).<sup>1</sup> Approximately three million people die from AIDS-related illnesses each year, making it the largest global killer. It accounts for at least 19% of deaths in Africa.<sup>2</sup>
- There is a close interplay between AIDS and TB (the second global killer, claiming two million lives per annum<sup>3</sup>); in Zambia up to 70% of TB patients are HIV positive and, conversely, up to 50% of HIV positive patients develop TB.<sup>4</sup> Without ARV treatment 100% of HIV positive people with TB die.
- The burden of the epidemic is shifting to women. Women are most vulnerable to HIV infection, because of the biology of transmission and the sociology of sexual behaviour.
- In 2003, 14 million children under the age of 15 had lost one or both parents to AIDS; many inherited HIV from their mothers. This number is expected to exceed 25 million by 2010.<sup>5</sup>

The HIV pandemic is creating a vicious circle of infection and poverty: those infected become impoverished, and those impoverished by the presence of HIV in their communities become more likely to contract the disease.

This cycle is illustrated by a recent World Bank report<sup>6</sup> which warns that HIV/AIDS causes significant long-term economic damage. AIDS kills young adults and weakens human capital because orphans are deprived of love and guidance and spend much less time in school. The poor education of children today translates into low adult productivity a generation later. Social customs of adoption and fostering may not be able to cope with the scale of orphanhood generated by the sharp increase in adult mortality, thereby shifting the onus onto the government. Governments, however, will be less able to finance this because tax bases are weakened when adults are killed by AIDS. The World Bank report stresses: "Keeping infected people alive and well, especially parents, so they can continue to live productive lives and take care of the next generation, is not only the compassionate thing to do, but is also vital for a country's long-term economic future."<sup>7</sup> The damage to life expectancy is clear: for instance, in Botswana, life expectancy peaked in the late 1980s at 62; by 2002 it had plummeted to 37, largely due to HIV/AIDS.<sup>8</sup>

**AIDS accounts for one-fifth of deaths in Africa.**

However, the situation need not be viewed as entirely hopeless. HIV prevalence in Uganda has dropped from 15-30% in the early 1990's to 4.1% in 2003. There are a number of reasons for this, one being the commitment of the political leadership to bring HIV into the open and to make the struggle against the disease a national effort at all levels.

## International response to the epidemic

**\$12bn is needed to tackle HIV/AIDS in 2005; only \$4.85bn was given in 2003**

The international response so far has been inadequate. UNAIDS estimates at least \$12 billion is needed annually from 2005, rising to \$20 billion by 2007.<sup>9</sup> However, the amount donated in 2003 was only \$4.85 billion. UNAIDS contrasts this with the estimated \$11 billion spent by the US government domestically on AIDS in 2000.<sup>10</sup> The funding figures available are contradictory, rarely presented on an annual basis and include an element of double counting. Table 1 gives a rough overview.

Table 1: Principal donors (\$ million per annum)	2003	2004e
US	580	2,000
UK <sup>11</sup>	450	900
Europe, Canada, Japan, Australia and other governments <sup>12</sup>	610	600
Developing country governments (data from 2002)	1,000	500
Global Fund – estimated pledged amount	1,000	1,000
UNAIDS and other UN agencies	120	200
World Bank (commitments spread over several years)	800	1,000
WHO	850	800
Bill and Melinda Gates Foundation	200	200
Other foundations (2002 data)	140	100
International NGOs (2002 data)	100	100
<b>Total identifiable funding flows</b>	<b>5,850</b>	<b>7,400</b>

### Multilateral and bilateral donors

**UNAIDS** is a joint initiative of UN agencies and member governments, which does not generally get involved in service provision itself, but coordinates and finances those directly tackling HIV/AIDS in each country.

**The WHO** is now committed to the '3 by 5' initiative to ensure three million people receive antiretroviral drug treatment by 2005, which is likely to cost between \$3.1-3.8 billion in 2005.<sup>13</sup> This suggests that treatment costs over \$1,000 per patient per annum. In countries such as South Africa where health infrastructures are already developed, actual experience is cheaper (\$550<sup>14</sup> per patient per annum), but given the need to improve many health infrastructures, these estimates are realistic. The WHO itself is committing \$564 million cumulatively until 2005.<sup>15</sup> The rest must be found from other organisations.

**The Global Fund** to fight AIDS, TB and Malaria was endorsed in June 2001 at the first UN General Assembly Special Session on AIDS. It aims to be a more independent and informed grant-maker than bilateral governmental aid. Local Country Co-ordinating Mechanisms (CCMs) distribute the funds. This keeps the size of the central secretariat to a minimum, devolving responsibility for application submission and management to the countries using the funds. Kofi Annan originally estimated that \$10 billion per annum was needed,<sup>16</sup> however as of July 2004 grants totalling only \$3 billion have been approved, funded by pledges which, from inception to 2008, amount to only \$5.5 billion. It is possible that more pledges will be received.<sup>17</sup> The Global Fund's annual spend may well average out to be only \$1 billion per annum, of which 60% is going to HIV/AIDS.<sup>18</sup>

**The World Bank's MAP** (Multi-Country HIV/AIDS Program for Africa) has provided just over \$1 billion to 28 African countries since September 2000. It supports programmes that are complementary to the efforts of others, and plugs unfunded gaps, such as health system development and TB control. It is not clear whether MAP will continue, because the World Bank is largely a loan-making, not grant-making, organisation.

**The US government launched the President's Emergency Plan for AIDS Relief (PEPFAR)** in 2004, with a pledge to spend \$15 billion from 2004 to 2008. The White House (probably optimistically) claims this will prevent seven million new infections, provide antiretroviral drugs for two million people, and care for ten million HIV-infected individuals and AIDS orphans.<sup>19</sup> The funds will be split into treatment (55%), prevention (20%), care for



the dying (15%) and protection of orphans (10%).<sup>20</sup> \$9 billion is reserved for 15 focus countries, \$5 billion will augment existing bilateral programmes and just \$1 billion will go to the Global Fund. There is concern that PEPFAR is creating an unnecessary parallel structure to the Global Fund, and that there are restrictions, such as an emphasis on the abstinence and fidelity elements of prevention programmes and the purchase of only US produced drugs.<sup>21</sup>

The **UK** announced in July 2004 that it will commit £1.5 billion (\$2.67 billion)<sup>†</sup> between 2005-2008. This is the largest absolute contribution after the US's and the largest as a percentage of GDP.

The German Technical Cooperation (GTZ) and the Belgian Technical Cooperation (BTC) are also particularly active in AIDS, providing technical support alongside their governments' bilateral funding.

### *Foundations, NGOs, faith based organisations and medical faculties*

Since 1994 the **Gates Foundation** has spent \$1.3 billion on HIV, TB and reproductive health. NPC estimates that in 2003 the foundation contributed \$200 million to HIV/AIDS and TB initiatives,<sup>22</sup> and it appears it will exceed this in 2004. As well as being the most significant non-governmental donor to the Global Fund, the Gates Foundation has provided long-term funding to essential research on microbicides and vaccines. Other US foundations contributed around \$140 million in 2002.<sup>23</sup> Major donors include Bristol-Myers Squibb,<sup>24</sup> Henry J.Kaiser Family Foundation, Ford Foundation, and the Rockefeller Foundation.

The **King Baudouin Foundation**, the sponsor of this report, was set up in 1976 to "improve living conditions for the population". Most of its activities are in Europe, but it has earmarked a budget of €1 million (\$1.34 million) to HIV/AIDS and stimulates others to become actively engaged, especially in Central Africa. It supports projects in a collaborative manner, encouraging dialogue between service providers and promoting cross-fertilisation of ideas.

NGOs such as Médecins Sans Frontières, ActionAid, Caritas International, World Vision and Oxfam collectively spent around \$95.5 million in 2002.<sup>25</sup> As well as in-country programmes, many are involved in advocacy work on topics such as drugs pricing. Faith based organisations and churches also play an important role.

A number of European and US medical institutes are working hard to advance clinical prevention and treatment of the disease including the Prince Leopold Institute of Tropical Medicine in Antwerp, the London School of Hygiene and Tropical Medicine (LSHTM), the Medical Research Councils in UK and South Africa, and in the US, the Centre for Disease Control, University of North Carolina, and Columbia University.

## Methods of tackling HIV/AIDS

The causes of the HIV epidemic are complex and there is no single solution. The response is being waged on the three main fronts: prevention and education; treatment and care for people with HIV/AIDS, and support for people, such as orphans, who are indirectly affected.<sup>26</sup> Projects often involve two or more of these approaches and favoured methodologies of combating HIV/AIDS are increasingly holistic.

This section examines the various approaches, but as interventions may target different issues and segments of variable populations, they do not necessarily sit in neat boxes. Figure 1 (next page) shows a person's progression from being healthy and HIV negative to becoming HIV positive with AIDS. It illustrates the various interventions at points during the progression to try to prevent or alleviate events.

Any intervention should bear in mind local factors, such as gender, attitudes to risk, religious beliefs, economic conditions, health systems and other infrastructure, as well as what local people want. It is difficult to encourage non-risky behaviour in environments where general expectations of life are extremely low. Similarly, it may be complicated to improve STI levels through a mass treatment programme if a community is unstable and half its population is on the move. The state of a country's health system is fundamental to the delivery of all

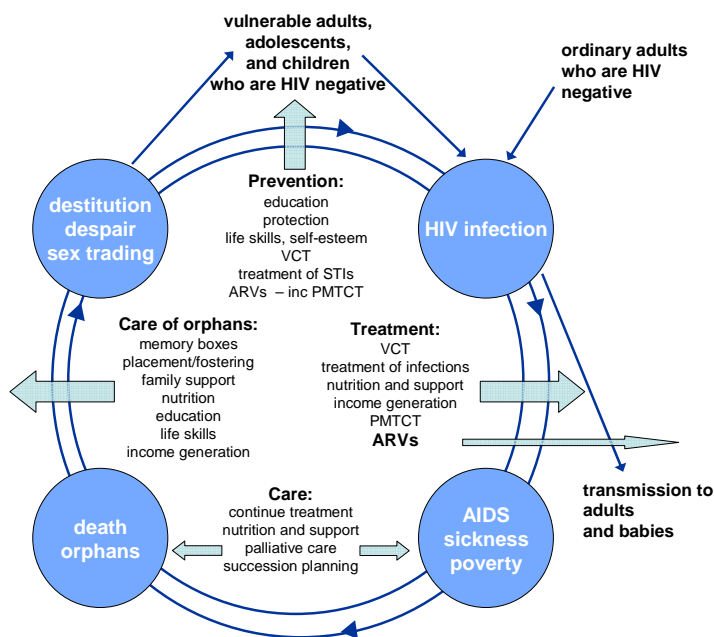
<sup>\*</sup> Botswana, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, S Africa, Tanzania, Uganda, Zambia, Guyana, Haiti, Vietnam

<sup>†</sup> US\$1.78:£1 used throughout (rate of conversion as at 15th September 2004 using [www.xe.com](http://www.xe.com) universal currency converter)

The King Baudouin Foundation has earmarked €1m for funding HIV/AIDS in Central Africa.

HIV/AIDS interventions. The importance of basic primary health care cannot be over-emphasised: it affects not only care and treatment of patients, but also provides an opportunity to get prevention messages across and motivate people to establish their HIV status.

**Figure 1: Direct interventions breaking the cycle of HIV**



## Prevention

The best place to tackle any virus is at the point of infection. The focus of any prevention work should be to stop the most infections for the minimum cost. A useful measure of outcome is the cost "per infection prevented" (pip), which is analogous to the cost per successful user.

This section covers the prevention of mother to child transmission, blood security and needles, and medical advances such as vaccines and microbicides. It then explores the extremely complex matter of sexual transmission and the numerous attempts to reduce transmission via this route. These overlapping interventions include treatment of STIs, voluntary counselling and testing, education and condom distribution.

The traditional prevention methodology is based around "ABC" public awareness campaigns. ABC stands for "practise Abstinence, Be faithful or use Condoms" but is quite a controversial approach because it glosses over important issues such as gender and poverty.<sup>27</sup>

### Prevention: mother to child transmission (PMTCT)

One of the most heartbreaking forms of transmission of HIV is from mother to child. In utero infection is rare; the most vulnerable moment for the child is during birth, where transmission rates are approximately 30%. The standard method for preventing mother-to-child transmission at birth is a dose of the antiretroviral drug Nevirapine to the mother at the start of labour and then to the newborn. This halves the risk of transmission to 15% and the drug cost is only about US\$4.<sup>28</sup> A full highly active antiretroviral drug (HAART) regime in the final trimester of pregnancy and during labour almost eliminates transmission, but requires intensive clinical supervision.

It is a cruel irony that successful PMTCT programmes exacerbate the orphan problem because children become more likely to survive their parents. On the other hand, a sick child is a greater burden to the parent while living than a healthy one. Ideally it is desirable for PMTCT programmes to include family planning so that further pregnancies are avoided.

**Nevirapine can halve the risk of HIV transmission to a baby, and HAART almost eliminates it.**

The total cost of PMTCT varies depending on whether the infrastructure to deliver the drugs already exists. There are debates over the probabilities of transmission with and without Nevirapine, and studies show a wide range of pip costs from \$21 to \$327.<sup>29</sup> The pip cost of HAART is just over \$862.<sup>30</sup>

The role of breast feeding in the transmission of the virus is not fully understood, and it may be that exclusive breast feeding is sufficiently low risk that it is preferable to formula milk mixed in less than sterile conditions. A six-month formula regime costs \$72 per family, unaffordable for many. If transmission risks through breastfeeding are assumed to be 10%,<sup>31</sup> then this implies a pip cost of \$720 (though one study estimates costs as high as \$6,680 pip).<sup>32</sup> Formula breast feeding may also create stigma for the family.

### Prevention: blood security, vaccines and microbicides

Blood security is crucial in preventing transmission of the virus within hospitals and the health system. There is data which emphasises its cost effectiveness: \$40-246 pip.<sup>33</sup> In many sub-Saharan countries blood security remains an unresolved issue. Intravenous drug use is not currently a significant issue in Africa, although transmission of the virus through poor needle practices (immunisation for instance) is a problem.

The holy grail of HIV/AIDS research is a vaccine that would enable the immune system to eradicate HIV as soon as infection occurs. Michael Gottlieb, the man who first identified AIDS in 1981, predicts: "By the year 2010 several of the most promising HIV vaccine candidates could be under study in controlled clinical trials [...] by 2021, one or more of these could have reached a level of effectiveness and safety that would allow its administration."<sup>34</sup> This is a long way off. There are currently 30 candidate vaccines being tested in small-scale trials. The **International AIDS Vaccine Initiative (IAVI)** is calling for \$1.3 billion to be spent annually, but in 2003 spending was only \$650 million per annum. The private sector has little incentive to contribute to efforts and only 15% comes from this source, 67% comes from governments (mainly US), with the rest from philanthropists.

Microbicides, HIV killing agents contained in vaginal gels, would give women more control over their own protection. The development of effective products will probably cost £1 billion but could save around \$12 billion in health care and antiretroviral drug costs. In 2000, the London School of Hygiene and Tropical Medicine, using conservative assumptions,<sup>35</sup> concluded that 2.5 million infections could be averted in a three year period with effective microbicides.<sup>36</sup> The Medical Research Council in South Africa is predicting commercial availability of partially effective products as early as 2008.<sup>37</sup> The Gates Foundation committed \$60 million to the **International Partnership for Microbicides (IPM)** in 2003, and a number of governments have also contributed. However, there are still a number of trials being conducted (eg, by the Medical Research Councils of UK and South Africa) where additional funding could accelerate results.

### Prevention: changing sexual behaviour

#### *Factors driving the heterosexual epidemic*

Over 90% of infected adults in sub-Saharan Africa acquired HIV through heterosexual intercourse.<sup>38</sup> In poor countries where men have few other indicators of success, sexual encounters are an important means of demonstrating masculinity. At the same time, women are often expected to submit to men (without being obviously promiscuous).<sup>39</sup> A significant issue is the economic and social dependence of women and younger people on men who control assets and income. The 'sugar-daddy' syndrome is clearly visible in some HIV prevalence statistics, highlighting the vulnerability of young women. Older men court younger girlfriends with gifts, groceries or cash, in return for sex. Acute poverty means sex is one of the few routes to a square meal.<sup>40</sup> Even when AIDS awareness is high, the risk of death from a disease that may manifest itself in the distant future seems less of a hazard than the immediate need for food.

Marriage represents a particular danger for women, as it is difficult for them to negotiate condom use, yet unfaithfulness is common and results in infection of the faithful spouse. It is worth mentioning here that the frequency of sexual contact is a significant factor in transmission: the average probability of HIV transmission during intercourse is surprisingly low, about 2% for an uninfected woman and 1% for an uninfected man.<sup>41</sup> However, even with these low probabilities, a couple having sex every day for a year has a 99% chance of viral transmission.

An HIV vaccine is not expected until around 2020

However, the use of sex-workers by men working far from home, such as miners or truck drivers, is also an important factor in the spread of the virus. Consumption of alcohol also increases the likelihood of unprotected sex between casual partners. Population migration is another social problem that increases such hazards.

Different population groups manifest different characteristics in terms of vulnerability and transmission routes to the rest of the population. The most effective prevention strategies recognise these differences and tailor activities accordingly. For instance, promoting condom use among dense groups of commercial sex workers during the early stages of an epidemic may reduce transmission to the rest of the population, but trying to promote condom use among a wide rural population of married couples may be less rewarding.

There are other more direct factors affecting sexual transmission, and consequently strategies for prevention. Sexually transmitted infections causing ulcers, inflammation and rashes provide HIV with easy entry points during intercourse and can reduce natural immunity. Poor health, including malnutrition, weakens the body's immune defence against the virus. The virus is less likely to invade cells and membranes that are well nourished, healthy and not weakened by repeated infection.<sup>42</sup> Sexual practices (eg, use of vaginal drying agents) and/or coercion might result in abrasion or laceration of membranes, which increases the likelihood of transmission. Anal sex, unfortunately sometimes considered to be "safe sex", is also extremely risky.

Prevention activities are often better undertaken where there are programmes involving care and/or treatment of people with HIV/AIDS and helping families affected. However, it may be useful to explore some specific prevention approaches.

### Education

Risky sexual behaviour does not merely stem from an ignorance of biological facts, but rather a failure to "internalise" risk, in other words, to understand the implications of such behaviour and to appreciate that it affects oneself. This means that education initiatives must address the complex cultural dynamics of the target population and work through the agents of change, such as tribal leaders, clerics, traditional healers and the media.

Risky sex results not only from biological ignorance but from a failure to internalise risk

**National campaigns:** It is difficult to ascertain the efficacy of national media campaigns, but evidence suggests they develop an open climate so that more targeted local campaigns find themselves pushing at an open door.<sup>43</sup> Radio and TV soap operas can cover a broad range of HIV issues. Billboard campaigns are widely used, although their value is unclear, particularly when much of the population is illiterate.



**Youth:** Teaching basic biological facts in school is a starting point, although not sufficient. Gender issues, specifically the right and ability of females to say 'no' or negotiate safe sex, need to be addressed early. Research shows that peer education projects, in which the young people themselves teach their contemporaries, are promising, although few have been operating long enough to record behaviour change in a statistically meaningful manner.<sup>44</sup> Because abstinence may not be realistic, the success of an education programme will be undone if condoms and services, such as treatment of sexually transmitted infections and HIV testing, are not available.

### Condoms and voluntary counselling and testing

To be effective, condoms need to be used in a high proportion of sex acts. It is probably easier to persuade people to use condoms in casual sexual relationships than in long term ones, because using them can be seen as a sign of promiscuity, or lack of trust.<sup>45</sup> Condoms



are not always available in resource-poor environments, and are unlikely to be used where procreation is desired.

There is surprisingly little recent or satisfactory data on the cost-effectiveness of male condom distribution. However, a study in Kenya of prostitutes with access to male condoms and treatment for sexually transmitted diseases shows this intervention is extremely cost effective at \$12-18 pip.<sup>46</sup> Another Kenyan study on female condom (femadom) distribution shows a range of costs depending on whether the group targeted is sex workers (\$290 pip) or medium risk women (\$2,300 pip).<sup>47</sup> This wide range reflects the number of occasions a woman is exposed to the virus and, therefore, the probability of being infected. It seems that in populations where prevalence is still most noticeably present in high risk groups (commercial sex workers, truck drivers), targeting that group is a cost effective containment measure.

Early detection of HIV through testing improves medical and psycho-social support for individuals, and if counselling persuades individuals to disclose their status then this is an added benefit. Significant reductions in risky behaviour by those who received counselling and testing were noted in 35 recent studies<sup>48</sup>. In East Africa it is estimated that one HIV infection is averted for every ten people accessing voluntary counselling and testing programmes.<sup>49</sup> Individuals testing negative are also given a reason to modify behaviour and protect themselves. Testing is rarely successful when offered in isolation, but is valuable as a component of a programme addressing issues of care, socio-economic needs and stigma. The availability of programmes to prevent mother to child transmission is a powerful incentive for pregnant mothers to be tested. Evidence from Tanzania and Kenya shows a cost of around \$460 pip.<sup>50</sup> Counselling couples is also an effective methodology.<sup>51</sup>

### *Treatment of sexually transmitted infections (STIs)*

Sexually transmitted infections significantly increase the risk of HIV transmission. One study indicates the probability increases to 6%.<sup>52</sup> Although this implies a threefold increase in risk per sexual contact, because of other correlating factors (eg, promiscuity) the actual increase in risk per sexual contact with someone with an STI is more likely to be tenfold.<sup>53</sup> It makes sense to tackle STIs, particularly genital ulcers and herpes. A comparison of three studies in Tanzania and Uganda,<sup>54</sup> shows the treatment of STIs is most likely to have greatest impact on HIV incidence among populations of sexually active individuals who have high rates of HIV.

As the epidemic progresses, more HIV transmissions occur in stable relationships with lower STI prevalence, so although the treatment of STIs remains useful, its impact is less significant. A clinic for sex-workers in Kinshasa set up in 1988 demonstrated that long term, consistent management of STIs among a high risk group can significantly reduce HIV prevalence. At the clinic the rate fell from 35% in 1988 to 12.4% in 2002.<sup>55</sup> A study of STI control programmes in Tanzania shows costs of approximately \$300 pip.<sup>56</sup> A Kenyan study even estimates that a combined STI treatment and condom distribution programme for sex workers in Kenya costs only \$15 pip.<sup>57</sup> It is unclear whether such incredible cost-effectiveness can be replicated today when prevalence is more widespread.

### *People with HIV/AIDS*

The better the care of people living with HIV/AIDS, the longer they live and the higher the quality of life. Antiretroviral drugs go a step further and in most cases achieve large increases in longevity and allow people to lead near normal lives. It is important to involve people living with HIV/AIDS in all interventions. Individuals can be very powerful in driving change as activists, educators, advocates and advisers.

### *Antiretroviral drugs*

Antiretroviral drug treatment (ART) inhibits the replication of HIV and thereby boosts the patient's immune system. Antiretroviral treatment is not a cure, but does bring substantial clinical benefits. However, non-adherence not only reduces benefits to the patient but also increases the likelihood of drug resistant virus strains developing. Furthermore, a degree of clinical sophistication is needed to determine the drug regime for a given patient.

Antiretroviral treatment is generally applied at Stage 4 of the syndrome when the immune system's CD4 count drops below 200. Antiretroviral drugs have been described as having a "Lazarus effect" in bringing AIDS sufferers back to life from the brink of immune system collapse, although some patients develop resistance to the drugs, and others (about 6%) have such extreme side effects that the drug regime is suspended. The introduction of ART

STIs can increase the risk of HIV transmission my three to ten times.

Antiretroviral drugs have cut AIDS death rates by more than 50% in Brazil

in Europe and the US has helped cut AIDS deaths by over 70%, while In Brazil AIDS mortality fell by 51% between 1996-1999 when medication became universal. The development of resistant strains, however, is gradually reducing the effectiveness of ART in some countries. In Central Africa the extent of resistant strains is not yet known, or whether indeed strains will emerge under treatment programmes.

Drug costs used to be prohibitive but fortunately are now are falling. Generic drugs, manufactured in countries such as Brazil and India, are reducing costs to just \$20-30 a month. In reality, because of export costs, actual prices in the countries in question tend to be higher. In addition, the drugs are mainly only available to purchasers of scale, governments for instance, at these prices. NGOs cannot always access these prices. It is also important to include the substantial costs of laboratory testing and medical infrastructure. A conservative estimate for the total cost of antiretroviral treatment is \$1,000 per patient per annum.<sup>58</sup> This includes drugs, medical infrastructure and laboratory testing costs. In countries such as South Africa, with a reasonable existing health infrastructure, the actual experience can be substantially cheaper (\$550<sup>59</sup> per patient per annum). The net cost to society is significantly less than this, since people receiving antiretroviral drugs will make less use of hospitals than untreated AIDS patients. Brazil saves around \$850 in hospital costs per patient per annum.<sup>60</sup>

The impact of antiretroviral drugs on a family is transformational: children are not orphaned and are relieved of the burden of caring for their parent, allowing them to attend school; mothers do not spend their days nursing sick children and can work; partners are less likely to infect one another. People are more likely to participate in HIV testing programmes if treatment is available. On the negative side, antiretroviral drugs have side effects such as vomiting, rashes, increased risk of cardiovascular disease, headaches and insomnia.

The provision of antiretroviral drugs raises some practical considerations:

- **Patient selection:** Who gets priority when resources are finite?
- **Nutrition:** Reasonable nutrition levels are a crucial component of the antiretroviral drug regime and access to income-generating activities (sometimes part of a programme) is helpful in this regard.
- **Counselling and support:** This is essential to manage patient expectations and to promote adherence to the drug regime and responsible sexual behaviour. Peer support groups can help reduce stigmatisation.<sup>61</sup>
- **Clinical supervision:** The administration of treatment is extremely labour-intensive and requires good medical capacity to supervise programmes.
- **Treatment of opportunistic infections:** Access to ordinary medicines for infections is an essential complement to ART, which has no prophylactic qualities.

Currently there is an urgent need for seed funding to develop infrastructure and training in anticipation of future international funding. NGOs can play a vital role in:

- Developing evidence-based models which can later be rolled out more widely.
- Building capacity and experience within health systems to cope with antiretroviral drugs and related health issues.
- Ensuring other health issues are not ignored due to efforts focused on HIV/AIDS.
- Offering stop-gap services while national governments develop operational plans and mobilise funding.

The duration of antiretroviral drug provision is a dilemma for private funders. Although medically possible, it is extremely difficult (and ethically questionable) to cease patient treatment with antiretroviral drugs once started (apart from treatment in connection with prevention of mother to child transmission efforts). The effect on the development of drug resistance is not yet clear. Programmes can start in expectation that more substantial funders will step in at a later date, but ultimately if this does not occur, private funders have to decide between continued funding or cessation of programmes. The risk of drug cessation is a sensitive issue to people who are HIV positive, and in some places there is scepticism over the sustainability of funding for treatment.

Traditionally doctors monitor patient progress through regular CD4 counts and viral load tests, which are costly and require laboratories that do not exist in many parts of Africa. Various trials are underway exploring the use of clinical monitoring only, which could save \$100-150 per patient per annum by eliminating most laboratory testing.<sup>62</sup>

There is an urgent need for seed funding to build up the infrastructure for ART delivery

## General care and support

As explained earlier, HIV patients are not generally suitable for antiretroviral treatment until the disease progresses to AIDS. Good prevention and management of opportunistic infections, nutrition and healthy living can delay the onset of AIDS. Furthermore, when there are insufficient resources to pay for any antiretroviral treatment, or when a person has a drug resistant HIV strain or suffers extreme side effects, it is important to provide them with a dignified way of spending their final years. Live-in hospices are too expensive to be a widespread solution and are not always suited to African lifestyles. Community based home care programmes can be effective in improving the quality of life.

Although there appear to be no clinical studies comparing malnourished control groups with well-nourished patients, medical practitioners agree that diet is a crucial component in the treatment of AIDS.<sup>63</sup> Projects attempting to encourage and improve cultivation in rural areas are helpful in this regard. Access to clean water is an issue for people with HIV/AIDS many opportunistic infections are waterborne.

### Integrated community based home care

The integrated community based home care model, developed in South Africa, links hospices, primary health care clinics and hospitals as well as caregivers in developing a care plan for patients, and training health professionals and volunteers. Caregivers work in teams with nursing and medical supervisors, social workers and bereavement counsellors who then go into the community to train and support carers of AIDS patients in basic home nursing skills.

This model of care also provides psycho-social and spiritual support to patients and the bereaved. There is anecdotal evidence that the psychological well-being of patients has a bearing on longevity and quality of life, helping to combat the isolation and depression frequently associated with AIDS. Such intervention also mitigates the trauma for children watching the passage of life of a loved one through sickness to death, and reduces the feelings of helplessness among family members. Bereavement support is part of this process and is essential if the children are to recover sufficiently to control their own lives.

The advantage of the home care model is that it uses caregivers who know the families concerned and are always on the look out for new cases. It also provides an entrée to the family when providing other services, such as bereavement counselling, help with placement planning of children, and placement once the children are orphaned. Caregivers report frequent opportunities to improve HIV/AIDS education in the immediate family and community.

### Box 1: Memory boxes, bags and books

A Memory Box<sup>\*</sup> is an initiative successfully deployed in South Africa and Uganda. It is created for the child by its parents or by the child itself (lovingly and beautifully hand-decorated) and might contain *documentation*: birth certificate and documents around parents' ID, a *family album* containing stories, photographs, drawings, a *family tree to help* identify relatives for future tracing, a will including intentions for the placement of child with trusted relatives and details regarding inheritance of possessions, *letters to the* child and other treasured objects. A Memory Box project provides a conduit through which people can confront AIDS and its implications. It is a useful tool to place at the heart of the bereavement process.

### Support groups

Interviews with HIV positive mothers in support groups emphasise the importance of mutual support and contact – without them they would have lost the will to live.<sup>64</sup> Support groups are less expensive than one-to-one counselling, and can reduce and even replace it. They are easy to establish and can be combined with self-sufficiency and income generation projects. Even in a society where death is commonplace from other causes, few people want to associate with AIDS patients; investing social, or other, energy in someone who is dying is viewed as wasted effort by the community at large. Support groups for people with AIDS, coupled with community education, help to overcome stigma within communities and reduce the isolation experienced by AIDS sufferers.

<sup>\*</sup> A Memory Box can sometimes be a Memory Bag or Memory Book with a pocket in the book sleeve

Effective home based care can make a huge difference to quality of life

The international focus on prevention and treatment may be overlooking orphans

Orphanages should only be the last resort and hopefully temporary.

## People affected by HIV/AIDS

There are many people, especially children, within the circle of a person with HIV/AIDS who are badly affected by the consequences of the disease. It is the view of some practitioners that given the emphasis on prevention and treatment, orphans and vulnerable children are not receiving the resources they need. The most successful interventions bear in mind that *"orphanhood is a process that starts long before the death of the child's caregiver."*<sup>65</sup> For a child the preferable outcomes after bereavement, in order, are:

- (1) **Remaining within the family** in the community in which he or she has been brought up. Assuming there is no abuse or neglect, this results in the least possible trauma for children (even in a child-headed household).
- (2) **Remaining within the community** through foster care or placement in small family homes so that children remain close to their roots.
- (3) **Fostering or placement with a good family** in a new community.
- (4) **Institutionalisation.** A temporary or permanent stay in an orphanage may be unavoidable and is preferable to life on the street, but is not good for development.

Apart from institutionalisation, all of the above are relatively low cost, although in countries where there are no social services, it will be the families and communities that foster the children who bear the cost of looking after them. In order to serve children best, there is a growing consensus that interventions must target the family caring for the child as a whole unit, rather than singling out the orphan for special attention.

Good placement or fostering, ideally with a member of the extended family or a neighbour, is crucial. However, the romantic ideal of the extended family is a myth in some areas where there have been population movements or a high mortality rate. Even if a grandmother is able to support children on immediate bereavement, she herself may be old or sick and lose the ability to care. Support for child-headed households therefore may be a reasonable alternative, particularly if it is both material and emotional and includes a mentoring element. The benefit of this is that children are more likely to retain their family assets, and sibling groups are not broken up. Mothers are more likely to abandon HIV positive children than their negative counterparts because they feel unable to cope with the prospect of caring for a sick child. In turn, these children are more difficult to foster.

Money is often short while people are sick. In the period after their death and funeral, costs are high. Consequently, families with patients or recently dead carers have shocking levels of nutrition and the development levels of children are retarded. Food parcels are often the only way to adequately nourish children. Maintaining education is also a challenge. Families who have lost the main breadwinner struggle to keep children in school. Older children quit education to earn income to support other family members. Inheritance practices can also deprive widows and orphans of land and other assets, placing them at even greater risk.

There are large numbers of children for whom there are no official records, and this has implications for their welfare and potentially puts large numbers at risk from abuse and trafficking, the worry being that they won't be missed if they disappear.

### Box 2: Role of faith based organisations (FBOs) in providing care across the spectrum – report by UNICEF

UNICEF researched the activities of 690 FBOs in six countries and found that they provided a broad range of community-based services, particularly material support to orphans and care for the sick. They found them to be adaptable and responsive. Although individually small, the cumulative impact of thousands of initiatives is considerable. The researchers also found that FBOs were well-organised: those lacking transparency and organisation were not supported by local communities. FBOs are able to tap into volunteer resources, although financial resources in such poor communities were often limited.

The problem of orphans is so large that in some communities the ideal models (placement with families) may not be achievable. So if a child has no one to look after them, there may be no option but to place the child in institutional care, preferably within local communities. HIV positive children are less likely to attract fostering or adoption. Children who end up living on the street harden quickly and a street child requires intensive rehabilitation. Street



children often come from disintegrating families split by poverty, which is why interventions keeping the remnants of the family together are so important. Good shelters will take trouble to trace communities and families as quickly as possible to try and place children back at home, but often there is no one for them to go to.

When helping orphans and vulnerable children it is important not to discriminate in favour of those orphaned by AIDS over those orphaned for other reasons.

## Outcomes from interventions

The resources available to tackle HIV/AIDS fall far short of what is needed. It is therefore desirable that giving is targeted at activities which have demonstrable results. Unlike governments, which may select programmes for political reasons, private donors have the freedom to focus on those that are most effective.

When assessing results it is useful to distinguish between the cost per user and the cost per successful user. All charitable activities should be targeted towards achieving positive outcomes, but some work more successfully than others. An intervention which succeeds in only 10% of cases has a cost per successful user ten times higher than its cost per user. As methods vary in their success rates, these two measures of unit cost are often considerably different and both are of interest to donors.

The effectiveness of each intervention can be assessed on three levels:

- (1) Raw output, eg, the number of condoms distributed by a safe sex project or the number of patients receiving antiretroviral drugs.
- (2) Direct outcomes, eg, the increase in condom use or the number of patients whose immune systems recover as a result of the drugs.
- (3) Quantified impact, eg, the number of HIV infections prevented, the years of life gained by patients, adjusted for quality, or the economic benefit to society.

The output (1) is by far the easiest of these to measure, and is therefore the level of assessment most frequently quoted by charities, but is not useful in making comparisons. Considerable information gathering is needed to measure the outcomes (2) reliably, but these figures are more useful in assessing the effectiveness of interventions and allocating resources. Comparable data on the impact (3) is the most useful measure of effectiveness and enables funders to make clearly informed choices between different kinds of intervention. Unfortunately, complex calculations, involving assumptions on issues such as the epidemiological spread of HIV and the expected life span of a person without HIV, are needed to move from the direct outcome data to a good estimate of impact.

Measuring results is an activity fraught with problems. There are considerable difficulties both in defining success and in costing projects aimed at success. There is also the problem of longevity of success in projects trying to achieve long term societal changes, which are not measurable within a two to three year time scale. The actual data available is poor and often out of date.<sup>66</sup> Nevertheless, grappling with these difficulties is a useful exercise, because some understanding of what constitutes success and the cost effectiveness of the interventions is better than none. Because of the difficulties, the discussion which follows should not be regarded as conclusive, but is aimed at helping donors interested in directing funding to HIV/AIDS projects in Central Africa.

Table 2 summarises the costs of the various interventions. Quantitative statistics should not be read in isolation however, and the efficacy of the particular organisation providing the intervention must also be considered. The results below highlight difficult decisions for donors in terms of resource allocation. Often the choice is between helping large numbers of people (eg, registration, palliative care) versus helping fewer people but in a more profound way (eg, antiretroviral drugs).

Table 2: Interventions and outcomes<sup>67</sup>

Intervention	Prevents infection	Improve or extend life	Protects children	Cost per user, \$	Cost per pip, \$
<b>Prevention</b>					
Education and awareness	✓	✗	✓	16-32	–
VCT	✓	✗	✗	4-39	264-367
Social marketing condoms				negligible	24
Condoms/STI treatment for sex workers	✓	✗	✗	6	19-30
Treatment of STIs	✓	✗	✗	2.50-16	11-260
PMTCT– Nevirapine	✓	✗	✗	4-8	27
PMTCT– HAART	✓	✗	✗	250	862
Blood security					52
<b>Treatment and care</b>					
Antiretroviral drugs	?	✓✓	✓	1,000 pa	<b>Cost over life</b> c10,000
Antiretroviral drugs – impact on children	✗	✗	✓	200 pa	2,000
Community based care	?	✓	✓	125-430 pa	–
<b>Services to children</b>					
Fostering	✗	✓	✓	390	–
Education	✗	✓	✓	71-480 pa	–
Nutrition	✗	✓	✗	103 pa	–
Combined family support in Rwanda – (ie, four children)	?	✓	✓	1,780 pa per family	445 per child

*The funding options available in some very poor regions may be different to those identified here and may not be so neatly packaged, but this is a useful tool to refer to as an approximation of the results of resource allocation.*

The cost of preventing an HIV infection can be as little as \$11

## Section 2: Burundi

**Civil war has severely affected Burundi and damaged its infrastructure. However, the national response to HIV/AIDS (at both government and NGO levels) is well-coordinated despite this. NPC believes there are a number of interesting funding opportunities in Burundi.**

This section first describes Burundi's history, social background, and HIV prevalence, and then examines existing provision for those affected and how international donors are supporting these efforts. It also highlights the gaps in the response and explores options for funders in a number of areas. In July 2004 NPC met 14 NGOs in Burundi, many operating outside the capital, as well as UN agencies, donors, and government representatives.

### History

Burundi is of a similar size, population (6.8 million) and ethnic composition (84% Hutu, 15% Tutsi and 1% Twa) to its better known neighbour Rwanda. During the colonial period, Belgium governed the two countries as a single unit from Bujumbura, Burundi's current capital. However, the recent histories of the countries have been quite different. Whereas in Rwanda Hutus controlled the state and the army from the 1960s through to 1994, in Burundi power has largely remained in the hands of the Tutsis. In Rwanda there have been a number of brief but intense periods of genocide against Tutsis separated by long periods of relative stability, while in Burundi there has been almost continual civil war at varying levels of intensity, with massacres of civilians committed by both ethnic groups. Furthermore Burundian Hutus and Tutsis have been internally divided into numerous factions with complicated agendas.

The period generally called the Second Civil War (the first was in 1972-6) began in October 1993 when the first elected president, Melchior Ndadaye, was assassinated. His Hutu replacement Cyprien Ntaryamira died soon afterwards in the plane crash of April 1994 that also killed the Rwandan president and preceded the genocide. Sylvestre Ntibantunganya, also a Hutu, held the presidency until July 1996 when he was deposed in a coup led by Major Pierre Buyoya, a Tutsi. International pressure, including economic sanctions, led to a transitional constitution in June 1998 agreed between Buyoya and the Hutu dominated parliament. The government, the Tutsi militias and some Hutu groups signed a ceasefire, but the two main Hutu groups – the FDD and FNL – remained at war.<sup>68</sup>

In 2001 the FDD joined the ceasefire and a three-year transitional government was established with the presidency held by Buyoya for the first 18 months and then by his Hutu vice-president Domitien Ndayizeye for the final 18 months before elections. The handover on April 30, 2003 was peaceful, despite fears that hardline Tutsi groups would attempt a coup to block a Hutu president. The Hutu FNL, however, shelled Bujumbura in summer 2003 and continues to fight, largely in the rural area south of Bujumbura. The government and the FDD had both been repeatedly violating their ceasefire, but on October 7, 2003 they signed a power sharing protocol in Pretoria which appears to have worked.

On August 15, 2004 a massacre of 150 Congolese Tutsi refugees (who had fled from Bukavu in June) took place in a border camp. The FNL claimed responsibility, but the Burundian government suggested that Rwandan Interahamwe (the remnants of the perpetrators of the genocide) based in Congo were also involved.

Elections scheduled for October 2004 were delayed until early 2005 because of logistical problems. The current proposal is for Hutus and Tutsis to share power equally in the Senate, while the lower house will be 60% Hutu and 40% Tutsi. The first president will be elected by the parliament and subsequent presidents will be elected directly by the people. The main stumbling block is whether Tutsis that are members of predominantly Hutu parties will be counted as part of the 40%, or whether this will be reserved exclusively for the ten Tutsi parties.

It remains to be seen whether the elections happen smoothly, but whatever the outcome politically, it will still be necessary to tackle HIV/AIDS. Many of the organisations involved in this work were created during the war and have experience of continuing operations in the face of conflict.

**Ethnic split: 84% Hutu, 15% Tutsi, 1% Twa. Civil war since 1993.**

## Social context

GDP per capita  
\$120, with 85%  
living on less than  
\$50 per annum.

Burundi is one of the poorest countries in Africa and the second most densely populated. The average farm size is only 0.5ha and GDP per capita is just \$120 per annum.<sup>69</sup> The general poverty is even more extreme than this figure suggests, with over 85% of the population living on less than \$50 per annum. This makes even the most basic health care, let alone antiretroviral treatment, completely unaffordable. Moreover, poverty drives people to informal sex work with its associated risk of HIV infection. As one widow from an internally displaced persons camp says: "We get AIDS because of poverty. If your children are crying from hunger then the only thing you can do is go and find a man to get some money."<sup>70</sup>

The civil war has displaced around half a million people internally and a similar number of Burundian refugees have fled to neighbouring countries. Both the war and HIV/AIDS have contributed to a dramatic reduction in life expectancy from 51 years in 1993 to 35 years in 2004. The general health crisis is illustrated by the child mortality rate of 19%. 45% of children under five are underweight and only 27% of the population have access to safe water. Burundi ranks 171 out of 175 in the UNDP's Human Development Index.<sup>71</sup>

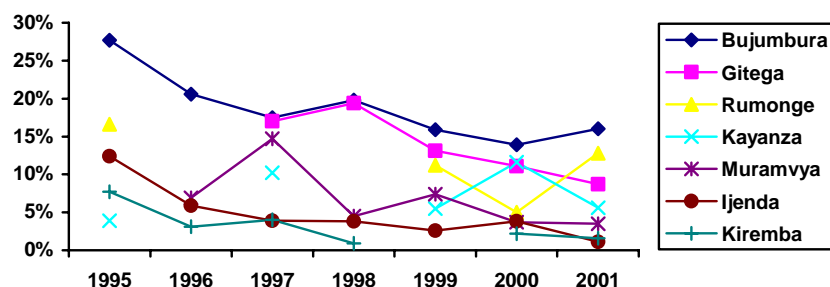
During the 1990s the doctor/patient ratio was only one per 100,000, the lowest in the world at the time. Only 20 doctors were trained each year and many left to practice in Europe. The situation has improved slightly in the last few years. Currently around 40 new doctors graduate each year, however, the national total is still only about 300 doctors<sup>72</sup>, which works out at around one per 50,000 people. Most are concentrated in the capital and many are involved in policy work for the government or NGOs rather than practising medicine. The lack of doctors is probably the biggest limiting factor to successful treatment of HIV/AIDS and also TB, Malaria and the other diseases ravaging Burundi.

## Prevalence and effects of HIV/AIDS

HIV/AIDS is clearly a major problem in Burundi, responsible for up to 70% of hospital bed occupancy.<sup>73</sup> However, it is difficult to gather accurate data on the prevalence of HIV/AIDS because of the disruption of the civil war. The figures, particularly those from the 1990s, must be treated with scepticism. In the absence of truly extensive and carefully sampled national surveys, extrapolations are made from HIV testing clinics and sites that provide statistics. Table 3 shows data from surveys among pregnant women aged 15-24 attending a few antenatal clinics. The period covered involved considerable population movements, making it hard to draw conclusions in the same ways as for a stable population. With these caveats in mind, the data shows a fall in prevalence in the capital city, although the picture is less clear elsewhere.

Table 3: HIV/AIDS trends in sentinel sites Burundi, 1995-2001<sup>74</sup>

Area	Site	1995	1996	1997	1998	1999	2000	2001
Urban	Bujumbura	27.7%	20.6%	17.5%	19.8%	15.9%	13.9%	16.0%
	Gitega	N/A	N/A	17%	19.4%	13.1%	11.1%	8.7%
Semi-Urban	Rumonge	16.6%	N/A	N/A	N/A	11.2%	5.0%	12.8%
	Kayanza	3.9%	N/A	10.2%	N/A	5.5%	11.6%	5.6%
	Muramvya	N/A	6.9%	14.7%	4.5%	7.4%	3.7%	3.5%
Rural	Ijenda	12.4%	5.9%	3.9%	3.8%	2.6%	3.8%	1.1%
	Kiremba	7.7%	3.1%	4.0%	0.9%	N/A	2.2%	1.6%



Live expectancy is  
only 35 years and  
45% of children are  
underweight.

Table 4 gives estimates for national prevalence levels. Overall the national prevalence seems to be between 3-4%, putting the number of HIV positive people at around 300,000.



The rate among the productive and sexually active adult population (generally defined as 15-49 years) is considerably higher, around 8%. In Bujumbura, where about 7% of the population live, prevalence is around 20%. The national figures appear to show a stabilisation (even reduction) in Bujumbura but a considerable increase in rural areas from less than 1% in 1989 to about 7.5% in 2001. A former minister for AIDS explains: "According to the figures obtained from urban areas over the past three years, we get the impression that the rate of infection has stabilised ... this is because, in urban areas, action in the fight against AIDS started much earlier. Furthermore, the people are more literate and have access to the media. Also, condoms have become more acceptable thanks to awareness campaigns, and they are available and accessible to city dwellers."<sup>75</sup>

**Table 4: National prevalence data**

Prevalence	Scope	Date	Source
3.2%	all	2004	Enquete nationale de seroprevalence
23%	Urban, adult	2004	Tearfund
7.5%	Rural, adult	2004	Tearfund
9.4%	Urban, all ages	2002	MIRC <sup>76</sup>
2.5%	Rural, all ages	2002	MIRC
3.6%	all	2002	MIRC
32.1%	Widows, urban, all	2002	MIRC
8.3%	adults	2001	CNLS
18.6%	Urban, adults	2001	CNLS
7.5%	Rural, adults	2001	CNLS
11%	Urban, adults	1989	UNAIDS
6%	Urban, adults	1986	UNAIDS
<1%	Urban, adults	1983	UNAIDS

Considerable numbers of Burundians engage in risky sexual behaviour. A survey in 2000 shows that 10.6% of the adult population had non-regular sexual partners in the previous 12 months, and that 18.4% of the 15-19 year olds were sexually active.<sup>77</sup> Traditional practices like *gutera intobo* (sex between the father and the daughter-in-law), *gusobanya* (sex between a man and his sister-in-law) and *guru* (inheriting the wife of a deceased son or brother) may also contribute to the spread of the virus.<sup>78</sup>

UNAIDS estimates the death toll from AIDS is currently 40,000 people per annum; there are 240,000 orphans and 35,000 children infected with HIV.

Experts say that stigma against people living with HIV/AIDS is lower in Burundi than in some of the neighbouring countries because a number of well respected public figures have revealed they are infected. Nonetheless there are reports of discrimination and one poll even suggests that 30% of the public would support incarceration of people with AIDS and 10% are in favour of executing them.<sup>79</sup>

## Existing provision

Burundi has responded vibrantly to HIV/AIDS. Throughout the 1990s most work focused on prevention through education and condom promotion. Recently emphasis has shifted towards voluntary counselling and testing (VCT) so that people can determine their sero-status and people with AIDS can access relevant services. The demand for voluntary counselling and testing is outstripping supply, and now that a significant number are aware of their positive status attention is focusing on providing care and treatment for them. Currently about 2,300 people are receiving antiretroviral drug treatment, mainly through the local NGOs ANSS and SWAA, plus a few in government hospitals in Bujumbura, Gitega and Ngozi. Some people get drugs through the private sector.

## Governmental response

Since mid-2002 the Commission Nationale de Lutte Contre le SIDA (CNLS), which is part of the president's office, has coordinated the Burundian response to HIV/AIDS. A different organisation, the PNLS, based within the Ministry of Health, used to be the main coordinating body. Now each ministry has an "Unite Sectorielle de Lutte contre le SIDA" (USLS) linked with the CNLS, which coordinates a broad multi-sector response. In 1999 the government developed a four year action plan, but this was superseded by a new plan for the years 2002 to 2006. The CNLS is organised and is increasingly decentralising now that the civil war has subsided in most provinces.

Traditional sexual practices may be contributing to the spread of HIV

The CNLS is well respected and is decentralising its operations.

A strong indicator of the high regard in which the CNLS is held is the fact that it administers the disbursement of the Global Fund and World Bank grants. This process is still far from perfect of course, and there appears to be a bottleneck because of staff shortages at the centre following the decentralisation process. This may be the reason why ABS, the umbrella group for local NGOs, reports that only 15% of the 229 projects its members submitted to the CNLS this year have received funding.

### International organisations and funders

The World Bank is providing \$36.7 million over five years and the Global Fund is disbursing \$8.6 million, also over five years. Burundi applied to the fourth round of the Global Fund, but was turned down, and according to the WHO this means that its Global Fund money is likely to run short in 2006.

The World Bank and ActionAid estimate that other bilateral donors, together with UN agencies and NGOs, earmarked \$47 million in the period 2002-2004.<sup>80</sup> UNAIDS estimates the total expenditure on HIV/AIDS in 2004 at \$35 million of which the UN agencies (mainly WFP, FAO, WHO, UNDP, UNICEF and UNFPA) account for \$12.7 million.

WHO and UNAIDS have developed a '3 by 5' plan for Burundi which envisages 12,500 people obtaining antiretroviral drug treatment by the end of 2005, and 25,000 by the end of 2006. This is a challenging and exciting scheme (bearing in mind that today only about 100,000 people are currently receiving antiretroviral medication in the whole of Africa), but it is unclear how much money WHO itself is able to contribute towards the goals, which will be largely funded by the existing World Bank and Global Fund grants. The estimate is that achieving the '3 by 5' targets will cost \$3.8 million in 2004 and \$11.2 million in 2005.

UNFPA focuses on prevention through partnerships with local organisations. It equips voluntary counselling and testing centres, distributes condoms and funds work tackling sexually transmitted infections and sexual violence.

UNDP has been assisting the CNLS in its decentralisation process, financing technical teams in four provinces and supporting people living with AIDS associations with grants for income generation projects. UNAIDS helps with coordination through a variety of theme-groups working on specific topics.

The British government is tackling HIV/AIDS through the SIPAA (Support to International Partnership against AIDS in Africa) programme managed by ActionAid. This is a three year programme across a number of African countries, and the Burundi component has a budget of £4 million (\$7.12 million) over three years ending April 2005. Initially a major component of SIPAA was financing local NGOs, although this came to a halt last year when World Bank MAP funds started to finance this. Now the focus is on helping the CNLS to decentralise. Currently SIPAA and UNAIDS are supporting an extensive mid-point evaluation of the 2002-2006 national plan.

The German government started work in Burundi this year, and provides €2 million (\$2.68 million) of funding for HIV/AIDS work. It has adopted the province of Ruyigi and is funding all the activities of the provincial CNLS there. The Belgian Technical Corporation has funded a home-based care project for 7,000 people living with AIDS in seven provinces, and is involved in a range of other projects.

Total annual AIDS spending is about \$35m, mainly World Bank, UN, Global Fund and DFID



Some private donors are already active in Burundi. The AEDES Foundation of Belgium is paying for antiretroviral drug treatment through the Society for Women against AIDS in Africa (SWAA) and the Association Nationale de Soutien aux Seropositifs et Sideens (ANSS); the King Baudouin Foundation is funding SWAA to do prevention work, as well as Famille Vaincre le Sida's work with orphans.

At present there is funding for supplying condoms, but NPC is concerned that this may reduce in future because it is not a priority for international donors such as PEPFAR. This is important as, unless supported in some way, the fully costed supply of condoms is generally

beyond the reach of poor members of society, and subsidy or free supply is necessary to support prevention programmes

### Box 3: Getting outside the capital

It is a common problem in developing countries, particularly unstable ones, that most social provision is only in the capital and other major cities. In order to get a feel of the situation up-country, NPC visited Kayanza province in the northwest, close to the Rwanda border.

The Society for Women against AIDS in Africa (SWAA) runs an HIV/AIDS centre on the edge of a small town and offers various services. The starting point is a voluntary counselling and testing programme to identify HIV positive people. It tests about 30 people each week, of whom 25-35% are positive. SWAA believes this indicates an underlying prevalence of about 13%, as many of those tested are already displaying symptoms of AIDS.

The demand for testing outstrips supply. SWAA provides home-based care for 330 people and gives them basic essential equipment, nutritional and psychosocial support and drugs for opportunistic infections when these are in stock. A further 450 orphans also receive some support.

SWAA helps HIV positive people to form small support groups of up to a dozen people, and provides them with a \$400 grant to enable them to do some basic work, such as petty trade. The activities are run by a full time doctor, nurse and health worker assisted by 47 volunteers. Funding comes through the SWAA head office from a range of international donors, such as Cordaid, UNFPA and WFP, who between them require six different reports, which is time consuming for the little Kayanza office.

NPC met a director of the provincial HIV/AIDS commission who explained they had recruited 534 part-time outreach workers in Kayanza who had been receiving monthly training on a voluntary basis. They receive a small salary (about \$10 a month) in return for producing reports on their activities. The outreach workers each distribute about 100 free condoms a month, talk about prevention, advocate for VCT and provide basic home care.

## Gaps in provision

### Gaps in geographical provision

As in many countries, provision by both the state and NGOs is heavily biased towards the capital city. In part this is because the civil war has made it difficult and dangerous to operate up-country.<sup>81</sup> The most serious problem is the acute shortage of doctors outside the capital, something mentioned to NPC by many people. In Bujumbura doctors have access to better facilities, opportunities to study and, most importantly, private clinics which can supplement their tiny government salaries.

UNAIDS revealed to NPC the shocking information that in some areas there are only two Burundian doctors for the whole province! There are other problems in the provinces such as disorganisation in procurement. Médecins Sans Frontières explains that while supplies of drugs for most common opportunistic infections are available in Burundi, inefficient stock management means provinces often run out. Ideally there should be at least one decent functioning hospital in each of the 17 provinces, presently this is not the case.

Table 5 shows the provincial distribution of voluntary counselling and testing centres, doctors trained in administering antiretrovirals and NGOs that are active. The greatest need is probably in the provinces on the Tanzanian and Rwandan borders, which are furthest away from the capital.<sup>82</sup>

The national AIDS plan attempts to tackle the geographical gaps by decentralising the CNLS with groups at each administrative level across the whole country. There are provincial committees (CPLS), community committees at the commune level (COCLS) and local committees (CLS) at the sectoral level. One of the plans being implemented is for each sector to have two HIV outreach workers to educate, distribute condoms, inform people about services available and provide home-based care. This system is still only a plan on paper in some provinces, but in others it has already begun.

The civil war limited provision to the capital until recently. Still there are very few doctors in rural areas.

Table 5: Distribution of VCT centres, ARV trained doctors and HIV/AIDS NGOs<sup>83</sup>

Province	VCT	Drs	NGOS
Bubanza	3	4	
Bujumbura-M	17	73	ABUBEF, ADRA, ANSS, FVS, JRS, NE, SWAA
Bujumbura-R	3	3	JRS, GVC
Bururi	7	2	
Cankuzo	2	2	
Cibitoke	4	2	
Gitega	11	3	ANSS, SWAA
Karuzi	4	2	
Kayanza	6	2	SWAA
Kirundo	4	3	ANSS
Makamba	1	1	
Muramvya	4	1	
Muyinga	4	1	SWAA
Mwaro	3	2	
Ngozi	4	1	HI, SWAA
Rutana	2	1	
Ruyigi	2	2	GTZ, SWAA
Nationally	81	115	Caritas RBP, PSI



### Gaps in care and treatment

Although there is now considerably more focus on antiretroviral drug treatment than in the past, particularly with the WHO's '3 by 5' initiative, NGOs, donors and UN agencies repeatedly state that the biggest gap in funding is for this area.

UNAIDS has drawn up a chart of funding provisions against needs. The budget for needs is taken from the 2002-2006 national AIDS plan projections, and therefore should be seen as merely indicative of what the real needs today are likely to be. What comes across clearly is that the biggest gaps are in treatment, both ART and drugs for opportunistic infections.

Even when organisations receive drugs as in-kind donations from the Global Fund they often find it difficult to get funding for the staff, equipment and other costs needed for successful administration of the treatment. One international NGO with credible plans for an ARV treatment programme explains it has been unable to get the necessary long term funding to initiate it because most international donors categorise Burundi as an emergency situation and only provide short term humanitarian relief funding (usually for three, six or twelve months).<sup>84</sup>

A significant problem, according to WHO and others, is that most of the care and treatment is done by NGOs and the private sector, not the national health system, which needs to catch up.

### Gaps in prevention

There is a danger that the recent emphasis on treatment might be at the expense of essential prevention work. There is not so much need for general Information, Education and Communication (IEC) style awareness raising, as most of the population already has a reasonable understanding of the danger of AIDS and the basics of sexual HIV transmission<sup>85</sup> and current spending on it exceeds the national plan's budget by 154%. However, there is still misunderstanding about blood transmission. Rural people prefer traditional healers to modern medicine because they have heard that needles transmit AIDS.

Antiretroviral treatment is the biggest gap.

One of the principle traditional healing methods, however, is scarification of the face. This is often done not only to the sick individual with HIV/AIDS, but to his whole family – a process that runs high risks of cross-infection.<sup>86</sup>

There is definitely a need for targeted prevention efforts. Arguably prevention of mother to child transmission of HIV (PMTCT) is the most essential of these, and is not particularly widespread in Burundi. UNICEF piloted a programme with the CNLS, but this had many problems, particularly in providing follow-up for the mothers. As a result, the government and most NGOs have been reluctant to start new PMTCT projects. Caritas and a few others are planning on new programmes learning from the mistakes of the UNICEF one. Table 6 shows that PMTCT funding is, at most, only \$620,000, just 39% of the budgetary requirement estimated in the national plan.

Another big gap, emphasised by UNFPA, is post-exposure prophylaxis, a short course in antiretrovirals for rape victims soon after the event which can dramatically reduce their risk of the HIV infection taking root in their bodies. Currently this is only provided in a few areas by MSF.

Table 6: Funding gaps US\$m 2004				
Intervention	Provision	Need	Gap	%Gap
IEC (Information, Education and Communication)	4.68	1.84	+2.83	+154%
Condoms	0.35	0.61	-0.26	-43%
VCT	1.24	0.65	+0.59	+91%
STI treatment	0.42	0.46	-0.04	-9%
Blood security	1.01	0.79	+0.22	+28%
PMTCT	0.62	1.59	<b>-0.97</b>	-61%
Psycho-social support	0.79	0.79	0	0%
OI treatment	3.23	14.02	<b>-10.8</b>	-77%
ARV treatment	3.08	18.10	<b>-15.0</b>	-83%
Advocacy for PLWA rights	0.49	0.19	+0.30	+158%
Orphans	5.00	1.12	+3.88	+346%
PLWA income gen.	1.23	0.40	+0.83	+208%
Research & evaluation	0.80	0.22	+0.58	+264%
Decentralisation	3.92	0.93	+2.99	+322%
Civil society	3.07	0.36	+2.72	+753%
CNLS costs	1.16	0.99	+0.17	+17%
<b>Total</b>	<b>31.1</b>	<b>43.1</b>	<b>-11.98</b>	<b>-28%</b>

## Options for funders

As a general rule of thumb, NPC recommends that funding should be long term (at least three years) and cover the full reasonable costs of operation, such as office rental, equipment and staff salaries. Many NGOs emphasised the problems they had with forward planning and project management because funders often only provide short term donations with strict restrictions on the activities they can be spent on.<sup>87</sup>

SWAA, for example, among its dozens of different donors has only one (Cordaid) which provides three year funding. It is particularly important that funding for drug treatment is long term, since there is a great fear among people with HIV in Burundi that even if money is available for treatment today, it may dry up in a few years time and they will have to come off treatment because at \$350 per annum it is impossibly expensive for most of them. Obviously



careful checks and balances are needed to prevent corruption or other misuse of funds, but this should be done primarily through reporting and evaluation.

### Strengthen the health system

The CNLS is the best organised in the region and worth funding directly.

NPC has a high regard for Burundi's anti-AIDS commission, the CNLS, which is currently the best organised in the region. Donors should provide it with direct financial support. Ideally this would be unrestricted funding, allowing the CNLS to allot it to areas it judges most critical, but providing careful reporting and accounting feedback to the donor.

A number of people interviewed were adamant on the importance of supporting the government systems. Although NGOs have less bureaucracy and are able to move ahead faster, the country is still unstable and NGOs might cease to function or leave when things get tense again. However, the hospitals and health centres will stay, whatever happens. One problem is that strong NGOs can lure qualified staff out of the public sector with better salaries and more opportunities for foreign travel.

One area NPC identifies as a funding opportunity and which the CNLS also considers critical, is developing a more equitable distribution of doctors and nurses around the country. Newly trained doctors need incentives to move to the provinces, such as a house near the hospital and an internet connection (to facilitate access to reference and training). Without trained medical staff throughout the country, effective distribution of antiretroviral drugs and the treatment of opportunistic infections will be impossible.

However, if funders do want to fund the CNLS directly, it is important this funding is accompanied by some technical support to make sure that national capacity building and change is lasting and sustainable.

#### Box 4: The role of churches

Burundi is a highly religious country, and the different churches can play both positive and negative roles in the fight against HIV/AIDS.

Condom use is a well-documented area of contention, but there are other less obvious, but important, issues which are relevant, such as the question of trust. One person interviewed explains that secular NGOs are often distrusted because people believe they are promoting promiscuity (indeed they are sometimes referred to as "sinfulness organisations") and because people suspect that they are really just schemes for making money from donors (as indeed some are).

The projects of other religious denominations may also be open to suspicion. As a result, churches may be unwilling to publicise available health services and members may decide against using them. This is particularly dangerous because people in church are likely to be particularly at risk because of the false assumption that Christians are unlikely to be infected. It is therefore very important to educate and resource the churches so they understand AIDS and work together to tackle it. This is precisely the goal of the **Christian Solidarity Against AIDS** network, which is working with the many fragmented protestant denominations. The government is considering establishing a forum for religious leaders. Properly harnessed, Burundi's churches could play a major role in disseminating information, delivering services and fighting stigma.

### Support an established local or international NGO

There are many excellent organisations working in Burundi which have a solid track record, clear accounts and either the capacity to expand their operations or a need to secure funding to continue their current work in the future.

Within the scope of this project NPC visited only a sample of many excellent NGOs working in Burundi, therefore those mentioned here are examples it found to be worth recommending and the list is not meant to be exhaustive.

Two of the largest and most highly respected local NGOs specialising in HIV/AIDS are SWAA and ANSS, both of which would be suitable recipients of funds.

**SWAA (Society for Women against AIDS in Africa)** is a well established organisation working in seven provinces, providing a full spectrum of services in collaboration with other NGOs and the government's anti-AIDS commission.

**ANSS** (Association Nationale de Soutien aux Séropositifs et Sidéens) was set up in 1993 as a grassroots organisation for people living with AIDS and began providing antiretrovirals in 2002. It is the largest provider in the country, treating around 1,000 people with a medical team of 16, including four doctors. It has another 2,200 people on file awaiting treatment when resources become available and has centres in Bujumbura, Kirundo, and is opening a new one in Gitega. It would like to expand to Makamba in the south, which is particularly remote. NPC was impressed with ANSS's detailed patient records and the organisation is planning on further improving its patient tracking system. ANSS also supports 300 orphans whose parents were members of the organisation.

There are also excellent non-specialist local organisations, such as **Caritas-Burundi**, which is an autonomous national organisation running five hospitals and 67 health clinics and hospitals throughout the country, and is part of the international federation of Catholic development agencies. It offers HIV/AIDS services, including voluntary counselling and testing, treatment of opportunistic infections and home-based care. In the future it plans on expanding testing, piloting prevention of mother to child transmission programmes and beginning antiretroviral treatment in partnership with an organisation which already has experience implementing treatment.

**CPBU** is a project of the local Pentecostal churches which currently runs six health clinics and plans to open another three this year.

**Scripture Union** has a sophisticated programme (Espoir Pour L'Avenir) to provide detailed HIV/AIDS education for children and help couples to actually practise faithfulness through marriage support courses in which partners learn how to communicate effectively and resolve conflicts which could lead to unfaithfulness.

**Rainbow Centre** (below) is an excellent orphan care project, which supports about 350 young children most of whom are fostered and hopefully adopted. The centre has accommodation for HIV positive women who are deciding whether to foster their infants. Apparently it is the only organisation in Burundi working with infants, as the other relevant organisations (**FVS**, **APECOS** and **Orphan's Aid**) work largely with older children.



Other well respected local NGOs that NPC did not have time to meet include **ABUBEF**, which works on family planning, and **Nouvelle Esperance**, which provides home based care for around 800 people with AIDS.

International NGOs working on AIDS include JRS, GVC, ADRA and PSI. **JRS (Jesuit Refugee Service)** is a Catholic relief agency which works with local parishes and health centres to deliver a full range of services (prevention, testing, nutrition, opportunistic infection treatment, establishing AIDS support groups, paying funeral costs) in about 15 communities in Bujumbura and Bujumbura-Rural.

**GVC (Gruppo Volontariato Civile)** is an Italian relief agency which focuses on tackling acute malnutrition in Bujumbura-Rural through therapeutic feeding centres. It has discovered

that a large number of people passing through its centre are relapsing into malnourishment as a result of AIDS. At present about 100 HIV positive people reside in their centres and another 570 receive monthly parcels of food and prophylaxis for opportunistic infections. It would like to establish a residential antiretroviral treatment unit, something which would probably be a first in this area of Africa where treatment tends to be non-residential.

**ADRA** (Adventist Development and Relief Agency) has run an HIV/AIDS project since 2000. Funded by Belgium, it now serves about 250,000 people in seven zones of Bujumbura. It works through the local health centres, training personnel and providing HIV testing and drugs for opportunistic infection. Together with the CNLS it has established a trial antiretroviral drug treatment project for 30 people.

**PSI** (Population Services International) specialises in marketing condoms on a non-profit basis, selling about two million a year (half the total distributed in Burundi). It educates people about prevention, particularly groups at risk, including youth, prostitutes and displaced people.

### Build the capacity of smaller local NGOs

In a country such as Burundi there is an understandable reluctance among donors to fund small and untested NGOs for fear the money will be used ineffectively or even corruptly, and also because making many small grants is far more expensive and time-consuming than making a few larger ones. However, the example of exemplary Burundian NGOs such as SWAA, which was small and untested itself only a few years ago, demonstrates the potential of some local organisations.

Tackling AIDS requires action at many levels, and smaller NGOs may have effective new ideas and approaches or the ability to cater for a particular region or social group. Also there are many local associations of people living with HIV/AIDS who could benefit from micro-grants to fund income generating projects and other activities.

In general NPC would not recommend the direct funding of small NGOs. The best way of providing seed funding to them is through an intermediary that can assist with the selection of appropriate projects, handle the logistics of grant disbursement, provide support to the NGO and monitor feedback to the donor. One option is to use the governmental structures as an intermediary, either on a national level (the CNLS) or focus on a particular province (through the relevant CPLS). The advantage of doing this is that it facilitates coordination and reduces the risk of parallelism and duplication.

If donors prefer not to distribute funds through the government, then there are a number of larger established NGOs, both local and international, who could perform a similar function. One of the most suitable is **Handicap International** which has been established in Burundi since 1994 and played a central role in SWAA and ANSS – now the largest HIV/AIDS local NGOs – when they were starting out and is now assisting 30 smaller NGOs.

**ActionAid** would be another good choice, as it has been managing the UK government funded SIPAA project for the last few years, the aim of which is to support local communities and civil society in responding to AIDS.

A third option is to fund through the Burundian NGO umbrella group **ABS (Alliance Burundaise contre le SIDA)**, which comprises about 80 local NGOs and was founded in 1999 to provide coordination, advocacy, and a forum for sharing best practice and skills training in areas such as financial control and project management. It is well equipped to identify suitable recipients and provide them with technical support and monitoring. **RBP+ (Reseau Burundais des Personnes vivant avec le VIH/SIDA)** is a network of 3,000 people living with AIDS across the whole country, organised into many local associations that distribute grants.

## Section 3: DRC

**The Democratic Republic of Congo has suffered extensively from civil war. Parts of the country are also extremely inaccessible because its infrastructure has never been fully developed. Consequently, in some parts of the country the HIV/AIDS epidemic is not as acute as elsewhere in Africa, but there are still urgent healthcare issues. These factors have implications for funding responses to HIV/AIDS.**

This section first describes the DRC's history, social background, and HIV prevalence, and then examines existing provision for those affected and how international donors are supporting these efforts. It also highlights the gaps in response and explores the options for funders in a number of areas.

In May 2004 NPC met 11 NGOs in Kinshasa, along with UN agencies, donors and government representatives. Unfortunately the renewed conflict in eastern Congo, starting in June 2004, prevented direct experience of this region where need is among the highest in the country.

### History

The DRC was created in the 1880s in one of the most unusual and cruel episodes of colonialism. King Leopold of Belgium, hungry for the financial and political clout of an empire, personally financed the creation of the Congo Free State, initially under the auspices of the American explorer Henry Morton Stanley. Because of the cataracts which limited the navigability of the Congo river and the dense rainforest basin, the other European Powers (France aside) were not particularly interested in the region and granted Leopold's *personal* claim to it at the Conference of Berlin in 1885. Leopold had styled himself as a philanthropist, spending his money in a difficult region of Africa with little hope of return in order to benefit the native people. In reality his agents established a harsh system of forced labour to exploit rubber and other resources, killing millions of Congolese in the process.

Gradually information about what was happening in the Congo trickled out and the Congo Reform Society and others campaigned for change. Belgium eventually took Congo out of King Leopold's personal control in 1908 and turned it into a more conventional state-owned colony. Some things may have improved, but there is good evidence that many of the abuses and atrocities continued throughout the half century of direct Belgian control. Following serious riots, independence was hurriedly granted in June 1960. The first few years were chaotic: Patrice Lumumba, the first prime minister, was murdered (reportedly with US and Belgian complicity), the rich Katanga province briefly seceded, and finally in 1965 General Joseph Mobutu took control in a coup. By 1971 Mobutu's power was so absolute that he even renamed the country Zaire.

Mobutu's government was one of the most corrupt in the world, with little investment in infrastructure or public service. By 1991 the country was in such severe financial straits that even the army was not being paid and consequently soldiers looted the capital Kinshasa. After this, Mobutu's personal power diminished considerably.

In 1996-7 a coalition of rebel groups from the eastern Kivu region, led by Laurent Kabila and backed by Rwanda and Uganda, achieved a series of rapid victories against the disorganised Zairean army and swept across the country all the way to Kinshasa. Mobutu fled (and died soon afterwards of prostate cancer) and Kabila became president of a transitional government. Unfortunately Kabila quickly fell out with his Rwandan and Ugandan allies, resulting in a second civil war in July 1998 when Kabila issued a decree expelling Rwandan troops from the newly renamed Democratic Republic of Congo. The Rwandan and Ugandan backed groups, particularly the Rally for Congolese Democracy and the Movement for the Liberation of the Congo, once again made rapid gains in the east. Kabila allied with various groups in the east such as the Mayi-Mayi and also got support from Angola, Zimbabwe and other countries to secure the west, turning the conflict into what US Secretary of State Madeleine Albright called "Africa's First World War".

Divisions and in-fighting among the rebel groups, reflecting in part the growing friction between Rwanda and Uganda, resulted in a stalemate leading to a partial ceasefire in July 1999. Kabila was assassinated in January 2001 and quickly succeeded as president by his son Joseph. UN efforts resulted in the departure of all foreign troops in 2002, and the African Union brokered a two-year power sharing transitional government which took office in

Since 1996 DRC has been ravaged by "Africa's First World War".

September 2003 with Joseph Kabila as president, and four vice-presidents representing the main rebel groups. An attempt has been made to unite all the militias into a new DRC national army. There have been some serious incidents in the last few years, including ethnic conflict around Bunia in the northeast in 2002 and around Bukavu in July 2003, but the transitional government has just about held together.

The conflict since 1996 has claimed an estimated three to five million lives, most of them indirectly through starvation and disease. The various groups have been motivated in part by ethnicity but also by Congo's natural resources, such as diamonds and coltan (a key material for mobile phones circuits).

## Social context

The DRC was a poor country even before the recent round of civil wars. Child mortality is 205 per 1,000 nationally, the world's ninth highest rate, and probably nearing 300 in the east. Between 2000 and 2002, infant mortality increased by 40% in the east, and Médecins Sans Frontières reports that half of all infant mortality is a result of malnutrition. Aside from HIV/AIDS, the DRC is ravaged by many diseases. 2003 saw outbreaks of cholera, haemorrhagic fever, ebola, measles and virulent flu. Polio has not been eradicated. In 1987, 58% of children were attending primary school, but by 1998 it had dropped to 32%. There were around 410,000 refugees abroad at the end of 2002 and around 2.5 million internally displaced people in September 2003, mainly in the east. The World Food Programme was providing 483,000 people in eastern DRC with food aid in August 2003 and estimates that about 17 million people from a population of 53 million face significant food shortages. As regards the physical infrastructure, little was built under Mobutu and much destroyed in the wars. Only about 10% of the road network from the Belgian period remains passable, leaving large areas of the country virtually cut off from each other.

Health services are largely provided by small health clinics and a few hospitals run variously by churches, NGOs, private practices and the state. The government has recently paid salaries to the health sector for the first time in a decade, a period during which state doctors and nurses were either funded by foreign NGOs or charged private practice fees. In general patients have to pay to use health services, although in some circumstances these are provided subsidised or free. The health infrastructure is minimal, as is most people's ability to pay.

In a seminal report on eastern Congo, Human Rights Watch writes: "Compared to other parts of eastern, central, and southern Africa, even those that are poorly served by health services, eastern Congo is desperately lacking in services related to HIV/AIDS. Services meant to prevent HIV/AIDS are almost nonexistent. The public health promotional messages and information campaigns that have come to be fairly widespread through much of Africa are virtually absent in eastern Congo."<sup>88</sup>

Some figures from Oxfam<sup>89</sup> underline the health care challenges across the whole country:

- At least 37% of the population has no access to any kind of formal health care.
- There are just 2,056 doctors, of which 930 are in Kinshasa. Outside Kinshasa there is only about one doctor for every 30,000 people. (In a developed country like UK there is one doctor per 600 people).<sup>90</sup> In fact the situation is even worse than these figures indicate as anecdotal reports suggest a large number of doctors are doing desk jobs rather than actively delivering services.
- DRC is ranked 152 on the UNDP index of 174 countries, a fall of 12 places since 1992.
- Two and a half million people in Kinshasa live on less than \$1 per day. In some parts of eastern DRC, people are living on just \$0.18 per day.

## Prevalence of HIV

Although surveillance systems were set up in the late 1980s and 1990s, because of the general problems of infrastructure, HIV testing is not widespread and data collection is limited. What is available is a range of anecdotal reports from voluntary testing centres in various locations. The official WHO estimate for the national prevalence in DRC is 5.1%, a figure that has hardly changed in a decade. The World Bank estimates prevalence somewhere in the region of 5-8%. The national AIDS programme (the PNLS) is currently working with the US Centers for Disease Control to develop better data.

The social context is dire. Over a third of the population have no access to formal health care.



Apart from in the East, HIV prevalence has been stable at 5-8% for decade, there are various theories why this is the case.

The low level of prevalence relative to many other African countries is surprising in light of the chaotic history of the country and the subsequent lack of health infrastructure. Reasons for this include:

- A natural **genetic immunity**. The argument is that HIV has been in circulation for the longest time in this region (perhaps for centuries) and a natural immunity may have developed, although there is little scientific evidence of this. The most common strains of HIV in the DRC may also be less virulent than the mutated varieties which have devastated other parts of Africa.
- **Sexual behaviour**. Whereas in other countries it is common for men to have many partners and use prostitutes, in the Congo it is traditional for a married man to have a long term mistress (a so-called "deuxieme bureau").<sup>91</sup> While fidelity is obviously most effective at reducing the spread of HIV, this Congolese preference for polygamy over promiscuity may be less risky (however if it results in lower levels of condom use it might actually be more risky than broader promiscuity using condoms). However, it is controversial whether this theory does accurately describe current sexual behaviour. One recent study finds Congolese men had four to five partners in the previous six month period.<sup>92</sup>
- **Early action** by the government. The DRC was one of the first countries to recognise and tackle HIV in the 1980s, although efforts fizzled out in the 1990s when the country descended into chaos and the PNLs itself was looted by soldiers. As recently as 2001 there were insufficient funds to operate the PNLs. As a result the older generations who received AIDS education tend to have better knowledge than those under 30 who missed out on this.
- **Public awareness**. There is some degree of openness in DRC about HIV/AIDS and it is discussed in public, not unlike Uganda. The first pop songs about HIV came from the DRC.<sup>93</sup>
- **Death by other means**. The high mortality rate from war and famine, which has claimed about four million lives since 1997, may have limited the spread of HIV as infected and vulnerable people have died before transmission can occur.
- The **isolation** of most of the Congolese population. This is probably the major reason. HIV has typically spread most rapidly in regions with mobile workforces, such as the truckers of East Africa and the miners of Southern Africa. The lack of passable roads and stagnation of the economy have meant that, aside from refugees displaced by conflict, there has been little regular population movement.

Reports suggest that prevalence varies considerably by location and is greater in parts of the eastern provinces, which have suffered the brunt of the conflict. Lumumbashi, Bukavu and Goma all have higher prevalence levels, as does Matadi, a trading port in the west bordering Angola.<sup>94</sup>

The prevalence in parts of eastern Congo might be as high as 25%.<sup>95</sup> High prevalence levels have been recorded at certain sites in Bukavu on the Rwandan border, although the evidence is not yet good enough to make a reliable estimate for the general population. The Médecins Sans Frontières VCT centre in Bukavu measured 17% in 2003.<sup>96</sup> A study in Bukavu General Hospital found levels of 32% among males, 54% among women and 27% among children.<sup>97</sup> Rates are also high among certain risky groups, such as sex workers and combatants (estimated at 60% by US Institute of Peace, but the source of this figure is unclear).<sup>98</sup>

Even if the overall prevalence levels in Kinshasa appear stable, a number of experts warn there is a worrying increase in incidence among young people which will translate in due course into a rise in total prevalence.<sup>99</sup>

## Effects of AIDS

In 2001, public health officials estimated that 1.3 million people were infected with HIV with 173,000 new infections per annum.<sup>100</sup> However the National Aids Control Programme (PNLS) now estimates there are 2.4 million HIV positive people. 15% (356,000) of them have developed full-blown AIDS and so are in need of antiretroviral drugs.<sup>101</sup> Currently less than 2,300 people are on medication, the vast majority in Kinshasa. These are mainly wealthy people who can afford the \$29 a month charged by Indian generic manufacturer CIPLA (the total cost of delivery is about \$50 per month including testing and administration).<sup>102</sup> This means that less than 1% of people in need of it are receiving appropriate treatment.

The families and communities of people with HIV/AIDS are also affected by the pandemic. UNAIDS estimates that 930,000 children have been orphaned because of AIDS. AMO-Congo, one local NGO that works with orphans, estimates that 10% of those under its care are themselves infected with HIV. This would imply that nationally between 50,000-100,000 children are infected.

## Existing provision

### Governmental response

The government's health budget in 2002 was \$199 million, 96% of which came from overseas donors. This works out at \$3.3 per person per annum. Of this total, \$23 million was set aside for AIDS. The DRC was, in fact, the first country in Africa to establish a national HIV/AIDS coordinating body. Although the PNLS (the national AIDS programme) does not extend much beyond the confines of Kinshasa, it is nonetheless an achievement that the programme has continued to function given the turmoil in the country and many changes in government.

### International organisations and funders

At present NPC calculates that about \$40-50 million is being spent on HIV/AIDS by foreign donors in the DRC, including the \$23 million going to the government. NPC has not been able to obtain precise figures of contributions, but estimates that \$15-25 million may be going to local and international NGOs. This means that about \$20 is being spent annually per person infected with HIV, or \$1 per capita across the whole population.

The most important new funds are commitments of \$35 million each from the **Global Fund** and the **World Bank** over the next two years, with a combined total of \$215 million pledged over five years. That is an additional \$18 per annum per person infected with HIV. These new funds are roughly doubling the amount of resources dedicated to AIDS.

Until about two years ago little HIV/AIDS work was happening outside of Kinshasa. Since then, international agencies and local NGOs have expanded operations to most of the 11 provincial capitals and a few other cities accessible by plane. Very little, however, is happening outside of these cities because most roads are impassable, particularly in the central and northern areas within the rainforest canopy.

The **German Technical Cooperation, GTZ**, is active in DRC and **King Baudouin Foundation** is collaborating with it to fund (\$370,000)<sup>103</sup> and develop initiatives in Lubumbashi and Kivu, providing voluntary counselling and testing and prevention of mother to child transmission.

### Antiretroviral therapy (ART) and prevention of mother to child transmission

The international NGO **Médecins Sans Frontières** runs two ART programmes treating 329 people in Kinshasa and 127 people in Bukavu, in eastern DRC.<sup>104</sup> There are a number of new antiretroviral projects in the pipeline for later this year, such as a 200 person programme in Kinshasa by the University of North Carolina and a 300 person programme in Bascongo and Equateur by the Belgian Technical Cooperation.

Despite the new programmes, the total number receiving drugs will still remain less than 5,000. The two big funding streams coming online from July, from the Global Fund and World Bank, are likely to provide medication for 15,000 and 5,000 people respectively.<sup>105</sup> Even after the new multilateral funding is implemented, around 330,000 people with full blown AIDS will still be without drugs. In theory it would cost at least \$200 million a year to provide all of these people with medicine, three to four times the resources currently deployed.

Hundreds of new medical staff would have to be trained to administer the drugs properly and a vast programme of testing would be needed to identify eligible patients. It would be an impressive achievement to provide treatment for even half of the urban population living with AIDS, around 100,000 people. One of the challenges in the provision of antiretrovirals is the availability of laboratory testing, although there are pilot projects in other parts of Africa trying to explore the possibility of drug delivery using symptom indicators rather than laboratory tests.<sup>106</sup>

Annual spending by donors on HIV/AIDS is about \$40-50m

A cheap and easily administered drug, Nevirapine, can halve the risk of HIV transmission from mother to child. In the DRC, UNICEF is a leading provider, working in 20 health centres in Kinshasa, Basongo and Sud Kivu. The German Technical Cooperation (GTZ) has provided treatment to 3,000 women in Kinshasa and 800 in Bukavu; it is now extending the programme to Lubumbashi and Matadi. The University of North Carolina School of Medicine aims to ensure voluntary testing and medication is available to 60% of pregnant women in Kinshasa.

## Prevention

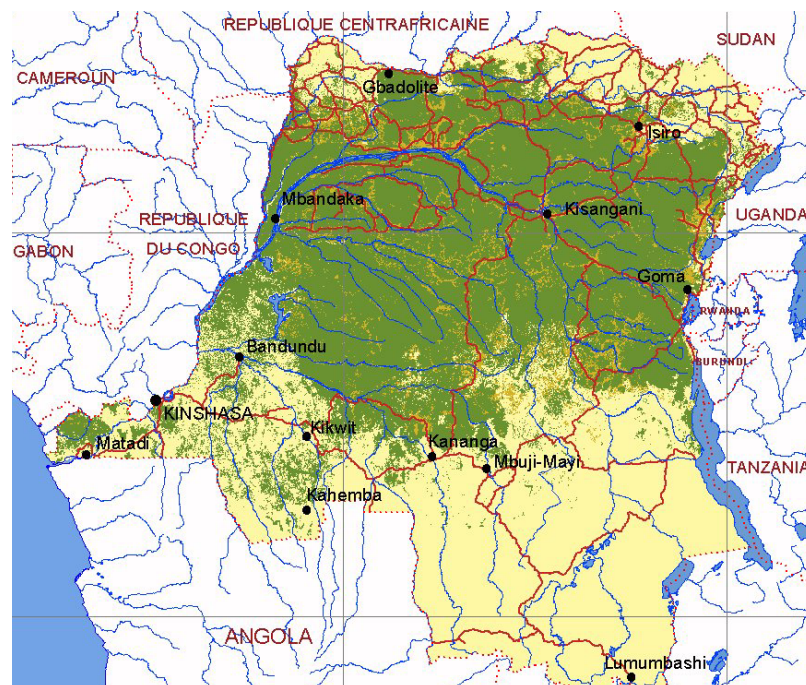
It is difficult to assess prevention activities across the whole country. There are many local NGOs that focus on educating people about prevention and international NGOs that provide it as a part of all their programmes. The leading organisation is Population Services International (PSI) which has been marketing condoms on a non-profit basis for 15 years. Their condoms are now widely available and 22 million were used in 2003. NPC does not recommend funding general prevention activities, as these are well covered by the PNLS and by the multilateral donors.

However, there may well be some strategic opportunities available, such as extending PSI's well established prevention programme on transport routes across southern Africa to the new roads currently being built in the DRC. One critical project is the Kivu-Kisangani highway, funded by the European Union, which will re-link the densely populated Kivu region in the east with Kinshasa (by road and then by river). This should result in an extremely beneficial boom in trade, but could exacerbate the spread of HIV, since prevalence rates in the Kivus are the highest in the country.

There is a clinic in Matonge targeting sex-workers, which has shown significant improvements in HIV prevalence (2002) since the early days of its activity in 1988. This is a project set up by the Centre of Disease Control in Atlanta and the Institute of Tropical Medicine in Antwerp, with the involvement of the Congolese government. The advantage of tackling sex-workers is that this then reduces the spread of HIV to their client population.

The German and Belgian development coorporations, GTZ and BTC, are leading the way in ensuring that 60,000 yearly blood transfusions are uncontaminated by HIV. They operate in most provinces, with GTZ focusing on the urban areas and BTC on the countryside. BTC claims about 70% of blood is now safe.

## Gaps in provision



Given the enormous challenges in delivering services across inaccessible terrain, there are gaps in provision everywhere one visits. However, there are marked geographical areas which lack more than others.

Many experts agree<sup>107</sup> the greatest unmet need is in the more remote provinces – Bandundu, Equateur, Kasai-Occidental, Maniema, Nord Kivu and Oriental – where there is poor transport infrastructure within the rainforest and there has been recent conflict. The rural areas, where half the population live, are badly served across most of the country. World Bank funding will focus on five provinces (Kinshasa, Sud Kivu, Katanga, Kasai-Oriental, and Oriental<sup>108</sup>) which have the greatest existing capacity for tackling HIV/AIDS. Private donors could focus on the other provinces.

GTZ Sante has just completed an excellent mapping exercise<sup>109</sup> for each province which NPC used to identify gaps in provision (see Table 7, ranked according to the current level of provision). Analysis of the mapping confirms that Bascongo, Kinshasa and Sud Kivu are well-provisioned, in relative terms, while the remoter provinces mentioned above have fewer NGOs operating on smaller scales and lack certain key interventions completely. There is currently no antiretroviral provision in Bandundu, Equateur, Kasai-Oriental, Maniema or Oriental. There is no prevention of mother to child transmission programme in Equateur or Oriental, and no systematic treatment of opportunistic infections in Kasai-Oriental or Oriental. Kasai-Occidental does not even have the most basic interventions such as HIV testing, psychosocial support or care for orphans. Key groups at risk, such as homosexuals, rape victims and refugees, are not receiving targeted support in most of these provinces.

The greatest unmet need is in the remote provinces within the forest canopy

**Table 7: Implementers and gaps in provision by province**

Province	Cities	Implementers	Gaps + (minimal provision)
Kinshasa	Kinshasa*	Many	few
Bascongo	Matadi	Many	few
Sud Kivu	Bukavu*	MSF-H, GTZ, CA, UNICEF	Coordination
Katanga	Lumbumbashi*, Kongolo	AMO-Congo, MSF-B, SWAA, PSI	(PMTCT)
Nord Kivu	Goma, Masasi	DOCS, MSF-H, MdM	(Psychosocial)
Bandundu	Bandundu, Kikwit	FFP, BTC, ABEF	STI, ART, Laboratory support (PMTCT, OIs)
Maniema	Kindu	MERLIN, UNAIDS, BDOM, FFP	(OIs, ART)
Kasai-Occidental	Kananga	UNICEF, FOMETRO, GTZ, SANRU	Psychosocial, VCT (OIs, ART, PMTCT)
Kasai-Oriental	Mbuji-Mayi*	UNICEF, FHI, UNFPA	OIs, ART, Laboratory support
Oriental	Kisangani*, Bunia	MSF-B, FFP, GTZ	PMTCT, OIs, ART
Equateur	Mbandaka	MSF-B, GTZ, FOMETRO, BDOM	PMTCT (VCT, OIs, ART, Laboratory support)

\*Areas likely to receive World Bank funding in the first year.

## Options for funders

### Strengthen the health system

Given the state of the infrastructure and low levels of development in some areas, many experts recommend that interventions relating to HIV/AIDS should not be stand-alone, but must be integrated with wider health and development initiatives, whether governmental or non-governmental.

It is hard to talk about a national health system as such in the DRC. Hospitals and clinics have kept afloat during long years without investment or salaries from the government by charging fees or receiving support from NGOs and churches. However, in the long term it is critical for this vast country prone to outbreaks of disease to have a health system with national coverage. At the moment this job is best left to governmental and multilateral



donors, and private donors should focus on supporting the reasonably dynamic civil society organisations.

### Support an established local or international NGO

As has been mentioned, the principal organisations delivering HIV/AIDS interventions are international NGOs, UN agencies (particularly UNICEF and UNFPA), local NGOs and churches, many of which are suitable recipients of funding from private donors.

- **International NGOs** include: Christian Aid, Concern, Cordaid, DOCS, FHI, Fometro, Medecins du Monde, Merlin, MSF, Population Services International, Save the Children and the University of North Carolina.
- **Local NGOs and churches** include: AMO-Congo, Fondation Femme Plus, SWAA, PAHO, Caritas (Catholic Church), SANRU (Eglise du Christ Congo), and the Salvation Army.

**Christian Aid** has played a leading role in setting-up AmoCongo and FFP (Fondation Femme Plus), which are now two of the leading local NGOs. It continues to provide them with part of their funding as well as training and support, and is one of the most experienced organisations at capacity building in the DRC. Another promising initiative is its work with an openly HIV positive Baptist pastor to train other clerics, a strategic way of tackling stigma and delivering messages about HIV/AIDS in churches, where they are more likely to be digested.

AIDS is one of the four core themes for **Cordaid**, which has a budget of \$4 million. In Kinshasa it focuses on psychosocial support and prevention through films and talks by people with AIDS. In Bukavu it works with Caritas to provide voluntary counselling and testing, peer education and support for orphans.

**Concern** has been running an HIV programme since 2003 in the poorest parts of Kinsenso Commune, itself the poorest region of Kinshasa. It works through local community NGOs who are able to go door to door, working on prevention and home based care.

**Medicine du Monde** is involved in Kinshasa and the east, with a total budget of \$2 million. In Kinshasa it provides STI treatment in 40 clinics. In Goma it provides testing and treatment of opportunistic infections as well as general STI treatment, and hopes to start antiretroviral treatment.

**PSI** (Population Services International) is as impressive in the DRC as in other countries in the region. It has been in Congo since 1987 and sold 22 million condoms in 2003. It carries out prevention work with the military and the police, and campaigns for behaviour change. One interesting programme it could develop is intensive prevention work with truckers. As the roads are repaired and trade begins to flow once more, prevention work will be needed in the southern half of the DRC, especially near the borders with Angola and Zambia.

**UNICEF** is active in the fields of prevention of mother to child transmission, youth behaviour change through peer educators and orphan care in Kinshasa (it estimates 10% of children are orphans, a third as a result of AIDS).

**AmoCongo** is one of the most respected local NGOs with a particular focus on orphans. It supports 5,000 children, a quarter of whom receive regular food and 80 of whom get vocational training. It operates a number of health clinics geared towards HIV/AIDS, providing free testing and opportunistic infection treatment. It works in Kinshasa, Bacongo and Lumumbashi and would like to expand operations to Mbuji-Mayi in response to





frequent requests for assistance there.

**Caritas-DRC** probably has a more extensive network than the government, through the 1,505 parishes and 47 dioceses of the Catholic church with a relay system which keeps the Kinshasa office informed on a daily basis about the situation on the ground. HIV is a significant component of its work across the country, and it is even beginning to provide antiretroviral drugs on a small scale.

**FFP** (Fondation Femme Plus) works with 5,000 adults and orphans in Kikwit, Baongo, Kisangani, Kindu and Gomas as well as in Kinshasa. It provides a range of services, including home visits by volunteers, treatment of opportunistic infections, training for people living with AIDS and material help. An exciting new initiative is a telephone help line, the first of its kind.

The association of PLWAs, **PAHO**, is seriously under-resourced even compared to its poor counterparts in Rwanda and Burundi. Nonetheless, it is full of energy and involved with tackling discrimination, educating HIV positive clergy, encouraging home based care and developing income generating projects.

**SWAA** (Society for Women against AIDS in Africa) has been running since 1989 in the DRC, making it one of the most established NGOs in this field. It works particularly with sex workers, young mothers and girls. Activities include an income generation project and nutritional support. It also operates in a number of remote areas, such as Bunia and Kananga.

**The Salvation Army** runs 28 health clinics, mainly in Kinshasa and Basongo. As part of this work it raises awareness about HIV, provides testing and counselling on a means tested basis and refers people in need of medication to other organisations.

### Build the capacity of smaller local NGOs

One considerable area of need is building capacity among Congolese organisations so they are able to receive grants from the Global Fund and World Bank and implement effective, coordinated and accountable programmes. At the moment there only appear to be a handful of local NGOs (BDOM, SANRU, AMO-Congo, FFP and SWAA) with the scale, experience and credibility to do this. However, there are hundreds of small and often newly formed NGOs, and although some are poorly managed and even corrupt, many could become effective service deliverers. Experts recommend looking at ways of training and supporting these smaller NGOs.<sup>110</sup>

Another problem which could limit the impact of the new multilateral funding is the poor level of coordination between the various participating organisations, both funders and implementers. Private donors are ideally suited to finance coordination activities (such as the maintenance of a detailed online database of need and delivery by the many different organisations, encouragement of regular discussions on priorities between agencies, workshops and round tables) which, while not glamorous, are essential to ensure resources are effectively and equitably distributed.

NPC has noted that in the DRC, collaboration is not as good as it might be and therefore support for initiatives that foster exchange of information and collaboration would be helpful. This would include cross-border collaboration, particularly in the light of the movement of displaced people.

Capacity building among local NGOs will help them utilise the World Bank and Global Fund money.

## Section 4: Rwanda

**Rwanda is a small, compact country with reasonable infrastructure. However, its history of violent conflict and its proximity to East Africa has left a legacy of higher HIV prevalence than the DRC or Burundi. Consequently, Rwanda has caught the attention of the international community and attracts reasonable levels of international funding.**

**There are good opportunities for funders. Strong bilateral support for national efforts might ease some of the country's logistical problems. Activities that supplement national efforts are most likely to be successful in the long term. However, funding at the top level is not yet reaching those affected on the ground. Donors also need to be wary of duplicating international efforts.**

This section first describes Rwanda's history, social background, and HIV prevalence. It then examines existing provision for those affected and how international donors are supporting these efforts. In July 2004 NPC met 11 NGOs in Rwanda, many operating outside of the capital, as well as UN agencies, donors and government representatives.

### History

Not much is known about Rwanda's history before colonialism, although since the 15<sup>th</sup> century it has been governed in a highly centralised way. Another feature is the distinction between Hutu and Tutsi tribes/classes. Originally Tutsis were the herders who formed the wealthier and ruling class, while the Hutus were agriculturalists. This division became more pronounced in the 20<sup>th</sup> century when first the Germans and then, from 1923, the Belgians, ruled Rwanda through the Tutsi feudal monarchy. Racist Europeans propounded a pseudo-scientific eugenics theory that the Tutsis were a genetically superior race originating from the north.

As colonialism began to unwind in the late 1950s, the Belgians switched their support from the Tutsis to the majority Hutus, and the transition to independence was marred by ethnic cleansing. Extremists whipped up the long ingrained Hutu resentment of Tutsi leadership and the fear that the Tutsis still might dominate the independent Rwanda. There were bouts of ethnic conflict throughout the 1960s. In 1973, a military coup led by Juvenal Habyarimana established a military government, which although authoritarian, did at least bring a measure of peace and stability.

However, ethnic conflict in Burundi stirred the situation in Rwanda (particularly in 1988 when 50,000 Burundi Hutu refugees fled into Rwanda) and the earlier bouts of violence against Tutsis resulted in hundreds of thousands of exiles. Many of these lived in Uganda and participated in Museveni's successful rebellion in 1986. These Rwandan Tutsi soldiers left the Ugandan army and formed the Rwandan Patriotic Front which invaded northern Rwanda in 1990. The RPF made some successful incursions, nearly capturing Kigali at one point. As a result, Habyarimana signed a power-sharing agreement in Arusha in August 1993, which was never properly implemented. Then in April 1994 a plane carrying both Habyarimana and the Burundian Hutu President was shot down as it approached Kigali airport. The RPF (probably incorrectly) was blamed which justified the launch of the infamous genocide in which Interhamwe militias killed nearly a million people, both Tutsis and moderate Hutus, in just 100 days. Neither the UN, nor any of its members, attempted to stop the genocide, which only ended when the RPF conquered the country.

Fearing retribution from the RPF, millions of Hutus, both those who participated in the genocide and those who did not, fled into bordering countries, particularly the DRC and Tanzania. In the camps the UN agencies and many NGOs provided considerable relief for the refugees, essentially financing the creation of a state in exile run by the Interhamwe. From the refugee camps, particularly the ones in Goma and Bukavu, the Interhamwe planned to reconquer Rwanda, and the northwest was a battlefield until 1997. Eventually the RPF successfully defeated the Interhamwe and repatriated the refugees, who had been forcefully prevented from returning by the Hutu militants who ruled the camps. The RPF stayed in the DRC from 1996 to 2002, playing a key role in overthrowing Mobutu and then later fighting against his successor Laurent Kabila. Perhaps 15,000 Hutu militants remain in the east of the DRC to this day, and are a source of tension in the region. Rwanda recently threatened to re-enter the DRC after a massacre of Tutsis on its border with Burundi.

**15,000 Hutu militants, who were responsible for the 1994 genocide, remain over the border in DRC.**

## Social context

Rwanda, with 8.5 million people, is the most densely populated nation in Africa with few natural resources or sources of income aside from agricultural land. The 1994 genocide wiped out around 10% of the population, 800,000 people, and a further 250,000 were killed in ethnic violence between 1959 and 1998. Almost two million Hutus fled into the DRC, Tanzania and elsewhere after the genocide, but almost all of these have been repatriated now. The average life expectancy is 38 years<sup>111</sup>, with malaria the leading killer closely followed by HIV/AIDS. The statistics are stark: only 41% of the population has access to safe water and only 8% to adequate sanitation. Out of every 1,000 children, 183 die before reaching adulthood and 43% of children under 15 are at least moderately stunted from malnutrition. All in all, Rwanda's Human Development Index (HDI) is .422, ranking it 158 out of 175.



Half a million people  
are infected with HIV

## Prevalence of HIV and Effect of AIDS

At the end of 2001, UNAIDS and WHO revised national data relating to HIV prevalence. In Rwanda, they estimated that adult prevalence was around 9% and that 500,000 adults and children were infected. As well as spreading through similar means as in other parts of Africa (such as via long distance truck drivers), there has been an explosion in HIV infection resulting from the genocide and vast population movements during the last decade, which has also largely erased the variance between the urban and rural HIV prevalence levels.

A study by AVEGA of 1,000 women in three provinces who had been raped came up with the shocking conclusion that two-thirds of these women were HIV positive. A UNAIDS survey shows that 3.2% of women reported being raped. Of this group, more than 50% were HIV-positive. Many anecdotal reports claim that during the gang-rape of Tutsi women in the genocide the rapists explicitly said they were trying to infect the women with HIV.

Another specific Rwandan issue is the release of the many tens of thousands of prisoners who have been captive for a decade because of involvement in the genocide. Their integration back into the community poses a serious risk because many are likely to be HIV positive (from unprotected homosexual intercourse in jail, still a big taboo in Rwanda) and will spread the virus as they return to former partners and make use of their new found freedom.

Although most of the population now has a reasonable understanding of the basics of HIV/AIDS, there are important gaps. One survey shows 47% of women and 57% of men are unable to identify signs of sexually transmitted infections (STIs) on the opposite gender.

STIs have their own direct effects, but more significantly, they increase the risk of HIV transmission during intercourse by about a factor of ten.

AIDS is clearly putting a strain on the health system. In Kigali Central Hospital, 70% of the beds are taken up by people with AIDS. UNICEF estimates there are 250,000 AIDS orphans.

## Existing provision

### Governmental response

There is high level government commitment to tackling HIV/AIDS from President Kagame, who has appointed a minister of AIDS. His wife is also actively involved with her own AIDS NGO.

In 2002, Rwanda released a new five year National Plan for HIV/AIDS, which was prepared in a participatory fashion with input from officials, NGOs, people with AIDS, faith groups, civil society and the private sector. The budget of this programme is about \$69 million, most of which will come from foreign donors. This is not the only plan for Rwanda, others will be described in more detail below. However, firstly it may be helpful to describe the rather confusing structure of the government's response to HIV/AIDS.

There is a **Minister of State for HIV/AIDS**, which is a special appointment within the Ministry of Health. There is also a national anti-AIDS commission, the **Commission Nationale de Lutte contre le SIDA (CNLS)**, which cross-cuts all ministries. It manages the distribution of World Bank MAP funds and now also the SIPAA funds from the UK's Department for International Development's funds. It has constructed a database of activities and gaps, and is also tracking funding flows. The government is trying to decentralise the CNLS into 12 provincial offices and 106 district level branches. However, there is not always enough financial support, so regional offices are under-staffed and many decisions are still taken in Kigali.

NPC met with one of the provincial commissions in Kibuye province to get a snapshot of activity on the ground in a rural area. It explained there were 17 active local NGOs, and no international ones although some were indirectly funding local ones. The province has two hospitals and four HIV testing centres, but no capacity to provide the essential follow-up counselling to people who test positive. The main support structures for them are 20 small PLWA associations.

Another government organisation, the **Treatment Research AIDS Centre**, deals with the technical and medical side of HIV/AIDS. It certifies which doctors can prescribe antiretrovirals and manages the national supply of the drugs, which currently cost about \$20 per person a month at the subsidised rate supplied by CAMERWA.

**CAMERWA** is responsible for the procurement of equipment and supplies, including the purchasing of pharmaceuticals, including antiretrovirals. The Treatment Research AIDS Centre is understandably cautious about promoting widespread availability of medication until treatment literacy has reached a basic level, and therefore only accredited NGOs and clinics (the accreditation process is quite arduous) can access the cheap drugs via CAMERWA. Others have to access them over-the-counter at much higher prices.

The **Kigali Central Hospital (CHK)** is the centre of excellence for HIV/AIDS treatment and also plays an important role in delivering treatment.

### International organisations and funders

Although the international community failed to tackle the genocide, and dawdled in its response to the aftermath, in recent years Rwanda has finally been getting some of the support it deserves. However, Rwanda, although now marginally ahead of its more conflict ridden neighbours to the south and west, is still desperately poor. The health service is minimal in much of the country and even where there are doctors and clinics, many cannot afford the small fees required for consultations and prescriptions.

There is more than one 'plan' for Rwanda. As mentioned above there is the national plan released in 2002. The **William J Clinton Foundation** has helped the government with its strategy and negotiated reduced drugs prices, it also developed a further plan in May 2003 for the period 2004-2008.<sup>112</sup> This plan is ambitious: nearly 58,000 people on treatment by

The five year national AIDS plan has a budget of \$69 million.

The Global Fund aims to get 19,350 people on ART and has funded 117 VCT and PMTCT centres.

2008, costing \$217 million over the period. It envisages that 326 doctors will be needed to achieve the plan, but as there are barely this number already existing in the whole of Rwanda it is not clear where this capacity will come from. There is considerable confusion about whether Clinton will provide actual additional funds, and one source says it was talking at one point about \$112 million over ten years, but has since downgraded its figures considerably.<sup>113</sup> Other sources suggest the Clinton Foundation will not be contributing any new funds and is merely providing technical assistance.

Meanwhile, the **Global Fund** is providing \$65 million over five years from 2004. This money will establish facilities for testing and prevention of mother to child transmission in 117 centres (\$8 million) and pay for antiretroviral (\$57 million) distribution in 36 health centres and hospitals. The Global Fund assumes the actual cost (unsubsidised) of treating adults is \$43 per month. The aim is to treat 15-30% of affected people, meaning about 19,350 people on antiretrovirals and 50,000 people on prophylaxis and receiving treatment for their opportunistic infections.<sup>114</sup>

The first major source of HIV/AIDS funding was the UK government's £2.95 million (\$5.25 million) **SIPAA** (Support to International Partnership against AIDS in Africa) project, managed by ActionAid, which started in October 2002 and expires in Autumn 2005. Various disputes and mishaps hindered and delayed the first year of SIPAA funding, but it now seems to be running smoothly and the administration has been handed over to the CNLS for the final year. In addition to this, the UK government's **DfID** Country Assistance Plan envisages £126 million (\$225 million) of general support to Rwanda, spread over three years from 2003/4 to 2005/6, gradually increasing each year.<sup>115</sup> However, in recognition of other donors' support for HIV/AIDS, DfID's assistance (other than SIPAA) will concentrate on capacity building in other health, infrastructure, education and development areas.

USAID has now become the largest bilateral donor because of **PEPFAR**, the US President's Emergency Plan for AIDS Relief, which is worth \$37 million over five years.

The **World Bank's** **MAP** fund totals \$32 million to be spent over a five year period that began in October 2003. It is split roughly three ways between civil society, treatment provision and the public sector. Another large donor is the **African Development Bank**, but no clear figures are available on how much it will provide.

**King Baudouin Foundation** contributes around \$528,000 to programmes supporting vulnerable families and prevention initiatives in collaboration with the UNFPA and Association Francois-Xavier Bagnoud.

Given the general poverty, there seems to be a misallocation of donor funds that go disproportionately into the HIV/AIDS field. There is obviously considerable need in this area, particularly if antiretrovirals are to be provided universally. However, again and again international NGOs report: "There is plenty of money for AIDS in Rwanda." This alone does not mean private donors should necessarily avoid funding projects in Rwanda, since the lump bilateral and multilateral funds do not appear to be adequately distributed and many local NGOs, even sophisticated ones with international connections, such as Hope and Homes for children, find it difficult to access the theoretically available funds.

The provincial anti-AIDS commission, which NPC visited, also complained that funds have not filtered down to the regional level in the expected quantities. What private donors may conclude is that in tackling HIV/AIDS in Rwanda they should think laterally and fund more general poverty alleviation projects that step outside the strict mandate of the HIV-earmarked official donor funds, but perform a much needed role in addressing the context of poverty within which HIV thrives.

It could be argued that if the international focus on HIV/AIDS is skewing scarce resources (particularly in the medical field) away from other diseases, then private donors might decide to support efforts to tackle other diseases, thereby helping to redress the balance.

Another concern for NPC is the funding for the supply of condoms. It seems that funding for social marketing ceases in August 2005,<sup>116</sup> and there is little other funding available, and this will impact their availability to the wider public. The benefits of awareness raising and prevention efforts will be lost if people are not given the tools to protect themselves.



## Gaps in provision

As one would expect, coverage in Rwanda is patchy.

**Table 8: Distribution of NGOs by province**

Province	NGOs	Pop. <sup>117</sup>
Butare	AVEGA, PSI, LWF, ARBE	718,000
Byumba		654,000
Cyangugu	Cordaid, PSI	518,000
Gikongoro	ARBEF, Red Cross, Care	503,000
Gisenyi	PSI, Red Cross, Care	894,000
Gitarama	Care	854,000
Kibungo	LWF	766,000
Kibuye	UNFPA, ARBEF	471,000
Kigali City	Solace, AVEGA, H&H, PSF, CHK, MSF, ARBEF	1,142,000
Kigali Ngali	MSF	290,000
Ruhengeri	Save the Children, ARBEF, Care	870,000
Umutara		311,000



**Caritas** is present in nine provincial dioceses via 11 teams providing care and support, and initiating prevention of mother to child transmission programmes. **FHI Impact** is also present in six provinces. Data relating to who is doing what geographically is far from complete. However, there are obvious operational gaps relating to widening provision of antiretrovirals, in particular the training of doctors and increased laboratory provision for CD4 counts.

NPC also has concerns that some population groups, for example, single women not covered by groups such as AVEGA or Solace Ministries, might not be accessing services more frequently delivered through ante-natal services.

One general comment is that there has been considerable emphasis on general awareness-raising, which has been quite successful, but this now needs to focus on more sophisticated messages, and must be accompanied by action on care and social support. What is the point of offering HIV testing services nationally, if there is no benefit to knowing one's status?

## Options for funders

### Strengthen the health system

Despite the initially polished appearance of parts of Kigali, Rwanda still has a minimal health system, rarely free at the point of use. Even survivors and orphans, two groups given a protected status, struggle to get basic health care. In this context, HIV/AIDS is not necessarily the most pressing concern. Any general support given to the Rwandan government to develop the health system and tackle poverty will play a role in controlling the effects of HIV/AIDS.

The **CNLS**, the national AIDS commission, is also an option for direct funding. Donors can support some of its projects, for example, assist one of the provinces, such as Gikongoro, which appears to be under-served by NGOs. The CNLS can provide donors with detailed

accounts and reports on projects. However, funding via this vehicle might be a slow process – the experiences of both donors and recipients vary.

Private donors could also play a useful role funding less fashionable areas of intervention.

### Support an established local or international NGO

International organisations are more involved in the delivery of HIV/AIDS interventions in Rwanda than they are in Burundi, where the local NGOs bear a larger part of the burden. This is because Rwanda has been relatively stable for most of the last decade and has been an easier place for international NGOs to operate than either Burundi or the DRC.

One excellent initiative is **Project San Francisco**, which has worked on HIV/AIDS in Rwanda since 1986 and is a research programme of Emory University in the US. It focuses on providing free voluntary counselling and testing for 2,400 couples per annum. It has found the risk of HIV transmission to the other partner in a discordant couple falls from 25% to 5% per annum with proper counselling. Those who test positive are referred to PLWA associations for support and hospitals for care and treatment. For the last year it has provided antiretroviral drugs to 85 people with money from the Global Fund. The research and operating costs of the project are covered by Emory University, however additional funding would enable them to expand drug treatment to more people.

**Population Services International (PSI)** is active in the marketing of condoms on a non-profit basis and does other prevention work. In 2003 it sold six million condoms (at \$0.02 each, a 50% subsidy), more than half the total number used in Rwanda. With PEPFAR funding it is working with the military using peer educators, organising a mass media “trusted partner” campaign to encourage fidelity, and running a youth focused project to support anti-AIDS clubs with training, a radio programme and a magazine. One of its most interesting ventures is a plan to franchise its successful Centre Doshi Chosi (a youth reproductive health centre in Buture) and open branches in 117 testing clinics financed by the Global Fund. All in all, PSI is the most active NGO working in prevention. There are other high risk areas they would like to develop, given funding, such as working with prisoners (society does not admit they have sex with one another), helping Congolese refugees and working more within the military.

**Save the Children UK** used to run a highly respected HIV/AIDS programme in the northern province of Ruhengeri, working closely with the regional health authorities and in partnership with local NGOs. Unfortunately funding expired for the project, and it is currently only maintained at a low level by the local partner organisations, but the charity would like to revive it if it had sufficient funding.

Dutch NGO **Cordaid** has a particularly impressive methodology of working based entirely on outcomes. It supports the local health structures in the western border province of Cyangugu. It sets appropriate targets for clinics, hospitals and HIV testing centres. Each recipient signs a contract to meet these targets, and agrees on a “business plan”. Cordaid then provides the required financing and monitors progress.



**Hope and Homes for Children** is a UK-based NGO, although the Rwandan branch is independent and run entirely by locals. Most of the funding comes from the UK. It is an organisation that systematically addresses the huge problem of orphans, both as a result of HIV/AIDS and also the genocide. It focuses on child-headed households, or households headed by a parent with AIDS or a frail grandparent (who often takes over the role of caregiver when parents die).

Referrals from community leaders identify those in the most extreme poverty. Hope and Homes for Children currently supports 200 families, averaging about seven children in each.

It establishes close relationships with the family unit through monthly visits and provides multiple interventions to address their particular needs. It donates food and other supplies, fees for school and health care, trauma counselling, support in income generation (such as providing goats, which are easy to rear, and bicycles, which the children can rent out) and legal support in cases of rape or disputes in property ownership and inheritance. Surviving parents with HIV/AIDS have been gathered into PLWA associations and Hope and Homes hopes to supply antiretroviral drugs to them.

An entirely home grown NGO is **Solace Ministries**. It was started by a male genocide survivor to meet the needs of widows and orphans, bringing them together into supportive communities of about 50 widows. There are currently 42 of these communities, mainly in Kigali, but also in Ruhengeri and Giterama. Solace's activities include paying school fees, providing counselling and helping with agriculture and job creation. About 350 of its members are known to be HIV positive (many more are likely to be infected without knowing or admitting to their status). It provides nutritional support, prophylaxis and treatment for opportunistic infections and antiretrovirals (currently to 20 women).

### Box 5: Visiting a widow

The woman greeted us with warmth and beckoned us out of the sun into her bare, but cool, mud hut. She was probably in her early forties, but could have easily passed for 80. She was one of the tenacious genocide survivors who form AVEGA, and although she had been multiply raped in 1994, she believes that she actually contracted AIDS long before that in 1985. Part of the cruelty of AIDS is its unpredictability, sometimes killing very quickly but occasionally causing secondary illnesses that can last for years. However, this woman's life was clearly ebbing away. For many years she had heard the promise of antiretroviral drug treatment but, although from a macro perspective the international community is finally taking ARV provision in Africa seriously, this lady felt that it was too little too late. She says: "We've all been waiting for a long time, and I think that before the ART does eventually arrive we will all have died."

While she clings onto life she is a passionate advocate in her community for the importance of using voluntary testing to determine your status and at least get some treatment for opportunistic infections. Somehow she finds the strength to farm in one of the widow cooperatives and produces sunflower oil. Her biggest needs, she says, are support in the farming and help at home.

A larger NGO, which works together with Solace, is the association of genocide widows **AVEGA-AGAHOZO** founded in 1995. It has a staggering 25,000 members and a further 75,000 child beneficiaries. It is split into four regions. The regional groups are now broadly autonomous and have slightly different styles and programmes.

NPC visited the eastern region based near Rwamagana, which has 3,000 widow members and cares for about 7,000 orphans. AVEGA East groups its members into 100 small cooperative associations for mutual support and collaboration in agriculture and petty trade. AVEGA quotes a shocking figure: in a survey of 1,000 women who had been raped, two thirds were HIV positive.

A doctor visits the AVEGA East centre twice a week to attend to the HIV positive widows, while the staff make home visits for counselling. It is planning to start antiretroviral drug treatment for 40 women in the near future. Additional funding could equip its clinic, increase the amount of nutritional support it provides to people with AIDS and orphans, and help with its transport (it has only one car to enable 25 staff to cover three provinces).

**PACFA**, First Lady Jeanette Kagame's NGO for the Protection And Care of Families with AIDS, currently supports 400 people with AIDS around the country, including 54 in the eastern region but unfortunately NPC was unable to meet this organisation.

One incredibly vibrant local NGO is **Hope After Rape**, which started as an educational project to provide victims of rape with the skills to help them rebuild their lives and find work. Word about the project spread quickly. Soon many other people, besides rape victims, were asking to join the classes, and it developed into an intensive adult education school called the Youth Association Fighting Against Illiteracy. Nearly 1,000 people attend the classes. Subjects taught include written Kinyarwanda, as well as basic French, English and business administration. The project has received no external funding, and is working in an abandoned building, with a teacher, blackboard (and no other equipment) and dozens of students crammed into every room and patch of shade outside. Education and employment

are critical to create an environment in which the spread of HIV is reduced and the affects of AIDS mitigated.



**The United Nations Population Fund (UNFPA)** is involved in prevention work, particularly with youth. It is the largest distributor of free condoms and also conducts voluntary counselling and testing and peer education. It works primarily in three provinces: Cyangugu, Kibuye and Umatara. It is also involved in providing anti-HIV prophylaxis (six weeks of antiretroviral treatment) to rape victims.

NPC was only able to visit a limited sample of organisations in Rwanda, and there are other well-regarded NGOs which NPC did not investigate which include the US-based **Family Health International (FHI)**, and **l'Association Rwandaise pour le Bien-être Familial (ARBEF)**. The FHI/Impact initiative, funded by USAID, has been important in undertaking focused awareness raising for HIV testing and follow up, and is now running antiretroviral clinics outside Kigali.

**Association Francois-Xavier Bagnoud (AFXB)** has been developing a programme of support for 240 affected families in Kigali, including educational support for 1,300 children and adolescents. AFXB has since expanded its operations to 160 families in Gitarama, and has also expanded its Kigali operations with support from the King Baudouin Foundation.

**Medicins Sans Frontieres (MSF)** provides voluntary counselling and testing, medical care, prevention of mother-to-child transmission and treatment for those who are HIV positive. MSF's objective is to treat 500 people with antiretroviral drugs. MSF also has a rural reproductive health programme in Ruhengiri and has been working with other organisations including Urunana (see below) to help women traumatised by violence.

**Urunana** (Hand in Hand) is a popular radio programme launched in 1999 by Health Unlimited in collaboration with the BBC World Service, with funding from the Department for International Development and the Community Fund. It is a short drama, which is followed by an agony aunt slot about the issues raised in the programme. It deals with a variety of issues, including sexual health for women and young people, education of girls, orphan rights, HIV, and post-genocide trauma. This programme, not unlike the BBC radio soap opera, *The Archers*, in style, reaches a wide audience: 220,000 people joined the voting on the most popular character when invited to do so.

There are other NGOs, such as the Adventist Development and Relief Association, which while not working directly on HIV/AIDS, are effectively tackling some of its causes and effects through more general poverty alleviation.

### Build the capacity of smaller local NGOs

As well as directly funding some of the larger organisations mentioned above, NPC suggests that donors could help to build up the capacity of small groups, from local associations of People Living With AIDS through to emerging NGOs with fresh ideas and approaches. A good partner in this work would be **The Survivors Fund (SURF)**, a UK-based charity founded and run by Rwandans which is essentially an engaged grant maker. It funds and supports a range of Rwandan charities, and lobbies the UK government for development aid. SURF has played a central role in building the capacity of two NGOs mentioned in this report, AVEGA and Solace Ministries, and has also run a high profile campaign in Britain calling for antiretroviral drug provision to genocide survivors with AIDS.

**ActionAid** is another possible partner in capacity building. It has managed the Support to International Partnership against AIDS in Africa (SIPAA) programme for two years, which

**SURF, ActionAid and ANSP+ are options for funding small NGOs**

has provided essential equipment, such as vehicles, to many local NGOs. ActionAid appears to have finally learnt from earlier problems with SIPAA funding and remains one of the most experienced and well-networked international NGOs in the HIV/AIDS field, and therefore might be suitable for distributing seed funding to small local NGOs.

Finally, **ANSP+** is the network of people with AIDS in Rwanda. It is an umbrella organisation which has nearly 200 member groups, each composed of an average of 80 individuals. Since its foundation in 2000, it has worked intensively in areas such as home based care, anti-discrimination and income generation. It produced a manual of guidelines for home based care and used this to train 355 caregivers. It has worked to tackle stigma by organising events at which respected officials are seen by the community to be talking to and eating with people with AIDS.



## Section 5: Funding recommendations

There are hundreds of NGOs in Central Africa, many doing an excellent job. Not all of these are specifically working with AIDS, but given the omnipresence of the problem, many organisations are dealing with the epidemic in some way. During the course of its research, NPC visited 45 organisations on the ground with significant HIV/AIDS programmes and also had conversations with, and obtained information on, a number of others. This section indicates five organisations in each country that NPC judges to be particularly interesting funding opportunities because of their quality, the impact of their operations and their need for secure or additional funding. NPC has selected a range of sizes and types of organisations, both local and international, working across the full spectrum of HIV/AIDS interventions. The recommendations cover organisations which could benefit significantly from as little as \$20,000 to those capable of making good use of well beyond \$100,000.

### How to fund

Funders should understand that grant-making in Burundi, the DRC and Rwanda can be tricky and is always risky. However, as demonstrated by the King Baudouin Foundation (KBF) and others, it is possible and is, without doubt, important. The histories and current conditions of Burundi, Rwanda and the Democratic Republic of Congo outlined in the report clearly show that these countries are unstable and lacking much of the most basic infrastructure. A newly built health clinic can be looted and burnt by a rebel group; the director of an effective local NGO can die unexpectedly from malaria; a doctor with an apparently spotless record can turn out to be corrupt. Funders need to be aware of these risks, but must not be discouraged from making grants, because the needs are very real.

The easiest organisations to fund are international NGOs or local NGOs affiliated to an international network (such as Hope and Homes for Children). Funds can be transferred via a bank account in Europe or via KBFUS and there is some assurance of regular reporting.

When funding a local organisation directly it will often make sense to enlist an intermediary such as GTZ, BTC or SURF to administer the funds and provide basic monitoring. Some intermediaries charge (to cover their operations) while others do not, being fully funded from other sources. It may sometimes be possible to work without an intermediary if the donor finds the recipient sufficiently trustworthy and is able to arrange a money transfer.

### What to fund

There are many excellent organisations tackling HIV/AIDS in this region. NPC met a significant proportion of the largest or most respected ones. From the 40 that were examined in detail, 15 have been recommended, five in each country. These are the NGOs (and in the case of Burundi, a government department) that NPC considers do particularly essential work with significant outcomes and are trustworthy.

Given the limited reporting of some of the organisations, the data upon which its recommendations are based is not as complete as one may like. This is unavoidable, but as a warning to donors NPC indicates the level of data upon which an assessment was made. The quality and quantity of data is reflected in a qualitative measure of the risk of funding each organisation. This also reflects a judgement on the trustworthiness of the management and external threats (for example DOCS is given a "High" risk rating because it operates in north Kivu, at the heart of the continued conflict in the DRC, even though NPC has a high regard for its management and detailed reports of its work). Generally there is little data available evaluating the efficacy of particular activities in this region, and the comparative advantage of pursuing particular initiatives.

In Table 1 organisations are by size, type and area of focus. For funders, the last column, indicating recommended grant size, is of particular importance. This is a function of the organisation's size and assessment of their capacity to absorb new funding. A similar table of the other 25 organisations visited, not included in the top 15 recommendations, but which may also be of interest to funders, is at the end of this document. Contact details for each organisation are available from NPC. For UK tax payers, NPC is able to "pass through" funds in order to qualify for Gift Aid.

An alternative to selecting a single organisation to fund directly is to contribute to KBF's fund for HIV/AIDS in Central Africa. This is a way to diversify risk across a basket of different organisations in the three countries. Alternatively donors can seek KBF's advice directly. KBF works closely with the German Technical Cooperation (GTZ), the Belgian Technical

Cooperation (BTC) and others to help chose local partners and projects, arrange the practicalities of funding, liaise with other funders and to monitor the reporting and progress of recipients. To date KBF has funded six organisations to a total of nearly €1 million (\$1.34 million). In Burundi it has funded SWAA and FVS, in DRC it has funded PMTCT and VCT projects in Lumumbasi and Bukavu, and in Rwanda it has funded a UNFPA centre in Kibuye and the Association Francois-Xavier Bagnoud's operations supporting affected families. This report and its recommendations will inform its selection of future projects. BTC occasionally handles substantial donations directly, arranged on a case by case basis.

## What to fund – Burundi

Burundi is a particularly interesting funding proposition because, although political insecurity has limited funding in recent years, there is a great deal of well organised activity on the ground. NPC believes Burundi should be a funding priority. UNAIDS' analysis of funding flows for Burundi, echoed by many experts, shows that drug treatment is one area with a significant funding shortfall, both the provision of antiretroviral drugs and treatment of opportunistic infections with conventional drugs. Burundi has a good plan in place for treatment, and this presents an opportunity for funders. However, even if the treatment plan is realised there will remain the continuing need to support families affected by AIDS, particularly orphans and vulnerable children, and also to continue the work around prevention and changing attitudes.

**Table 9: Burundi top 5 recommendations visited by NPC**

Name	Type	Size	Main Area	Activities	Data	Risk	Grant size
ABS	L	Small	Capacity	Umbrella providing support and training for 80 local NGOs	Mid	Mid	Medium
ANSS	L	Large	Treatment	Over 1,000 members on ART	High	Low	Large
CNLS	G	Small	General	Government coordinating body	Low	Mid	Large
Rainbow Centre	L	Small	Orphans	Fostering and support for 350 orphaned infants	High	Low	Small
CSAA	L	Small	Attitudes	Tackling ignorance and stigma in Protestant churches	Mid	Low	Small

## What to fund – the Democratic Republic of Congo

The DRC is clearly a difficult country for funders as it is huge and largely inaccessible. Therefore it is easiest to find a good international NGO to fund or a technical operator to oversee implementation. The situation is most serious in the east of the country, which has suffered the brunt of the civil wars and is still unstable today, the reason why NPC was unable to visit there. NPC has, however, met with representatives of two organisations working in the east that are particularly impressive and are well placed to pioneer treatment in areas that are currently under-served, as well as working on HIV testing and STI treatment as a contribution towards prevention efforts. If hostilities cease, and the Kivus become more connected to the rest of the country then tackling the epidemic in this area will become even more important. Other parts of the DRC, however, should not be ignored and many regions have little in the way of provision. Even if prevalence rates are lower in these areas it is important that prevention and care is provided in order to keep them low.

Table 10: DRC top 5 recommendations visited by NPC

Name	Type	Size	Main Area	Activities	Data	Risk	Grant size
AmoCongo	L	Medium	Orphans	Supporting 5,000 orphans, also runs two HIV/AIDS clinics	Mid	Mid	Medium
DOCS	I	Medium	Treatment	Trains doctors and provides VCT and treatment in Goma	High	High	Large
FFP	L	Large	General	A full spectrum of services in six cities	Mid	Low	Medium
Merlin	I	Medium	Treatment	Reproductive health, rape victims & PMTCT in the East	Mid	High	Large
PAHO	L	Small	PLWA	Network of PLWA's, tackling stigma and job creation	Low	High	Small

## What to fund – Rwanda

At an official level Rwanda appears to be well-funded and, although there will always be parts of the infrastructure that lag behind and might provide opportunities, overall the international community appears committed to supporting Rwanda's health system. However, the genocide has caused enormous suffering on many levels, not least because of the amount of HIV infection resulting from rapes in 1994. Actual funding for families affected (whether in terms of antiretroviral treatment or other support) has been slow to trickle down to the beneficiaries, and there is also a substantial need to support orphans, vulnerable children and families, whether destitute as a result of HIV or conflict. This suffering has resulted in the formation of a number of passionate organisations by genocide survivors, whose work has become increasingly focused on HIV/AIDS in recent years. So "bottom up" support for these grass roots organisations based within the community is vitally important to complement efforts at the national level. The core of their work is support groups and home based care, and private funding could help them continue these essential activities while expanding small ARV programmes.

Table 11: Rwanda top 5 recommendations visited by NPC

Name	Type	Size	Main Area	Activities	Data	Risk	Grant size
ANSP+	L	Medium	PLWA	Umbrella group of almost 200 associations of PLWA	High	Mid	Large
AVEGA	L	Large	Care	Genocide survivors association, provides care, VCT, ARV	High	Mid	Medium
Hope & Homes	N	Medium	Orphans	Holistic support for 200 households of vulnerable children	High	Low	Medium
Project San Fran.	I	Medium	VCT	VCT for couples, could expand into ARV treatment	Mid	Low	Medium
Solace Ministries	L	Medium	Care	Home based care for 350 HIV positive widows	High	Mid	Small

KBF has also successfully funded a programme by AFXB caring for orphans and is very happy with effectiveness.

**Table 12: Other organisations visited, but not in top 15**

Name	Type	Size	Main Area	Activities	Data	Risk	Grant size
<b>a) Burundi</b>							
ActionAid	I	Small	Capacity	Implements SIPAA program	High	Low	Large
ADRA	I	Small	Treatment	VCT and OI treatment in Bujumbura, 30 patients on ART	Mid	Mid	Medium
Ass. Muryango	L	Small	General	HIV education and support for refugee camps near Buj.	Low	High	Small
Caritas-Burundi	N	Large	General	Interventions through Catholic parishes	Low	Mid	Medium
CPBU	L	Large	Treatment	Six health clinics run by Pentecostal churches	High	Low	Medium
GVC	I	Medium	Treatment	Developing a residential hospital for ARV treatment	Mid	Mid	Large
Handicap Intern.	I	Small	Capacity	Helped incubate ANSS and SWAA, working with smaller NGO	Mid	Low	Large
JRS	I	Medium	Treatment	Treatment programme in Bujumbura and environs	High	Low	Medium
PSI	N	Large	Prevention	Social marketing of condoms and prevention education	High	Low	Medium
RBP+	L	Medium	PLWA	Network of 3,000 PLWA providing grants for job creation	Low	High	Small
Scripture Union	N	Small	Attitudes	Courses to educate youth and support marital faithfulness	High	Mid	Small
SWAA	L	Large	General	A full spectrum of services in seven provinces	High	Low	Large

b) DRC							
Caritas-DRC	N	Large	General	Working throughout the country through Catholic parishes	Low	High	Medium
Christian Aid	I	Medium	General	Incubated AmoCongo and FFP, provides training & support	High	Low	Large
Concern	I	Small	Prevention	Working through community in poorest part of Kinshasha	Mid	Mid	Medium
Cordaid	I	Medium	Prevention	Peer education and VCT in Kinshasa and Bukavu	Mid	Mid	Medium
Medicine du Monde	I	Medium	Treatment	STI treatment and some VCT, OI and ARV in Goma	High	High	Large
PSI	L	Large	Prevention	Social marketing of condoms and prevention education	Mid	Low	Medium
Salvation Army	N	Large	Treatment	VCT and OI treatment in 28 health clinics	Low	Mid	Small
SWAA	N	Small	General	Centres for vulnerable women and sex workers, also VCT	Low	High	Small
UNICEF	I	Large	Orphans	PMTCT, youth peer educators, ensuring orphans in school	Mid	Low	Large

c) Rwanda							
ActionAid	I	Medium	Capacity	Used to implement the SIPAA program	High	Mid	Large
CNLS	G	Large	General	Government coordinating body	Mid	Mid	Large
Cordaid	I	Medium	General	Supporting the local health system in Cyangugu	High	Low	Medium
Hope After Rape	L	Small	Education	Vocational training for rape victims and others	Low	High	Small
PSI	I	Medium	Prevention	Social marketing of condoms and prevention education	Mid	Low	Medium
Save the Children	I	Medium	General	Programme in Ruhengeri suspended due to lack of funding	Mid	Mid	Large
SURF	I	Medium	Care	UK-based funder, supporting AVEGA and Solace Ministries	High	Low	Large

Type: Local, International, Network (local but part of an international network), Government.

Grant size: Small = up to \$50,000, Medium= \$50-100,000, Large=> \$100,000

Data: Low – only a visit report, Mid – some documentation, High – much documentation

Risk: Based on a mixture of data quality, the structure of the NGO and the nature of its work.

Size of Organisations: a rough indication of personnel and capacity.



## Brief profiles of recommendations visited by NPC

### ABS (Burundi)

There are many small NGOs and associations across the country that could develop into significant providers of services. With this in mind, NPC recommends the local NGO umbrella group Alliance Burundaise contre le SIDA (ABS) as the best choice for providing technical support and financing to build the capacity of some of the most promising of the smaller NGOs, particularly those in far-flung provinces such as Cankuzo and Makamba, which do not currently have any sizeable HIV/AIDS organisations. ABS comprises about 80 local NGOs. It was founded in 1999 to provide coordination, advocacy, a forum for sharing best practice and skills training. It is well equipped to identify suitable recipients and provide them with technical support and monitoring.

At coordination meetings the member organisations explain their activities, geographical focus and target populations, in order to help the NGOs harmonise their activities, and discuss their problems and successes to share best practice. ABS assists members with proposal writing, project cycle management, computer training, fundraising and financial control. It also provides intensive assistance to individual NGOs by visiting them in the field for a week and helps them to prepare three year plans of action, which also help the NGOs in their communications with potential donors.

ABS is involved in advocacy through representation at many levels: it is a member of the executive committee of the national anti-AIDS commission (CNLS), the administrative council of SIPAA, the expanded theme group of UNAIDS, the Country Coordinating Mechanism for the global fund, and the pilot committees of UNDP and GTZ. ABS is increasingly involved at a provincial level.

Currently ABS receives funding from donors including SIPAA, UNDP, UNAIDS and the CNLS, however funding for salaries is scant. In 2003, ABS submitted 229 projects to CNLS for funding (by World Bank MAP money) on behalf of its member organisation. Of these, only 35 were accepted. ABS is now organising a workshop to find out why so many projects were refused.

### AmoCongo (DRC)

AmoCongo is one of the most respected local NGOs, established in 1992, with a particular focus on orphans but also involved in other HIV/AIDS services. It has been supported for some time by Christian Aid, which provides training and technical advice as well as partial funding. Other partners include the Belgian Technical Corporation and the World Food Programme.

It supports 5,000 orphans, a quarter receive regular food and 80 get vocational training (in taxi driving, sewing and computers). It runs two health clinics geared towards HIV/AIDS which provide voluntary counselling and testing and opportunistic infection treatment for free. It has a network of about 200 active volunteers who conduct twice-weekly home visits to people living with HIV/AIDS and provides basic kits (mattress, sheets and towels) to people who are bed ridden.

AmoCongo currently works in Kinshasa, Baongo and Lumumbashi and would like to expand operations to Mbuji-Mayi in response to frequent requests for assistance there. It would cost around \$60-100,000 to establish a new office, and this would be a very interesting funding opportunity as this is a mining town with a rising prevalence rate and little existing service provision.

### ANSP+ (Rwanda)

Association Nationale des Séropositifs (ANSP+) is the network of people living with HIV/AIDS in Rwanda. It is an umbrella organisation that has nearly 200 member groups spread across all provinces in the country, each composed of an average of 80 people.

Since its foundation in 2000, it has worked intensively in areas such as home-based care, anti-discrimination and income generation. It produced a manual of guidelines for home based care, which has been endorsed by the government and used to train 355 caregivers. It has worked to tackle stigma by organising events at which respected officials are seen by the community to be talking to and eating with people with AIDS. Additionally, it has made a

video with testimonies by people living with HIV/AIDS, and is working on new awareness raising messages for youth in the form of music and theatre.

It explains that its work is hampered by a reliance on piecemeal opportunistic funding (from UNDP, USAID, WFP etc.) for specific projects, such that it lacks permanent staff and offices and has to rely entirely on the voluntary efforts of the executive committee. A reasonably small grant could give it a solid basis for their work.

## ANSS (Burundi)

Association Nationale de Soutien aux Séropositifs et Sidéens (ANSS) started in 1993 as a grassroots organisation for people with AIDS. It began providing antiretroviral drugs in 2002 and is now the largest provider in the country, treating around 1,000 people with a medical team of 16, including four doctors. It has another 2,200 people on file awaiting treatment when funding becomes available. NPC was impressed with ANSS's detailed patient records, which it is planning on improving through a computerised patient tracking system. ANSS also supports 300 orphans whose parents had been members of the organisation.

ANSS is decentralising and has opened another centre in Kirundo, which has the highest prevalence in the country (25%), with one doctor, two nurses, a social worker and a counsellor. After one year it has 700 people on file, of which 72 are receiving medication. Soon it will open another centre in Gitega, which is the second largest city in the country. It hopes to expand to Makamba in the south, which is particularly remote.

Besides seeing people in its centres, ANSS makes home visits with a psychologist and a nurse before starting treatment and visits patients periodically during treatment. In addition it distributes small grants to help people to begin income generating activities. It is starting a project for orphans, because other NGOs cannot cope with the numbers of orphans referred to them by ANSS.

## AVEGA (Rwanda)

AVEGA-AGAHOZO, the association of genocide widows, was founded in 1995 soon after the genocide. It has a staggering 25,000 members and a further 75,000 child beneficiaries. It is split into four regions. The regional groups are now broadly autonomous and have slightly different styles and programmes.

NPC visited AVEGA East, based near Rwamagana, which has 3,000 widow members and cares for about 7,000 orphans. AVEGA East groups its members into a 100 small cooperative associations for mutual support and collaboration in agriculture and petty trade. One shocking (although unverified) figure quoted by AVEGA is that a survey of 1,000 women who had been raped revealed that two thirds were HIV positive.

A doctor visits the AVEGA-East centre twice a week to attend to HIV positive widows, while the staff make home visits for counselling. It is planning on providing antiretroviral treatment for 40 women in the near future.

Additional funding could equip its clinic, increase the amount of nutritional support it is able to provide to people with AIDS and orphans, and help with its transport (it has only one car to enable 25 staff to cover three provinces).

Organisations such as AVEGA are often well-targeted by international donors to run substantial programmes. However, such funding frequently fails to recover costs fully – the core of the organisation remains unfunded. In addition, there are sometimes elements of these programmes, such as material support for beneficiaries that are not attractive to donors. AVEGA would benefit from general purpose funding to provide it with the necessary flexibility to achieve its goals holistically.

## CNLS (Burundi)

NPC is sufficiently impressed by the Conseil National de Lutte contre le Sida (CNLS), the national AIDS council, that it would recommend funding this government body directly. It is well managed, effective and spoken of highly by experts in the region, and could make very good and accountable use of a significant grant. This is the first time NPC has recommended a governmental body for private grants and has only done so because of the particular contribution the CNLS is making, and could make, with targeted funding.

NPC recommends funding incentive packages to encourage doctors, almost all of who are currently based in the capital, to move out to the provinces. Without a good distribution of doctors across the country it will be nearly impossible to implement a widespread antiretroviral treatment programme, even though funds for drugs are available through the Global Fund. Official donors with top-down mandates are unlikely to fund this kind of local incentive scheme, and therefore this is an area where private donors are particularly well placed to play an essential and strategic role. The practicalities of funding a governmental body would need to be explored further, however.

## Doctors On Call for Service (DRC)

Doctors on Call for Services (DOCS) is a unique organisation with a focus not only on service delivery, but crucially on training the next generation of African doctors. It was founded by an international NGO and receives funding and volunteers from abroad. It is run by an American-Congolese couple who have settled permanently in Goma, so it has a good mixture of local and international contacts. Unfortunately, a period of renewed conflict in the area prevented NPC from visiting, but it met a representative and corresponded extensively enough to be certain about recommending DOCS as a safe pair of hands in a difficult region.

The DOCS Learning Centre in Goma runs a residency programme for Masters degrees in Family Medicine, designed to equip doctors to run rural hospitals. The programme aims to enable doctors to become life-long learners and also teachers. Research is shared in The Great Lakes Medical Journal.

DOCS's service delivery, closely tied to the training, has a strong focus on HIV/AIDS. With support from the UK-based NGO Tearfund it runs an education and awareness programme on HIV/AIDS called Choisir La Vie that brings together all the faith-based groups in Goma and nearby Masisi, providing training in youth awareness, counselling and palliative care. It also provides testing, treatment of opportunistic infections and some antiretroviral therapy. It works on STI treatment, a critical aspect of HIV prevention work, and has good relations with the local military and so can provide STI treatment in the barracks.

## Fondation Femme Plus (DRC)

Fondation Femme Plus (FFP) works with 5,000 adults and orphans in Kikwit, Baongo, Kisangani, Kindu and Goma, as well as Kinshasa, and NPC was fortunate enough to visit at a time the regional heads were gathering and so met people from all of these locations. It is one of the most well respected local NGOs, working closely with Christian Aid. It provides a range of services, including home visits by volunteers, treatment of opportunistic infections, training for people living with AIDS and material aid. An exciting new initiative is a telephone help line, the first of its kind, with eight lines manned by volunteers from 8am-10pm.

Its prevention work focuses on couples in order to include husbands who are the source of many problems. Its work with people living with HIV/AIDS focuses on positive thinking and includes counselling their families to discourage them from expelling them from home, a real danger.

FFP is at a stage where it could probably expand operations to another province, and this could be an interesting funding opportunity (about \$100,000), however, it would also be worthwhile providing unrestricted funding to cover its existing operations.

## Hope and Homes for Children (Rwanda)

Hope and Homes for Children is a UK-based NGO, although it is structured in such a way that the Rwandan branch is independent and run entirely by locals. Most funding comes from the UK. NPC has had contact with Hope and Homes' work in Eastern Europe and holds the organisation in high regard for its ability to challenge common, but ineffective, methods of supporting vulnerable children.



In Rwanda, Hope and Homes is one organisation systematically addressing the huge problem of orphans, both as a result of HIV/AIDS and also the genocide. It focuses on child-headed households, or homes headed by a parent with AIDS or a frail grandparent (who often takes over the role of caregiver when parents die). It focuses on those in most extreme poverty through referrals from community leaders. On a budget of around \$360,000 a year, it currently supports 200 families (averaging about seven children in each or 1,400 children in total).

The greatest fear of many people dying of AIDS is what will happen to their children, and Hope and Homes provides them with assurance that they will be well cared for. The project helps with housing, education, health care, legal support and counselling. Collectively this helps protect vulnerable children from abuse, which can lead to the spread of HIV.

The organisation establishes close relationships with each family unit through monthly visits and addresses particular needs. Hope and Homes provides food and other supplies, school and health care fees, trauma counselling, support in income generation (such as providing goats, which are easy to rear, and bicycles, which the children can rent out) and legal support in cases of rape or disputes in property ownership and inheritance. It has gathered surviving parents with HIV/AIDS into PLWA associations and hopes to obtain antiretroviral drugs for them.

### Merlin (DRC)

Merlin (Medical Emergency Relief International) is a UK-based NGO, founded in 1993, providing healthcare in emergency situations in 30 countries. It has about 20 expats in Congo and a team of local staff, and is mainly funded by official donors such as DFID and ECHO. It has been working in the remote Maniema province (in Punia and Kindu towns) since 1997, throughout the height of the civil war. The work has since spread to cover areas of Kasai Oriental, North Kivu and Orientale provinces. Merlin is the sole source of essential medical support for 138 primary and secondary health facilities in the east of the DRC, providing healthcare, drugs, maternal services and epidemic monitoring for more than 1.1 million people.

Although it does not have a separate HIV/AIDS programme, this is part of its work. In particular it is working on reproductive health (including mother to child transmission) and gender based violence. It supports the crumbling local health system by paying "incentives" to health staff who haven't received their salaries from the government. Merlin does not consider antiretrovirals to be an appropriate intervention in unstable regions such as eastern DRC where resistance might develop and drugs can only be provided inequitably to a fraction of the eligible people.

### PAHO (DRC)

Burundi and Rwanda have national associations of people living with HIV/AIDS (RBP+ and ANSP+ respectively) which play an active role in ensuring that the views of people with AIDS are heard by the government and donors. In the DRC, however, this is not the case. Donors could help to set up such a grass roots network.

The People Affected by HIV/AIDS Organisation (PAHO) is seriously under-resourced, even compared to its poor counterparts in Rwanda and Burundi. Nonetheless it is full of energy and involved with tackling discrimination, educating HIV positive clergy, encouraging home based care and developing income generating projects.

The basis of PAHO's work is home visits to gain the confidence of fellow HIV positive individuals and helping them understand that in spite of stigma they have the same rights and duties as other human beings. It forms support groups of 30-50 where people can feel secure and accepted and share their feelings and experiences of stigmatisation. It also arranges sessions where people living with HIV/AIDS can talk to the wider public to dispel myths but also encourage prevention.

### Project San Francisco (Rwanda)

Project San Francisco is one of the longest running HIV studies. Emory University in the US launched it in 1986 as a research programme and has maintained it almost continuously since then, although it was suspended briefly after the 1994 genocide. The core of the work, funded by the University, is voluntary counselling and testing for 2,400 couples a year, a method which is geared towards counselling discordant couples (where just one is HIV

positive) to prevent infection of the other partner. It has found that the risk of transmitting HIV to the other partner in a discordant couple falls from 25% to 5% per year with proper counselling.

Those who test positive are referred to PLWA associations for support and hospitals for care and treatment, although for the last year, the Global Fund has directly provided antiretroviral drugs to 85 people. The research and operating costs of the project are covered by Emory University, however additional funding would enable it to expand treatment to more people. Given that PSF already has the skills and contacts, it would be an easy and effective way of expanding the provision of antiretroviral treatment.

### Rainbow Centre (Burundi)

Rainbow Centre is a well-run centre for orphans, which NPC recommends because of its unique focus on children under five. It is the only organisation in Burundi that targets children this young; the other relevant orphan organisations, FVS, APECOS and Orphan's Aid, mainly work with older children.

The Rainbow Centre itself, which is well equipped, functions mainly as a day centre not an orphanage, since most of the 350 children it helps are fostered and eventually adopted in the community. The staff support the adoptive parents with food supplies, counselling and time off when the children come to play in the Centre. The centre also has accommodation for HIV positive women who are deciding whether to foster their infants.

Rainbow Centre has close partnerships with other NGOs such as SWAA, ANSS and Nouvelle Esperance and with the Kigali hospitals which refer infants to it for support. It has received some funding from American foundations.

### Christian Solidarity Against AIDS (CSAA)

Burundi is a highly religious country and church leaders could play a critical role in encouraging people to take HIV prevention seriously and to accept and care for those already infected. For this reason NPC highly recommends funding the SCS Network which is already, with almost no budget, having a noticeable impact.

The SCS Network is working with the many fragmented Protestant denominations in Burundi. The Network is headed by Reverend Nathan Ndayiziga, an Anglican vicar who has been pioneering work on HIV/AIDS in his own church and across Burundi throughout the civil war.

The Network, currently consisting of 17 denominations and NGOs, was formed because of recognition that there was duplication of activities and a desire to ensure a more even national coverage, particularly in rural areas. The Network promotes coordination and sharing of information and expertise among the churches and faith-based NGOs. It is developing guidelines for counselling, home based care, and monitoring and evaluation of activities.

Future plans include establishing a resource, training and counselling centre, compiling a directory of faith-based AIDS organisations, and developing an advocacy programme to challenge practices and attitudes which discriminate against people with AIDS.

### Solace Ministries (Rwanda)

Solace Ministries was created in 1995 by a male genocide survivor to meet the needs of widows – many have no surviving family – and orphans, bringing them together into supportive communities of about 50 widows to offer solace and support. There are currently 42 such communities, mainly in Kigali, but also in Butare, Ruhengeri and Giterama.

Solace's activities include paying school fees for orphans, providing counselling, helping with agriculture and job creation. Other work includes outreach to prostitutes and a youth drama team promoting HIV/AIDS prevention messages in the community. Job creation projects include soap making, basket handicraft and farming cooperatives.

About 350 of its members are known to be HIV positive (many more are likely to be infected without knowing or admitting to their status). It provides nutritional support, prophylaxis and treatment for opportunistic infections and antiretroviral drugs (currently to 20 women). Each of the solace communities is self-organising and provides home visits for members with



HIV/AIDS or other illnesses. Like AVEGA, Solace is often funded by international donors for specific programmes, but for the same reasons would benefit from general purpose funding.

## KBF projects

KBF also has projects which it is currently supporting which KBF recommends to donors. KBF has found these organisations to be efficient and transparent - reporting on these projects has been good and KBF is happy with the outcomes.

**Association Francois-Xavier Bagnoud in Rwanda.** This supports 240 affected families in Kigali, including educational support for 1,300 children and adolescents. AFXB has since expanded its operations to 160 families in Gitarama, and has also expanded its Kigali operations with support from KBF.

**GTZ sponsored projects in Democratic Republic of Congo.** Together KBF and GTZ, with other partners, are developing testing centres and prevention of mother to child transmission programmes in areas such as Lubumbashi and Kivu.

**BTC sponsored projects in Burundi.** BTC has been working with Society for Women against AIDS in Africa (SWAA-Burundi) and La Famille Vaincre le Sida to help increase awareness, care for those infected, and also to care for orphans.



## Section 6: Conclusion

HIV/AIDS is a blight on modern society. The pandemic is decimating communities and the cost, in terms of human misery, is huge. The disease is largely confined to developing countries, which are the least resourced to cope with the scale of the problem.

On a world scale, the Global Fund remains under-financed, and even where money is available, actually applying the funding is an enormous challenge. However, charitable projects are producing exciting outcomes in Central Africa that illustrate there is hope for those affected by HIV/AIDS and their families.

This presents opportunities for donors to fund initiatives to tackle the pandemic. The purpose of this report has been to analyse a range of interventions on the ground and to discuss the qualitative and quantitative outcomes created by these interventions. NPC's analysis is a tool to help donors effectively direct their funding.

The report highlights the suitability of the following areas for support by private philanthropists:

- Support for people infected with HIV, particularly care of the sick and initiatives to encourage positive living.
- Support for people affected by HIV/AIDS, especially orphans and vulnerable children, but also other family members. Families should be supported where possible to remain together.
- It may be helpful to support antiretroviral drug treatment programmes, particularly where delivery is scarce, but NPC urges caution that these should only be supported if the programme includes capacity building in terms of drug delivery, and that such medical infrastructural development should not be to the detriment of delivery of medical services for other life-threatening conditions.
- HIV education and awareness is useful, but donors should ask themselves if the programme being supported is developing as fast as local knowledge, and whether it is useful.
- Programmes specifically providing voluntary counselling and testing, treatment of opportunistic infections and other sexually transmitted infections are all important.

The efficacy of individual projects is not purely dependent on the means of intervention. The project itself needs to have professional and committed management, be integrated with the local community it is serving, and have stable amounts of future funding. Above all, projects must respond to critical local needs, and produce positive outcomes in the lives of their users. There is no one model that has shown better results over all others, and even if it were found, it would not fit all social environments.

As well as efficacy, donors may have other strategic objectives:

- Desire to catalyse change, for instance in national policy or social behaviour, as well as benefiting confined local groups.
- Innovation and support of new models or pilot projects with potential for replication.
- Engagement of local philanthropists in order to leverage foreign funding and efforts.
- Collaboration with other NGOs and where possible public/private partnerships to maximise local efficiencies.
- Joint initiatives with other funders.
- Initiatives in the wider context of sub-Saharan Africa.

NPC has visited a number of projects in Burundi, Democratic Republic of Congo and Rwanda which meet these criteria. Donors can choose between local initiatives (which NPC believes are able to account for money received and report on progress and outputs) or provide grants to intermediary NGOs based outside the region. Grants from \$10,000 to \$1 million and more can generate benefits for those affected that will make a life-saving difference.

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#### **Further reading**

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## Glossary

**AIDS:** Acquired Immunodeficiency Syndrome

**ARVs:** Antiretroviral drugs. A Q&A about ARVs is available separately on the NPC website.

**ART:** Antiretroviral treatment or therapy. See above

**AZT:** Azidothymidine (chemical name), Zidovudine (generic name), Retrovir® (brand name) – drug used as part of triple-therapy antiretroviral treatment.

**CBO:** Community based organisation

**CD4+ T-lymphocyte:** A type of white blood cell which is critical to the immune system. The normal count for a healthy person is 500-1600. A count below 200 is considered highly dangerous and is often the trigger for ARV treatment.

**DRC:** Democratic Republic of Congo (the French acronym is RDC)

**Discordant:** Refers to a sexual partnership where one party is HIV positive and the other HIV negative.

**Donors:** Persons or organisations choosing to make a financial contribution to a project, charity or programme – covers a wide range from grant-makers, bi-lateral country to country donors, to companies and private individuals.

**Great Lakes region:** in this report it refers to the region incorporating Burundi, Democratic Republic of Congo and Rwanda.

**HIV:** Human Immunodeficiency Virus

**HIV positive:** A positive diagnosis occurs if antibodies for HIV (not HIV itself) are detected. HIV negative indicates that no antibodies have been detected and implies a lack of infection.

**HAART:** Highly Active Antiretroviral Treatment or therapy, closely monitored treatment with triple-therapy ARVs. May also be referred to as ART.

**ICHC:** Integrated community based home care

**Microbicide:** Substance that can substantially reduce transmission of sexually transmitted infections (STIs) when applied either in the vagina or rectum.

**Morbidity:** Incidence of sickness/disease, diseased/sick condition

**Mortality:** Death rate, death.

**MTCT:** Mother to Child Transmission of HIV

**Nevirapine:** Nevirapine (trade name Viramune) is one of a class of drugs called non-nucleoside reverse transcriptase inhibitors (NNRTIs) used in the treatment of HIV/AIDS.

**NGO:** Non-governmental organisation

**Opportunistic Infections:** Diseases which attack, and may eventually kill, someone whose immune system has been weakened by AIDS.

**Orphan:** International convention is that an orphaned child may have lost either one or both parents<sup>118</sup>

**pip:** Per infection prevented, a shorthand coined in the outcome section of this report.

**PMTCT:** Prevention of mother to child transmission of HIV, using ARVs to reduce the risk.

**STI or STD:** Sexually transmitted infection or disease

**TB:** Tuberculosis

**US\$:GPB exchange rate:** US\$1.78:£1 used throughout (rate of conversion as at 15th September 2004 using [www.xe.com](http://www.xe.com) universal currency converter)

**Viral load:** A measure of the density of HIV in body fluids.

**VCT:** Voluntary Counselling and Testing

## Acronyms of NGOs, national and international organisations

<b>ABS</b>	Alliance Burundaise contre le SIDA
<b>ADRA</b>	Adventist Development and Relief Agency
<b>AMREF</b>	African Medical Research and Education Foundation
<b>ANSP+</b>	Association Nationale des Séropositifs
<b>ANSS</b>	Association Nationale de Soutien aux Séropositifs et Sidéens
<b>BTC</b>	Belgian Technical Cooperation
<b>CNLS</b>	Commission Nationale de Lutte contre le SIDA
<b>CPLS</b>	Commission Provinciale de Lutte contre le SIDA
<b>DfID</b>	Department for International Development, the part of the UK government responsible for overseas aid and development
<b>DOCS</b>	Doctors on Call for Service
<b>FFP</b>	Fondation Femme Plus
<b>GTZ</b>	Deutsche Gesellschaft für Technische Zusammenarbeit or German Technical Cooperation
<b>GVC</b>	Gruppo Volontariato Civile
<b>HI</b>	Handicap International
<b>ICRC</b>	International Committee of the Red Cross
<b>JRS</b>	Jesuit Refugee Service
<b>MSF</b>	Médecins Sans Frontières (Doctors without Borders), a leading medical NGO
<b>NE</b>	Nouvelle Esperance
<b>PAHO</b>	People Affected by HIV/AIDS Organisation
<b>PSI</b>	Population Services International
<b>RBP+</b>	Reseau Burundais des Personnes vivant avec le VIH/SIDA
<b>SIPAA</b>	Support to International Partnership against AIDS in Africa
<b>SURF</b>	Survivors Fund
<b>SWAA</b>	Society for Women against AIDS in Africa
<b>TAC</b>	Treatment Action Campaign, lobbies for universal ART in South Africa
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNDP</b>	United Nations Development Programme
<b>UNFPA</b>	United Nations Population Fund
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>UNICEF</b>	United Nations Children's Fund
<b>WHO</b>	World Health Organisation
<b>WTO</b>	World Trade Organisation

## Footnotes

- <sup>1</sup> UNAIDS: Report on the global AIDS epidemic: 4<sup>th</sup> global report, July 2004
- <sup>2</sup> WHO: The World Health Report 2003 Annex Table 2 (NB WHO has withdrawn the annex from its website due to dissatisfaction with the quality of data. NPC recognises this health warning, but it is still interesting data for comparison purposes.
- <sup>3</sup> UNAIDS: Report on the global AIDS epidemic: 4<sup>th</sup> global report, July 2004
- <sup>4</sup> WHO: Tuberculosis strategy & operations [http://www.who.int/gtb/policyrd/TBHIV\\_old02oct.htm](http://www.who.int/gtb/policyrd/TBHIV_old02oct.htm)
- <sup>5</sup> UNICEF website accessed 10/08/04 [http://www.unicef.org/aids/index\\_orphans.html](http://www.unicef.org/aids/index_orphans.html)
- <sup>6</sup> Shanta Devarajan, Hans Gersbach, Clive Bell (2003) *Long-run Economic Costs of AIDS: Theory and an Application to South Africa*
- <sup>7</sup> Shanta Devarajan, Hans Gersbach, Clive Bell (2003) *Long-run Economic Costs of AIDS: Theory and an Application to South Africa*
- <sup>8</sup> UNAIDS: Report on the global AIDS epidemic: 4<sup>th</sup> global report, July 2004 p.10
- <sup>9</sup> Taking Action: UK's strategy for tackling HIV and AIDS in the developing world – page 18. Published by DfID 21/07/2004
- <sup>10</sup> UNAIDS: Report on the global AIDS epidemic: 4<sup>th</sup> global report, July 2004
- <sup>11</sup> £1.5bn committed by DfID in strategy review <http://www.dfid.gov.uk/pubs/files/hivaids-factsheet.pdf> accessed Nov 04
- <sup>12</sup> 2004 report on the Global AIDS epidemic, UNAIDS, p138
- <sup>13</sup> Juan Pablo Gutierrez, Benjamin Johns et al Achieving the WHO/UNAIDS antiretroviral treatment 3 by 5 goal: what will it cost? The Lancet 2004; 364: 63064
- <sup>14</sup> Figures borrowed from ARK's budget for operations in South Africa (PEPFAR application) and rounded by NPC: US\$220 drugs; US\$110 lab testing; US\$110 patient advocacy; US\$110 medical supervision (NPC's estimate).
- <sup>15</sup> Treating 3 million by 2005: Making it happen – the WHO strategy
- <sup>16</sup> Statement at G8 Summit (2001), <http://usinfo.state.gov/topical/econ/group8/summit01/www01072025.html>
- <sup>17</sup> Pledges to date amount to a total of US\$5.5bn for the period from inception to 2008. The current position is inadequate, as the fund estimates that for 2005 US\$3.6bn is needed, but although pledges in 2005 amount to US\$2bn, these pledges are to run to 2008. So the actual pledges for 2005 only cover a quarter of the US\$3.6bn required. A quick summation of: total grant approvals for round 1-4; expected approvals for rounds 5 and 6 (imminent) and renewals of rounds 1, 2, 3 amount to US\$6.35bn. So there is a substantial shortfall even before further rounds in 2006-8 are mooted and renewals for rounds 4 onwards are included. The US will only commit to pledging a maximum 33% of funds (and its commitments are already exceeding this level), which leaves the EU countries carrying the lion's share.
- <sup>18</sup> The Global Fund Progress Report 10<sup>th</sup> May 2004
- <sup>19</sup> The White House, <http://www.whitehouse.gov/news/releases/2003/01/20030129-1.html>
- <sup>20</sup> Wall Street Journal August 2004, as quoted by [www.kaisernetwork.org](http://www.kaisernetwork.org) accessed September 18<sup>th</sup> 2004
- <sup>21</sup> Dr Yusuf Hamied, Chairman of Cipla, conversation August 2004
- <sup>22</sup> Gates Foundation website accessed 27 July 2004 <http://www.gatesfoundation.org/GlobalHealth/HIVAIDSTB/Grants/default.htm?showYear=2003>
- <sup>23</sup> 2004 report on the Global AIDS epidemic, UNAIDS, p141
- <sup>24</sup> both company and foundation engage in philanthropy
- <sup>25</sup> 2004 report on the Global AIDS epidemic, UNAIDS, p141
- <sup>26</sup> The phrase "affected" is used to differentiate between people who are infected by HIV AIDS and those who are affected by the epidemic because family members are infected. People affected may also be infected, and vice versa.
- <sup>27</sup> Dr Geeta Rao Gupta, President of the International Centre for Research on Women, lecture February 2004
- <sup>28</sup> Pfeffer D, Nafissa O, Vaz P (2002), *PMTCT: Cost-benefit analysis of a program in Mozambique*.
- <sup>29</sup> Creese A, Floyd K, Alban A, Guinness L (2002) *Cost-effectiveness of HIV/AIDS interventions in Africa, The Lancet 2002; 359: p1640*. pip costs converted from \$ (2000) to £ (April 2003) using average FX rate of 1\$/£0.66 and inflation of 5.9% from June 2000 to April 2003
- <sup>30</sup> 250 ÷ 29% = US\$862; 29% = risk improvement from 30% risk of transmission to 1% risk of transmission if treated with HAART.
- <sup>31</sup> Damian Walker: *Cost and cost-effectiveness of HIV/AIDS prevention strategies in developing countries: is there an evidence base?* Health policy and planning; 18(1) 4-17 OUP 2003 p10
- <sup>32</sup> Soderlund N, Zwi A, Kinghorn A, Gray G. (1999), *Prevention of vertical transmission of HIV: analysis of cost effectiveness of options available in South Africa, BMJ 1999; 318: 1650–56*.
- <sup>33</sup> Damian Walker: *Cost and cost-effectiveness of HIV/AIDS prevention strategies in developing countries: is there an evidence base?* Health policy and planning; 18(1) 4-17 OUP 2003
- <sup>34</sup> International Herald Tribune (6/6/01)
- <sup>35</sup> 20% of individuals reached through existing services; 50% usage in all sex acts; 60% efficacy
- <sup>36</sup> Mobilization for Microbicides, the Decisive Decade, funded by the Rockefeller Foundation 2000 [http://www.rockfound.org/Documents/488/rep1\\_summary.pdf](http://www.rockfound.org/Documents/488/rep1_summary.pdf) accessed 05/08/04

- <sup>37</sup> IRIN Africa newsPlus 7<sup>th</sup> September 2004 "Moving towards marketable microbicides".
- <sup>38</sup> Anne Buve, Institute of Tropical Medicine, Antwerp, email 20<sup>th</sup> October 2004
- <sup>39</sup> Leclerc Madlala (2002):
- <sup>40</sup> Leclerc Madlala (2002):
- <sup>41</sup> Cost-effectiveness of voluntary HIV-1 counselling and testing in reducing sexual transmission of HIV-1 in Kenya and Tanzania: Michael Sweat et al, *The Lancet* 08/07/2000 volume 356 no 9224
- <sup>42</sup> Nicoli Nattrass, *Social Dynamics Vol 28 no 1 2002*, Centre for Social Science Research, University of Cape Town
- <sup>43</sup> Damian Walker, *Cost and cost-effectiveness of HIV/AIDS prevention strategies in developing countries: is there an evidence base?* Health policy and planning; 18(1): 4-17 OUP 2003. Damian Wlaker is at London School of Hygiene and Tropical Medicine
- <sup>44</sup> AMREF – results from Mwanza
- <sup>45</sup> Donald Skinner (2001): *ibid*
- <sup>46</sup> Moses S, Plummer FA, Ngugi EN, Nagelkerke NJD, Anzala AO, Ndinya-Achola JO (1991), *Controlling HIV in Africa: effectiveness and cost of an intervention in a high-frequency STD transmitter core group*, *AIDS* 1991; 5: 407–11.
- <sup>47</sup> Creese A et al (*Lancet* 2002) *Cost-effectiveness of HIV/AIDS interventions in Africa: a systematic review of the evidence*
- <sup>48</sup> Michael Sweat et al (July 2000) *The Lancet*
- <sup>49</sup> Michael Sweat et al (July 2000) *The Lancet*
- <sup>50</sup> Sweat M, Gregorich S, Sangiwa G, et al. (2000), *Cost-effectiveness of voluntary HIV-1 counselling and testing in reducing sexual transmission of HIV-1 in Kenya and Tanzania*, *The Lancet* 2000; 356: 113–21.
- <sup>51</sup> Sweat M, Gregorich S, Sangiwa G, et al. (2000), *Cost-effectiveness of voluntary HIV-1 counselling and testing in reducing sexual transmission of HIV-1 in Kenya and Tanzania*, *The Lancet* 2000; 356: 113–21.
- <sup>52</sup> LF Johnson and R Dorrington (2002): *Study in Cameroon 1998*
- <sup>53</sup> Centre for Disease Control, <http://www.cdc.gov/>
- <sup>54</sup> DfID and MRC Knowledge Programme on HIV/AIDS and STIs Briefing Note 1: What is the role of STD control in the prevention of HIV? Findings from the STDSIM simulation study.
- <sup>55</sup> J. Vandepitte (1), F. Malele (2), D.M. Kivuvu (2), S. Edidi (3), J. Muwonga (3), F. Lepira (4), S. Abdellati (1), C. Van Overloop (2), A. Buvé (1) (2004) *Female Sex Workers attending a designated clinic in Kinshasa, DRC: Decline in prevalence of HIV and other Sexually Transmitted Infections between 1988 and 2002*.
- (1) Institute of Tropical Medicine, STD/HIV Research & Intervention Unit, Antwerp, Belgium
- (2) Médecins Sans Frontières Belgium
- (3) Laboratoire National de Référence SIDA et IST (LNRS)
- (4) Programme National de Lutte contre le SIDA et les IST (PNLS)
- <sup>56</sup> Gilson L, Mkanje R, Grosskurth H, et al. (1997), *Cost-effectiveness of improved treatment services for sexually transmitted diseases in preventing HIV-1 infection in Mwanza Region, Tanzania*, *The Lancet* 1997; 350: 1805–09.
- Hayes R, Wawer M (1997), *Randomised trials of STD treatment for HIV prevention*, *Genitourinary Medicine* 73(6): 432–43
- <sup>57</sup> Moses S, Plummer FA, Ngugi EN, Nagelkerke NJD, Anzala AO, Ndinya-Achola JO (1991), *Controlling HIV in Africa: effectiveness and cost of an intervention in a high-frequency STD transmitter core group*, *AIDS* 1991; 5: 407–11.
- <sup>58</sup> Juan Pablo Gutierrez, Benjamin Johns et al Achieving the WHO/UNAIDS antiretroviral treatment 3 by 5 goal: what will it cost? *The Lancet* 2004; 364: 63064
- <sup>59</sup> Figures borrowed from ARK's budget for operations in South Africa (PEPFAR application) and rounded by NPC: US\$220 drugs; US\$110 lab testing; US\$110 patient advocacy; US\$110 medical supervision (NPC's estimate).
- <sup>60</sup> NPC estimate. Brazil estimates that it saved \$1.1bn over 4 years and kept 358,000 patients out of hospital.
- <sup>61</sup> Sonja Gielse – University of Cape Town 2003
- <sup>62</sup> approximation using figures from ARK's budget for antiretroviral programme in South Africa. The cost will vary from country to country depending on who offers a laboratory testing service.
- <sup>63</sup> Dr Robert Book: Medical Officer for Naledi Hospice; Dr Paul Roux, Groote Schuur Hospital
- <sup>64</sup> Visit to Pinetown Child Welfare, February 2003
- <sup>65</sup> Sonja Giese, Children's Institute Cape Town
- <sup>66</sup> Damian Walker, *Cost and cost-effectiveness of HIV/AIDS prevention strategies in developing countries: is there an evidence base?* Health policy and planning; 18(1): 4-17 OUP 2003. Damian Wlaker is at London School of Hygiene and Tropical Medicine
- <sup>67</sup> **Source of figures in Table Section 5:**
- Education/awareness Student Partnership Worldwide / NPC estimates;
- Voluntary counselling and testing: Michael Sweat et al (2000) (see above);
- Condoms: cost/user from Pepper D (2002 "Prevention of mother to child transmission cost benefit analysis of a programme in Mozambique page 13)

Condoms: cost/success from Creese A, Floyd K, Alban A, Guinness L *Cost-effectiveness of HIV/AIDS interventions in Africa: a systematic review of the evidence* The Lancet vol 359 May 11 2002, 1991 figures so inflated up to 2003 by 4%

STIs: Damien Walker (see above)

The PMCTC cost per success calculations are as follows:

Nevirapine shot drug costs US\$4: Pfeffer D, Nafissa O, Vaz P (2002), *PMTCT: Cost-benefit analysis of a program in Mozambique*. In some places real cost of delivery may be higher.

Nevirapine: one shot per HIV positive mother reduces the risk of transmission from 30% to 15% (i.e. 15% improvement),  $US\$4 \div 15\% = US\$27$

HAART: course per HIV positive mother reduces risk of transmission from 30% to 1% (i.e. 29% improvement),  $US\$250 \div 29\% = US\$862$

Blood security: Yaounde in Cameroon, Damien Walker

ARVs: figures from Crusaïd, Cost/success assumes 20% non adherence, resistance or drop out due to side effects over a 10-year period; Assume 10 years of treatment while children growing up

community based care NPC estimates from South Coast Hospice and Hensher study;

fostering NPC estimates from projects visited in South Africa;

registration, were it included, would be US\$108 based on NPC estimates from projects visited in South Africa. However, registration not crucial intervention in areas where there are no grant systems.

education NPC estimates from projects visited: : low end of scale = school fees and uniforms, upper end of scale = early education support;

nutrition = cost of Epat to adult or child per annum (R60 per month)

family support in Rwanda = Hope and Homes for Children budget 2004

<sup>68</sup> This section has drawn on Don Brandt and Matthew Scott, *An ounce of prevention*, World Vision, Q3 2004.

<sup>69</sup> Evaluation of Scripture Union Burundi EPA project, Tearfund, February 2004

<sup>70</sup> Quote from a widow in an IDP camp, met through Association Umuryango

<sup>71</sup> Figures from Don Brandt and Matthew Scott, *An ounce of prevention*, World Vision, Q3 2004.

<sup>72</sup> UNDP interview

<sup>73</sup> OXFAM International: *A Situation Analysis On The Hiv/Aids Epidemic In Burundi*, April 2003

<sup>74</sup> PNLS/MST, *Bulletin épidémiologique annuel de surveillance du VIH/SIDA/MST*, July 2001

<sup>75</sup> IRIN interview with HIV/AIDS Minister Sindabizera, February 2002

<sup>76</sup> *HIV/AIDS still constitutes a big problem in Burundi*, Medical Information and Research Centre

<sup>77</sup> <http://www.plusnews.org/AIDS/burundi.asp> accessed June 2004

<sup>78</sup> IRIN, Women wake up to HIV/AIDS, 25 November 2002

<sup>79</sup> WHO, 3by5 mission to Burundi report

<sup>80</sup> Vera Bensmann: *The response to HIV/AIDS in conflict situations, a research study into Rwanda, Burundi and Eastern DRC* 22<sup>nd</sup> Jan 2003 [http://home.tiscali.nl/~xp115801/my\\_project/default\\_explanation.htm](http://home.tiscali.nl/~xp115801/my_project/default_explanation.htm)

<sup>81</sup> For example in July 1993 three Swiss workers for ICRC were killed near Cibitoke, either by the army or rebels. See Christian Jennings, *Across the Red River*, 2000, p250

<sup>82</sup> SIPAA

<sup>83</sup> *Plan opérationnel pour l'accélération de l'accès aux soins des personnes vivant avec le VIH-SIDA*, WHO-Burundi, Draft 15 July 2004

<sup>84</sup> interview with GVC – should be reference this?

<sup>85</sup> *Social-behavioural study on HIV/AIDS infection in Burundi*, Information and Research Centre for Infectious Diseases (CEFORMI), 2001

<sup>86</sup> Handicap International

<sup>87</sup> We heard this same message from NGOs, UN agencies and international NGOs.

<sup>88</sup> Csete, Joanne & Kippenberg, Julianne, *The War Within The War*, Human Rights Watch, June 2002.

<sup>89</sup> Oxfam, *No End in Sight*, August 2001

<sup>90</sup> Department of health NHS workforce statistics

<sup>91</sup> MSF

<sup>92</sup> UNC

<sup>93</sup> Anne Buve, Institute of Tropical Medicine, Antwerp

<sup>94</sup> PSI

<sup>95</sup> UNAIDS (Kinshasa)

<sup>96</sup> MSF PR [1/10/03](#)

<sup>97</sup> WHO, DRC Health Update, July 2001, p. 2

<sup>98</sup> United States Institute for Peace, "Special Report: AIDS and Violent Conflict in Africa," October 2001, p.5

<sup>99</sup> USAID, UNAIDS (Kinshasa)

<sup>100</sup> WHO, DRC Health Update, July 2001, p. 2 – figures from "public health officials"

<sup>101</sup> PNLS document "Bilan, Defis et perspectives". Orally the PNLS told us that 165,000 need ARVs.

<sup>102</sup> UNC

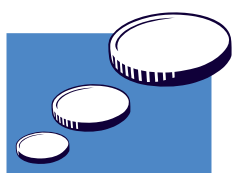


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- <sup>103</sup> \$.Euro conversion at \$1.32::1.00 as at 13<sup>th</sup> January 2005
- <sup>104</sup> MSF website updated 15/10/04 accessed 01/11/04  
<http://www.msf.org/countries/page.cfm?articleid=6142E492-A180-4608-87CCBF0F0A0B812B>
- <sup>105</sup> PNLS
- <sup>106</sup> Medical Research Council, UK
- <sup>107</sup> PSI, Dr. Frank Lepira
- <sup>108</sup> It is not clear whether the World Bank funds will cover areas outside of the provincial capitals.
- <sup>109</sup> PNLS/GTZ, Cartographie des intervenants et des interventions (April 2004)
- <sup>110</sup> UNC, DFID, MSF
- <sup>111</sup> World Health Report 2004
- <sup>112</sup> *Government of Rwanda HIV/AIDS Treatment and Care Plan 2003-2007 developed with the William J. Clinton Foundation* May 2003  
<http://www.usaid-rwanda.rw/SO2/RwandaDoc05.07.03.pdf>
- <sup>113</sup> Other sources suggested that the Clinton Foundation had put together a budget of US\$172m to treat over 380,000 for five years, but it is not clear who would fund this.
- <sup>114</sup> Decentralisation of for the overall management of people living with HIV/AIDS, Proposal for Global Fund round 3, signed 30 June 2004.
- <sup>115</sup> DFID Country Assistance Plan for Rwanda <http://www.dfid.gov.uk/pubs/files/capr Rwanda.pdf>
- <sup>116</sup> Sue Enfield, March 2005
- <sup>117</sup> FAO/WFP Crop and Food Supply Assessment Mission to Rwanda, 1 July 1997  
<http://www.fao.org/WAICENT/faoinfo/economic/gIEWS/english/alertes/srrwa797.htm>
- <sup>118</sup> Anne Buve, Institute of Tropical Medicine, Antwerp, email 20<sup>th</sup> October 2004

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