

Chapter 6

The Democratic Republic of Congo case study

Chapter overview

This chapter provides a case study of the collaborative situation in the Democratic Republic of the Congo (formerly Zaire). First it provides a brief overview of the religious-health landscape in that country, in the context of the HIV and AIDS epidemic. Then it presents the country-specific findings, followed by recommendations arising from the research.

6.1 DRC country context

Country Information²⁵⁸

Geography: DRC is located in Central Africa, bounded to the West by the Republic of Congo and Gabon, to the North by Central African Republic and Sudan, to the East by Uganda, Rwanda and Burundi, to the South by Angola, Zambia and Tanzania. DRC is geographically vast with a total area of 2,345,000 km² but sparsely populated.

Capital: Kinshasa

Language: French (official), Lingala (lingua franca trade language), Kingwana (dialect of Kiswahili or Swahili), Kikongo, Tshiluba.

Politics: Because of the civil war prevailing in the country since 1998, almost 1/3 of the country is under rebel occupation.

Administration: DRC is divided into 11 administrative provinces.

Urban Rural Split: Of the 60 million people living in the DRC, the majority (70%) live in rural areas, while 10 million of the population are living in Kinshasa the capital city.



Religion in DRC²⁵⁹

Roman Catholic 50%, Protestant 20%, Kimbanguist 10%, Muslim 10%, other (includes syncretic sects and indigenous beliefs) 10%

WHO Mortality Summary ²⁶⁰	Year	Male	Female	Both Sexes	Top ten causes of death all ages - DRC 2002 ¹⁹	Deaths (000)	Years Life Lost %
Population (millions)	2005	28.5	29.0	57.5	All causes	978	100
Life expectancy (years)	2004	42	47	44	Diarrhoeal diseases	112	13
Under-5 mortality (per 1000 live births)	2004	217	192	205	HIV/AIDS	111	11
Adult mortality (per 1000)	2004	576	446		Lower respiratory infections	108	13
Maternal mortality (per 100000 live births)	2000		990		Malaria	97	12
					War	44	4
					Perinatal conditions	39	5
					Measles	37	5
					Tuberculosis	33	3
					Cerebrovascular disease	26	1
					Ischaemic heart disease	24	1

²⁵⁸ CIA 2007, Lusey-Gekawaku 2003, WHO-Afro 2006

²⁵⁹ CIA 2007

²⁶⁰ UNAIDS 2006a. See also WHO-Afro 2006

As a general note to this introductory section, there is little up-to-date and reliable information on the social and economic sectors of the DRC. Some data are of limited value since most are derived from small scale studies, or based on specific locations within the DRC. This is demonstrated visually with the following map from the latest UNAIDS EpiUpdate 2007 (see figure 6.1 below):

2007 AIDS EPIDEMIC UPDATE | SUB-SAHARAN AFRICA

HIV prevalence from national population-based surveys in countries in West and Central Africa, 2003–2007

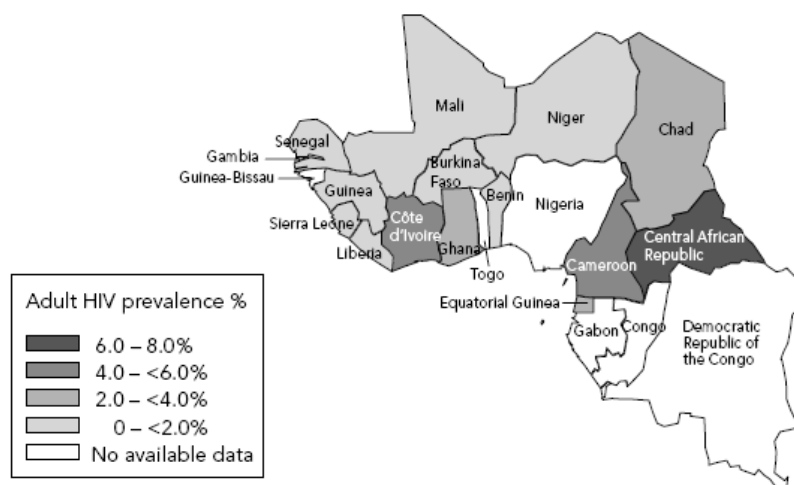


Figure 6.1: Source UNAIDS 2007

6.1.1 Religious-health landscape in the DRC²⁶¹

A. The history of religious involvement in health

In the DRC, the history of medical mission and health professionals working with religious entities goes back more than a hundred years. The Protestant medical mission began in 1882 and the Catholic mission in 1889, both enabling the creation of hospitals and health services. Protestant missionaries thus led the way in establishing the first hospitals in the DRC. We know less about the efforts of other religious groups in health at this time. A significant event took place in 1928 in an effort to improve the coordination of services.²⁶²

Significantly in 1999 the Ministry of Health turned over responsibility for health care in 60 health zones to a coalition of mostly faith-based non-governmental health organizations.²⁶³ In the face of political and economic crisis and instability, religious entities have continued to play a long-term and obvious role in healthcare at a national level. The DRC thus demonstrates a unique situation of public-private partnerships in health. The large Christian majority in the country means that most of the religious entities are from a Christian background, with Protestant and Catholic efforts being most prominent according to secondary literature.

²⁶¹ Unless indicated otherwise, this summary is from Schmid et al 2008

²⁶² Baer 2007

²⁶³ IDT 1998, Baer 2001

International 'FBOs' have also played a critical role, often providing assistance during times of conflict and to remote locations even after other organizations have pulled out. More research is needed on faith-based efforts in health at a local and community level.²⁶⁴

B. Religious entities in the DRC health sector

The DRC national health system is currently based on 515 Decentralized Health Zones. Secondary literature states that faith-based organizations and networks currently provide between 50%-70% of health services in the DRC. This range is depicted by the following statements:

...70% of health services are delivered by churches and church related institutions with meaningful results.²⁶⁵

50% of hospitals in the DRC are owned and managed by local churches.²⁶⁶

In the DRC virtually the whole health care infrastructure is currently provided by faith organizations as the government health system has practically collapsed. It is estimated that the Roman Catholic Church alone provides 25% of all HIV/AIDS care including home based care and support of orphans.²⁶⁷

It is possible that this predominantly facility-based contribution of CREs to the public health systems has shaped the nature of the response of CREs to the HIV and AIDS epidemic in the DRC. The participatory research indicated a very strong *medical* focus on the epidemic, with surprisingly less attention given to what are traditionally seen as 'spiritual or pastoral' matters.

C. Religious entities involvement in HIV and AIDS

Less is currently known of the history of the religious sector's involvement in HIV and AIDS specifically, rather than health generally. The 2005 Congolese UNESCO study, noted:

For several years, religious bodies have remained passive. It is only in 2003 that the religious sector made a move by setting up a committee, *le comité interconfessionnel* (The Interfaith Council to Fight AIDS - CIC) to coordinate its actions against HIV/AIDS. Other charitable organizations, religious or otherwise, are contributing to the national response largely through the provision of psychosocial support to people affected by the epidemic.²⁶⁸

This statement does not perhaps adequately reflect the health-services-related response to HIV and AIDS delivered through the substantial facility-based religious health sector as described above. In the participant discussion below (section 6.2), we will engage with this issue further.

²⁶⁴ See CCIH 2007, Lusey-Gekawaku 2003, SANRU 2007

²⁶⁵ ECC 2007

²⁶⁶ Baer 2001

²⁶⁷ CCIH 2007

²⁶⁸ Doupe 2005

6.1.2 The HIV and AIDS epidemic in DRC²⁶⁹

HIV and AIDS Estimates ²⁷⁰	Estimate
Number of people living with HIV	1 000 000
National HIV prevalence among adults (ages 15-49)	(2005) 3.2
Adults aged 15 and up living with HIV	890 000
Women aged 15 and up living with HIV	520 000
Deaths due to AIDS (during 2005)	90 000
Children aged 0 to 14 living with HIV	120 000
Orphans aged 0 to 17 due to AIDS	680 000

A. State of the epidemic²⁷¹

The Democratic Republic of the Congo is in the grip of what can be termed a 'widespread' epidemic. Prevalence varies from 1.7 to 7.6% depending on the region, and may be as high as 20% among women who have suffered sexual violence in areas of armed conflict.²⁷² The epidemic is strongest among young people between the ages of 15 and 24, and women consulting at antenatal clinics. Figures suggest that prevalence rates within these two groups are increasing.²⁷³

In the Democratic Republic of the Congo HIV prevalence among antenatal clinic attendees has remained relatively stable in the capital, Kinshasa (between 3.8% in 1995 and 4.2% in 2005), but prevalence has risen in the country's second-largest city, Lubumbashi (from 4.7% to 6.6% between 1997 and 2005), as well as in Mikalayi (from 0.6% to 2.2% between 1999 and 2005) (Kayembe et al., 2007). Prevalence is also high in the cities of Matadi, Kisangani and Mbandaka (where 6% of women using antenatal services were HIV-positive in 2005), as well as in Tshikapa (where prevalence was 8%) (Programme National de Lutte contre le SIDA, 2005).²⁷⁴

HIV and AIDS as one of many problems: It is clear that the DRC faces a plethora of development and health issues which the HIV and AIDS epidemic compound. The epidemic in the DRC is further complicated by extreme poverty and weak or nonexistent public health infrastructure.²⁷⁵

Conflict history: The country has suffered numerous conflicts, which have dashed development efforts and given rise to disastrous humanitarian consequences. Some of the direct health impacts include disease spread and death, violence (both physical and sexual), refugees and internal displacement requiring the provision of emergency health services, often in the context of the collapse of social and physical infrastructure, and high HIV prevalence in military personnel.²⁷⁶ The armed conflicts in the DRC have prompted large scale population movements within the country. An estimated 1.4 million people have been

²⁶⁹ This report emerged as international epidemiological fact sheets were being updated. New figures are expected by August 2008.

²⁷⁰ Unless indicated otherwise, these figures come from UNAIDS 2006a

²⁷¹ This acts as an introduction to the chapter, not all HIV estimates are presented - such as the effect of the epidemic on social and economic sectors. See PNMLS 2008 for a more complete update.

²⁷² UNAIDS 2006a

²⁷³ UNAIDS 2006a

²⁷⁴ UNAIDS 2007

²⁷⁵ WHO 2005

²⁷⁶ See Schmid et al 2008

displaced from their home province to another by the conflicts. About a quarter of the Congolese population live in the two economically strong provinces of Kinshasa, the capital and Katanga, the mining hub.²⁷⁷

The DRC is categorised among the poorest countries in the world ... The country is in a post-conflict period following two successive wars (1996-1997 and 1998-2003), which led to the collapse of the economic and social infrastructure. Poverty, the lack of appropriate medical system and migration of the population because of the war may have fuelled the spread of HIV/AIDS.²⁷⁸

The Democratic Republic of Congo (DRC) has seen the end of large-scale conflict only recently. Areas of unrest remain, for example, in June 2008, the United Nations Security Council renewed a push for civilian rule in the DRC's militia-plagued eastern (Goma) region

... the country's hilly eastern border area - the scene of the worst fighting and a humanitarian crisis in the Central African nation - has been lawless for so long that citizens have given up on any sort of government ... the DRC's UN peacekeeping force is the world's largest with 17 000 troops, more than 90% of those stationed in the east.²⁷⁹

At the same time, the country is now seen to be in a process of national reconstruction with AIDS control as part of the Poverty Reduction Strategy Paper (PRSP).²⁸⁰ Major reconstruction plans have been drawn along the so called presidential '5 axes', including the health sector.²⁸¹ The HIV and AIDS epidemic is caught in the middle of these dualities of conflict and reconstruction.

B. Timeline of significant events in DRC's AIDS epidemic

This timeline does not depict every AIDS-significant event in DRC, but rather is an amalgam of events important to the participants, recorded in government documentation, and participant responses to the questionnaire. It therefore also contains events important to the religious entities.²⁸²

1889	Appointment of Dr. Adrien Atiman, the first medical doctor to work in Congo for Catholic missions.
1928	40 protestant missionary societies from 12 countries create the Protestant Council of the Congo
1971	The Mobutu 'authenticity movement' required all protestant groups to unite within one authorized national church. The Protestant Church of Zaire (ECZ, currently ECC) is formed with around sixty member communities, and a medical office (the Direction des Oeuvres Médicales - DOM) to interface with the Ministry of Health.
1974	Zairianism introduced which stressed that Congolese need to manage their own affairs.
1975	ECC DOM and the Catholic Church co-sponsor a national conference in collaboration with the Ministry of Health which establishes a national consensus for the concepts of 'decentralized health zones' and 'primary health care.'
1977	Social programmes handed over to churches as a result of the Zairianism ideology.

²⁷⁷ CIA 2007

²⁷⁸ Kayembe 2005

²⁷⁹ Lederer 2008

²⁸⁰ UNAIDS 2006a, WHO 2005

²⁸¹ Participant correspondence - 2008

²⁸² See Baer 2007, Kayembe 2005, Lusey-Gekawaku 2003, PNMLS 2008, SANRU 2007, UNAIDS 2006a, WHO 2005, participant workshops

- 1980 Based on requests from Protestant health services for assistance, USAID with ECC/DOM designs a project to create fifty health zones around Protestant hospitals. ECC chosen to manage this multi-million dollar bilateral project called the Basic Rural Health Project, one of the first projects of this size to be managed by an umbrella organization of any Church body.
- 1981 (1981-1991): The Basic Rural Health Project becomes better known as SANRU (Projet Santé Rurale), the project is opened to health zones created around Catholic, governmental, and other NGO-managed hospitals. This approach transforms SANRU into a national health project.
- 1982 Arrival in Congo of Dr. Aaron Sims, the first in a long list of medical doctors to work in Congo for Protestant missions.
- 1983 The DRC one of the first African countries to acknowledge the existence of HIV and AIDS in its territory. The first case was reported by an international team that worked with Congolese researchers.
- 1984 Creation of AIDS Project to collect epidemiological data in order to implement HIV prevention and AIDS control.
- 1984 (1984-1987): ECC accepts the management of an additional project for the physical rehabilitation of 200 health centers across Congo. Working in collaboration with the Organization for Rehabilitation by Training (an NGO of the Jewish faith) and USAID.
- 1985 Government allows establishment of 'Projet SIDA' in Mama-Yemo hospital (Kinshasa General Hospital), as a joint project between the CDC, the National Institutes for Health (NIH), The Institute of Tropical Medicine of Antwerp (IMT), and the Government of the DRC. The mission of the project was to conduct epidemiological and clinical research to better understand the patterns of the disease, the modes of transmission and its natural history.
- 1985 Creation of the National AIDS Control Commission (comité national de lutte contre le Sida - CNLS).
- 1987 The DRC officially reported its first cases of AIDS to the World Health Organization (WHO).
- 1987 The Government established a central office to coordinate the national response (*Bureau central de coordination SIDA*, BCC-SIDA) and the National Committee on HIV/AIDS (PNLS). A steering committee whose members were from different sectors including public and private sectors, civil society, was also established. During this initial period, the MoH was primarily involved in the response to the epidemic, because HIV and AIDS was perceived essentially as a medical problem. BCC-SIDA elaborated several plans of action, including short-term plans and a mid-term plan.
- 1987 (1987-1991): SANRU becomes SANRU II. By 1987, more than 200 decentralized health zones are functioning throughout Congo. Between 1982 and 1987 access to primary health care services in SANRU assisted health zones increases from 10% to around 50%.
- 1990 In the 1990s, NGOs joined the national response - some established to address different HIV-related issues such as education, psychosocial support and assistance to OVC.
- 1991 Ransacking and looting of resources and public offices.
- 1991 Elaboration of revised Medium Term Plan 1991-1994. Adoption of the revised MTP submitted to funding agencies.
- 1991 (1991-2001): The political disruptions in Congo in 1991 force USAID to close its offices and discontinue funding for the SANRU project. However, projects continue through a variety of projects and funding sources.
- 1993 Ransacking and looting of resources and public offices.
- 1994 Government announces a protocol signature between the WHO and the National AIDS Control Programme (NACP). "Subsequently, the need to coordinate the NGOs was felt. In 1994, BCC-SIDA established Forum SIDA, or FOSI in 1994, a coordinating body for all NGOs involved in HIV/AIDS programmes. For a very long time, the other components of the public and private sectors and the religious sectors were not involved. Even though the religious sector was represented at the National Committee on HIV/AIDS, this sector did not undertake specific actions against HIV/AIDS."²⁸³
- 1995 AIDS Forum created in Kinshasa.
- 1996 Civil war, President Mobutu leaves.

²⁸³ Kayembe 2005

- 1996 2 years emergency Short Term Plan of UNDP, WHO and UNAIDS to strengthen the NACP.
- 1996 Ebola outbreak: SANRU offices at ECC become the coordination center for all NGO and governmental agencies.
- 1997 End of civil war. Meeting of the National AIDS Council to strengthen the NACP and mobilisation of all national sectors in the struggle against HIV and AIDS. (The National AIDS Council had not held meetings since 1991.)
- 1998 National Interdisciplinary Task force and National Strategic Plan adopted on HIV and AIDS.
- 1999 A 10 year strategic plan (1999-2008) adopted that stressed prevention, care, advocacy activities that highlight community participation, human rights and ethics, and needs of persons living with HIV and AIDS.
- 1999 The National Strategic Plan for HIV/AIDS for 1999-2008
- 2000 Presbyterian and other protestant churches begin to engage the HIV and AIDS epidemic.
- 2000 National AIDS Control Programme restructured.
- 2001 Death of President Laurent Kabila.
- 2001 (2001-2006): Funders such as USAID return to Congo as conflict ends.
- 2001 In conjunction with U.S.-based Interchurch Medical Assistance, a five-year \$25 million SANRU III project is funded to assist sixty health zones throughout Congo.
- 2002 Peace project to fight the HIV and AIDS epidemic.
- 2002 Acceptance of a HIV and AIDS project by synod of CEK.
- 2002 Creation of the Interfaith AIDS Council - CIC (*le comité interconfessionnel*).
- 2002 Antiretroviral therapy (ART): The MoH signed an agreement with a private company, "la Générale Congolaise des Services de Santé, GSS" to import and distribute generic antiretroviral drugs throughout the country. Under this agreement, the imported medicines are cleared from customs free of charge and GSS has the obligation to sell them at a lower price agreed upon with the MoH.
- 2002 The National AIDS Control Programme developed national guidelines for antiretroviral therapy and the treatment of opportunistic infections in adults in collaboration with the German Gesellschaft für Technische Zusammenarbeit (GTZ).
- 2003 President Joseph Kabila attends a United Nations (UN) special session on HIV and AIDS, inaugurates a blood bank building in Kinshasa and starts to talk about HIV and AIDS in his public speeches.
- 2004 President Kabila signs a decree establishing the National Multisectoral Programme on HIV/AIDS (PNMLS), which operates under the coordination of his cabinet.
- 2006 Partnership between the Presbyterian organization APCS and the Global Fund
- 2006 Elections take place.
- 2008 Law to protect the rights of HIV positive people will be finalised at the end of 2008.
- 2008 New national strategic plan to be completed at the end of 2008 for the period 2009-2014.

C. DRC's HIV and AIDS national policy

*The lack of a national strategic plan which has been updated and budgeted for and of long-term vision is a hindrance to the involvement of civil society and of the different sectors, as well as to the harmonization and integration of interventions by all stakeholders.*²⁸⁴

In the timeline above, it can be seen that the government's response to the HIV and AIDS epidemic has been tied to the country context. The current national strategic HIV and AIDS plan, created in 1998-1999 is outmoded, and the new one should be emerging at the end of this year (2008). The National Strategic Plan for HIV/AIDS for 1999-2008 has been the primary guiding document. There have also been subsequent policy documents, such as the national

²⁸⁴ UNAIDS 2006b

guidelines for ART developed in 2002 (with GTZ), or the 2005 National Strategic Plan for Scaling Up Access to Antiretroviral Therapy for the Period 2005-2009. We will therefore not provide any description here of the older one, but provide instead a few observations emerging from secondary literature on the national HIV and AIDS policy environment.²⁸⁵

Political involvement: An area of critical challenge is to increase the level of political commitment and leadership around HIV and AIDS. There are some indications that with the end of hostilities and the establishment of a transitional government in 2003, a renewed commitment to the fight against HIV and AIDS was witnessed. However, others have noted that the general public has been critical of the Government's "inadequate response, lack of prioritisation and inability to address the stigma, discrimination and rejection attached to HIV/AIDS."²⁸⁶

Government structures: There are several government structures dealing with HIV and AIDS work. The two main structures are PNLs and PNMLS:²⁸⁷

- **PNLS (NACP): Programme National de Lutte contre le SIDA (National AIDS Control Programme):** Established early in the epidemic (around 1987), by presidential decree PNLs holds national responsibility for the HIV response. PNLs is specifically seen to lead the national effort to scale up access to antiretroviral therapy in the country, to provide leadership in the health sector response to HIV/AIDS, and provide leadership in surveillance, monitoring and evaluation.
- **PNMLS: Programme National Multisectoriel de Lutte contre le VIH/SIDA (National Multi-Sector Program against HIV and AIDS):** Established in 2004, PNMLS is made up of the public sector represented by the Ministry of Public Health, the private and enterprise sectors and the NGO and faith communities in the DRC. PNMLS is tasked with national coordination of all sectors involved in HIV/AIDS and STI prevention and is assisted in this effort through provincial and local representation. There are national, provincial and local committees within PNMLS (Le Comité National Multisectoriel de lutte contre le VIH/SIDA, Les Comités provinciaux multisectoriels de lutte contre le VIH/SIDA, Les Comités locaux multisectoriels de lutte contre le VIH/SIDA). PNMLS has four components: 1) the public sector which includes all ministries including the Ministry of Higher Education; 2) the private sector; 3) the community; and 4) the monitoring and evaluation component. The first three components are expected to implement services (prevention, treatment, care and support for their personnel and/or clients). The fourth component is coordinating M&E activities implemented by the three components.

It has been noted that in the DRC, the division of labor between these structures, committees and bodies is not always clear. The WHO notes that in the presidential decree which places national responsibility for the HIV response with PNLs, the decree does not clearly determine the operational or structural links between PNLs and PNMLS, saying, "this situation is

²⁸⁵ Because of DRC's lack of national strategic policy at the time of writing this report, this chapter is differently structured from the preceding two country case-studies. There is little currently shown in secondary literature about DRC's multisectoral collaboration, how participatory the current process is, to what extent the Three Ones play a role in the new strategy, what form of national M&E will emerge in the future, and whether the new policy is informed by culture and religious contexts in the DRC. See participant discussion below.

²⁸⁶ Lusey-Gekawaku 2003

²⁸⁷ See PNMLS 2008, UNAIDS 2006b, WHO 2005

responsible for a weak national leadership which is detrimental to coordination of programmes.”²⁸⁸

This unclear division between a medical and multisectoral response to HIV and AIDS is reflected elsewhere, where it has been noted that in the initial response, HIV and AIDS were perceived essentially as a ‘medical’ problem.²⁸⁹ The more recent push for a multisectoral response (since around 2004) - not just multisectoral in terms of involving multiple parties, but multisectoral as in seeing HIV as a disease of ‘development’ - has had less time to impact on the national response, which has been heavily medical for a long time. The grey area between PNLS and PNMLS could be as a result of an established expectation for medical disease response and guidance now coming into conflict with international encouragement of multisectoral collaboration in the context of HIV and AIDS (see below for further participant discussion on this).

6.1.3 A brief survey of the state of collaboration in DRC²⁹⁰

Multisectoral collaboration around HIV and AIDS in the DRC is a hugely complex and under-researched area.

As in Kenya and Malawi, secondary literature suggests that collaboration between CREs and government happen through two main avenues: the collaboration of CRE-owned health facilities with the government health services (e.g. through the MoH and PNLS), and the collaboration of CREs as part of ‘civil society’ (e.g. through PNMLS). However, that is where any similarity ends, as CREs in the DRC seem to be involved in a web of complex collaborative relationships.

For example, the Catholic Church notes a complex HIV and AIDS intervention strategy, which is done in close collaboration with international and national partners such as CORDAID, Trocaire, CAFOD, CRS, local dioceses, *Bureau Diocésain des Oeuvres Médicales* (Diocesan Office for Medical Works - BDOM) and Caritas etc.²⁹¹

A second example of this complexity is the unique SANRU project (see timeline above). Since 1980 the *Basic Rural Health Project* (later known as *SANRU Projet Santé Rurale*) has worked towards the creation of health zones around Protestant, Catholic, governmental, and other NGO-managed hospitals in partnership with USAID.

(altogether) FBO networks in DRC currently not only provide 50% of health services, but also co-manage around 40% of Congo’s 515 health zones.²⁹²

...of the 515 health zones, 65 are currently co-managed by the ECC.²⁹³

This collaborative relationship is built on a highly complex layer of collaborative partnerships. For example, a strong partnership is said to exist between this project and the government (again, in relation to health services provision),²⁹⁴ which results in the HIV and AIDS context, results in a strong partnership in the promotion of preventative medicine and the provision of care in the HIV and AIDS context.

²⁸⁸ UNAIDS 2006b

²⁸⁹ See Kayembe 2005

²⁹⁰ This section is from Schmid et al 2008

²⁹¹ Participant correspondence

²⁹² Baer 2007

²⁹³ Baer 2007, Dimmock 2005, Lusey-Gekawaku 2003

²⁹⁴ See CCIH 2007

Furthermore this project requires interfaith collaboration - not only between the more prominent Catholic and Protestant groups, but also the other faith groups involved, such as the Kimbanguists. It also requires collaboration between REs and secular organizations,²⁹⁵ and further collaboration between funders.²⁹⁶ “The fragile and sometimes volatile political situation in the DRC has created an unusual, and by all appearances, effective collaborative partnership in a time of crisis,”²⁹⁷ although not enough is known of its collaborative strengths and weaknesses, and how this plays out in the context of HIV and AIDS.

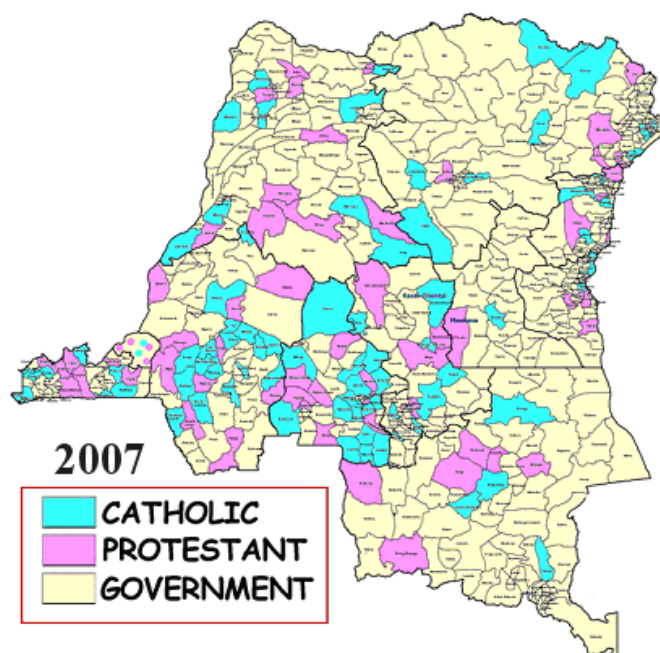


Figure 6.2: Healthzones managed by CREs, Baer 2007

6.1.4 A brief survey of the state of funding in DRC

It was not the purpose of this study to do a complete assessment of the national funding situation. However, during the desk review, certain key issues emerged that are most relevant to this study, and speak to general funding trends in the DRC.

- The government of the DRC was unable to adequately finance the national response against HIV/AIDS for many years. This was largely due to the lack of sufficient funds. Therefore, the Government of the DRC has had to rely largely on outside funding arrangements.²⁹⁸
- There is a large funding community involved in the DRC - and funding is still balanced more towards 'humanitarian' than towards 'development' assistance.
- The political disruptions in the DRC from 1991 to 2001 caused several significant funding organizations to withdraw from the country. However, many have returned as the conflict has dwindled, and funding support has increased during this period of reconstruction.²⁹⁹

See the following section for a list of some of the key funding partners present in the DRC. Again, not enough is known of the entire HIV and AIDS funding situation.

²⁹⁵ See Lusey-Gekawaku 2003, Schmid et al 2008

²⁹⁶ Project AXxes (within the SANRU project), focused on health-systems strengthening, is funded in collaboration between USAID, IMA World Health, ECC, CRS, WVI and Merlin

²⁹⁷ Schmid et al 2008

²⁹⁸ Kayembe 2005

²⁹⁹ See SANRU - CCIH, Kayembe 2005

6.1.5 The key players in the DRC HIV and AIDS context

We provide here a simple listing of some of the key organizations that secondary literature shows are working in the DRC multisectoral context. This is in no way a comprehensive exercise.

Collaborative networks or networking organizations: the *National Council of Interfaith-based Alliance* (CIC) comprised of religious leaders is a structure for HIV/AIDS-related discussion and lobbying. This council is set up to integrate the religious and government responses to HIV/AIDS;³⁰⁰ *The Health NGOs National Council* (Conseil National des ONG de Santé, CNOS); *The National Business Coalition against HIV/AIDS in the DRC* (The Comité Inter Entreprises de Lutte Contre le VIH/SIA, CIELS), *Association of Women Living with AIDS* (Fondation Femme Plus)

Multilaterals, bilaterals and major donors providing support to address DRC's HIV and AIDS epidemic:³⁰¹ Belgian Technical Cooperation (BTC), CAFOD, Caritas Internationalis, Catholic Relief Services, CORDAID, European Union, French Cooperation, German Agency for Technical Cooperation (GTZ), Global Fund to fight AIDS, TB, and Malaria (GFATM), IMA World Health, Médecins Sans Frontières, Merlin, SWAA, Trocaire, U.S. Agency for International Development (USAID), United Nations (UN) agencies (UNAIDS, UNDP, UNFPA, UNICEF, WFP and WHO), United States Centers for Disease Control and Prevention (CDC), World Bank (WB) Multi-Country AIDS Program (MAP), World Vision International.

Christian religious entities engaged in HIV and AIDS: secondary literature does not provide a comprehensive mapping of CREs engaged in HIV and AIDS in the DRC. The work undertaken via desk review, as well as in the snowballing sampling process, helped to identify a wide range of CREs that are responding to health generally, and the HIV and AIDS epidemic in particular. A full listing is provided in Appendix 6.3. Please note, this listing is limited and does not capture every organization working in HIV and AIDS in the DRC. Several named here are networks or umbrella bodies that incorporate a number of individual religious entities or programs. Furthermore, some international organizations have local offices and therefore make categorisation difficult. It is our hope that this listing highlights the scope and range of AIDS-engaged religious entities in the DRC, and is a working document that can be utilized and developed further.³⁰²

With the above in mind, we will now turn to the findings based on the information gained from the participant workshops held in the DRC.

³⁰⁰ See Lusey-Gekawaku 2003, WHO 2005

³⁰¹ See Kayembe 2005, PNMLS 2008, WHO 2005. PEPFAR is notably absent from the DRC

³⁰² There have been several reports that religious entity (or FBO) mapping has been occurring on a large scale in the DRC. However nothing was accessible in time for this report. See Capacity Project and CCIH. (Personal report Frank Baer 2008).



Figure 6.3: Kinshasa, DRC - 2008

6.2 The findings of the research in DRC

The research process was designed to identify findings in four key areas:

5. Concerning the context in which Christian religious entities (CREs) are working
6. Concerning the work of CREs in the promotion of Universal Access
7. Concerning the strengths and weaknesses of collaborative partnerships between CREs and other stakeholders
8. Concerning the potential and challenges of collaborative partnerships between CREs and other stakeholders

Within these four areas, the participatory research process produced the following six findings in the DRC:

1. CREs in the DRC perceive themselves to have had a long engagement with the epidemic from a medical perspective. However, it is only since 2000 that there has been a significant pastoral engagement. CREs also perceive the HIV and AIDS epidemic to be strongly related to other social and political crises in the country, and acknowledge that initiatives have been hampered, until recently, by the civil war.
2. CREs in the DRC are committed to and involved in promoting Universal Access to prevention and treatment, and to a lesser extent care and support. Prevention involves education and the distribution of condoms, and there is an extensive involvement in the provision of ARVs. CREs recognise that their beneficiaries are women and Christians. Work is undertaken in both urban and rural settings.

3. *In their contribution to Universal Access*, CREs in the DRC are acknowledged by collaborative stakeholders as having three key strengths, namely, reach, credibility and well-developed structures. These strengths represent vital assets that are essential to strengthening multisectoral collaboration.
4. CREs in DRC are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths but a large number of weaknesses. (1) The main strengths are perceived to be the relationships that CREs have with their funding partners and particularly the Global Fund, relationships with government departments. (2) The main weaknesses are perceived to be the lack of relationship between and coordination of work amongst CREs, the different levels of knowledge and value systems between the partners, the difficulty of producing and administering a national policy in the midst of wider political crises, and a lack of government funding together with the vulnerability caused by reliance on external donors.
5. CREs and their collaborative stakeholders see both challenges and potential in such partnerships. The challenges have to do with the fragile state of the country and of coordinating structures, the dependency syndrome with funders, the lack of knowledge about HIV and AIDS amongst CREs, and the conservative doctrinal emphases of certain churches. Yet it was also acknowledged that the potential for partnerships lies in the relationships that both government and CREs have with international donors, the recognition of mutual strengths, and a desire to work together.
6. There is an obvious commitment to strengthening the partnership between CREs and collaborative stakeholders from both sides. From the CREs there is a desire for greater participation in the decision making around the control of funds. From the collaborative stakeholders there is a desire that CREs be drawn into the National Plan, its policy formulation and implementation.

We now examine each of these findings in greater detailing, drawing from the evidence that emerged in the workshops and questionnaires. The chapter concludes with a set of clear recommendations based on these findings.

6.2.1 Findings concerning the context in which Christian religious entities are working

Finding 1: Christian religious entities in the DRC perceive themselves to have had a long engagement with the epidemic from a medical perspective. However, it is only since 2000 that there has been a greater pastoral engagement. Christian religious entities also perceive the HIV and AIDS epidemic to be strongly related to other social and political crises in the country, and acknowledge that initiatives have been hampered, until recently, by the civil war.

In the workshop with CREs, participants were asked to contribute to a communal time line that helped to map the history of their engagement in social life, and specifically in responding to the epidemic. The following information emerged from the timeline.

There is relatively little awareness of the role of the church in social life prior to the 1970s. In 1974 the government policy of Zairianism meant that the Congolese were to manage their own

affairs “whether they were ready or not”. As part of this policy, all social services were handed over to the churches in 1977.

In the 1990s, when the HIV and AIDS epidemic was starting to become a factor in social life, there was the outbreak of civil war upon the death of President Mobutu Sese Seko. This severely dislocated the ability of the state and the CREs to respond to the epidemic. However, it was also felt that in times of conflict, people do turn to CREs for help.

Collaboration between government and others just stopped...the state was not able to provide care and support ... here the churches through the medical and health departments were already involved ... when the state fails it is through the churches that people receive care and support.

Owing to the fact that CREs had taken over much of the health services in the DRC, they were involved at a very early stage in working with people living with HIV. However, as was noted earlier, the fact that it was left to Christian medical officers to manage meant that for CREs the epidemic was primarily seen as a medical problem to be dealt with by medical services. Participants acknowledged that the more pastoral aspects of dealing with people living with HIV were not dealt with until fairly recently. This was the case even though some attempts were made to offer HIV and AIDS education to leaders of non-medical CREs in the early 1990s.

What also became clear was that the issue of condom promotion was contentious. Some participants suggested that the sexual nature of the epidemic meant that it quickly became a taboo subject within the religious sector. The fact that many CRE participants in the research workshops were medical practitioners, suggests that the epidemic is still primarily seen as a medical concern.

The context of war and conflict in DRC makes it difficult to focus exclusively on the HIV and AIDS epidemic, because there are pressing public health issues that need to be addressed. This could be one of the reasons why much of the current work around HIV and AIDS only began after 2000 when the country gained relative peace through the ending of the civil war. It was also at this time that non-medical CREs were drawn into talks concerning multisectoral collaboration. UNAIDS appears to have been instrumental in ensuring involvement from the national government. As a result, a number of CREs focusing on HIV and AIDS were formed during this period. In the past four years some of the denominational CREs such as the Presbyterian, APCS and CEK, have developed policy statements on the HIV and AIDS epidemic. Since 2006, free ART has been more readily, although there is some uncertainty as to the extent of the roll-out of this programme throughout the country. Legislation protecting the rights of people living with HIV is currently under review and is expected to become law before the end of 2008.

There was a general feeling by Christian Entity participants that the response to the epidemic is not well co-ordinated. This is partly related to the fact that “funding is provided in a disparate way”.

We are doing our best ... but the national strategy of 1998 will be reviewed, and by the end of 2008 we will have another strategy.

The new strategy will include a National AIDS Council and a National Aids Programme. Participants felt that as a result of this strategy, there will be improved national co-ordination.

Because there was a misunderstanding ... Forum of partners put in place PNMLS (National Aids Council) was funded by the World Bank ... now more Congo owned ... Represented by all sectors of the nation.

In summary, CREs in the DRC perceive themselves to have had a long engagement with the epidemic from a medical perspective. However, it is only since 2000 that there has been a greater pastoral engagement. CREs also perceive the HIV and AIDS epidemic to be strongly related to other social and political crises in the country.

6.2.2. Findings concerning the work of Christian religious entities in the promotion of Universal Access

Finding 2: Christian religious entities in the DRC are committed to and involved in promoting Universal Access to prevention and treatment, and to a lesser extent care and support. Prevention involves education and the distribution of condoms, and there is an extensive involvement in the provision of ARVs. Christian religious entities recognise that their beneficiaries are women and Christians. Work is undertaken in both urban and rural settings.

The work undertaken via desk review, as well as in the snowballing sampling process helped to identify a wide range of CREs that are responding to the HIV and AIDS epidemic These include: National Ecumenical Structures, Denominational bodies and their AIDS programmes, Denominational programmes and initiatives, AIDS Collaboratives, Health and development projects and a variety of other organizations. See Appendices 5.5, 5.6 and 6.3 for listings of organizations found through this research.

While not each and every Christian Entity noted here is equally involved in all aspects of Universal Access, it is clear that taken as a whole, CREs in DRC perceive themselves to be involved in Prevention, Treatment, Care and Support, as well as some 'Other' tasks. Asking the Christian Entity participants to depict and describe the three 'main' areas they were each involved in HIV and AIDS work, the following basic table was derived.³⁰³

Prevention	Treatment	Care	Support	Other
Salvation Army CEK ECC Presbyterian church Conerela BDOM Kimbanguiste ECC BDOM Anerela+ Vorsi CEK Conerela Presby church EPS	Salvation Army Kimbanguiste ECC BDOM Vorsi	Salvation Army Kimbanguiste ECC BDOM Vorsi <i>EMAUS</i> <i>Catholic</i> <i>Magnificat</i>	Salvation Army Kimbanguiste ECC BDOM Anerela+ CEK Conerela	Salvation Army Anerela+

Figure 6.4: Depiction of participatory exercise, Kenya 2008

³⁰³ See Appendix 1 for acronyms. Those in italics did not have representatives at the workshop, but were added by fellow participants.

A. Prevention

In prevention, four kinds of activities are undertaken. Firstly, as with Kenya and Malawi, CREs are predominantly involved in education and awareness work. Of note is the fact that some are engaged in training of trainers through peer education programmes. The Salvation Army also engages their leaders in training in order to ensure that they are not encouraging stigma and discrimination through their theological messages. Anerela+ is active within networks of religious leaders and, as in the other countries, adopts the SAVE approach in their prevention messages. Some CREs see condom promotion as a point of conflict with government, while others are engaged in condom promotion in a targeted way.

We distributed condoms with the Global Fund ... not easy as a religious organization. The strategy is to go to places where the need is greatest. We went to areas where there was a need ... hotels, military camps, police stations ... We said, we know that the churches are preaching abstinence, but we cannot be the safeguards of those who cannot be faithful. We are not encouraging immorality, but saving those who can still be saved from infection.

Our project distributed condoms for 5 years. It was not easy for churches to get the green light ... but we are trying to help them understand through training.

In DRC, unlike Kenya and Malawi, it seems condom distribution is carried out by some CREs.

Some Christian groups backed off [distribution of condoms] because it was seen as an immorality problem and others were pushing for condoms.

Distribution of condoms to target groups such as “those who will not abstain, discordant couples in the church, those who are HIV positive” also seems to be quite widespread. It appears that there is not as a dogmatic approach to the matter as was the case in Kenya and Malawi. The reason for this more pragmatic approach to condom distribution could be related to the fact that, to a large extent, it is medical practitioners that are engaged in mitigating the epidemic.

B. Treatment

CREs play a major role in the distribution of ART. See section 6.1.1 above.

C. Care and Support

Christian Entity participants were reluctant to distinguish between ‘care’ and ‘support’ which could have been because, unlike Kenya and Malawi where this was not the case, many were medical practitioners and not pastors. Clearly, some CREs are to an extent engaged in micro-credit activities and in developing networks of HIV positive support groups. One impressive example of such a network consists of over 1500 people who meet informally in church halls.³⁰⁴ The area of care and support is seen to be carried out, without exception, by CREs.

When collaboration between government and others was just stopped ... the state was not able to provide care and support ... here the churches through the medical and health departments were already involved ... when the state fails it is through the churches that people receive care and support.

³⁰⁴ However, initiated by *Médecins Sans Frontières*

D. Other

Anerela+ is particularly engaged in capacity building through the establishment of networks of HIV positive people. The Salvation Army is involved in a unique project that addresses sex trafficking and issues facing commercial sex workers. This project attempts to deal with the question of poverty that underlies why young girls become involved in sex work.

One of the key issues is that of gender, because of the feminization of HIV and AIDS. Sexuality is still taboo in our country ... so how do you deal with this in a patriarchal society like the DRC? We still have more questions than answers.

It is important to note, also, that a number of CREs work in very close cooperation with other CREs in sharing the engagement in Universal Access. So for example, Catholic Relief Services works with a range of international Catholic relief services such as Cordaid, Trocaire, CAFOD, and Caritas. While each one has specific tasks, the partnership provides for a comprehensive approach.

E. Beneficiaries

In terms of **age**, Christian Entity participants were reluctant to specify one particular age group that were the dominant beneficiaries of their services. Most felt that they work with all age groups. The two exceptions were Vorsi, who worked primarily with people under the age of 15 years, and Anerela+ whose constituency tends to be primarily those older than 40 years.

In terms of **gender**, most participants recognised that their work was mainly with women.

Although they would like to work with everyone, they are working mainly with women.

The people coming forward for help are mostly women.

None of the CREs specifically target men with the exception of Conerela+ who do work with large numbers of men.

In terms of **location**, most participants acknowledged that their work was mostly in urban areas. However, they also indicated that there were many CREs working in rural areas; these include amongst others, Caritas and *Bureau Diocesain Des Oeuvres Medicales* (BDOM). This is confirmed by secondary literature. Participants felt that the majority of work carried out in rural areas is done so by CREs and that there is little involvement of government at this point.

In conclusion then, CREs in the DRC are committed to and involved in promoting Universal Access to prevention and treatment, and to a lesser extent care and support. Prevention involves education and the distribution of condoms, and there is an extensive involvement in the provision of ARVs. CREs recognise that their beneficiaries are women and Christians. Work is undertaken in both urban and rural settings.

Finding 3: In their contribution to Universal Access, Christian religious entities in the DRC are acknowledged by collaborative stakeholders as having three key strengths, namely, reach, credibility and well-developed structures. These strengths represent vital assets that are essential to strengthening multisectoral collaboration.

As discussed in chapter 3, religious entities are seen to have key strengths that can be leveraged in the HIV and AIDS epidemic. In the introduction above, (see section 6.1.1 above) we further presented some of the assets religious entities are said to hold in the DRC health

system. While this particular study did not focus on identifying the specific assets of CREs that can be leveraged towards providing Universal Access (for example, the number of facilities held or patients served), this was nevertheless clearly demonstrated throughout the discussion and in the organizational documentation collected through the desk review and questionnaire response.

A. Perceptions of collaborative stakeholders with regard to the work of Christian religious entities

When representatives of other collaborative stakeholders such as government, donors and other religions were asked to reflect on the work of CREs, they identified three major areas of strength.

(1) The first related to the **reach** of CREs, particularly in the rural areas. It was felt that they were one of the few organs of civil society that were accessible to 'grassroots people' and therefore were in a position to mobilise and influence large groups.

Most important is the churches capacity to reach the grassroots.

(2) The second major strength of CREs in the DRC is the fact that they have **credibility within communities** and are therefore trusted. Additionally, they are a moral voice and thus in a position to integrate HIV and AIDS information into their teachings. Participants saw this as an enormous asset which could be harnessed in the future.

(3) The third major strength is the fact that many CREs have **well developed structures** which enable them to work in an organized way in the rural areas. The example given in this regard, was that of the Catholic Christian entity, Caritas.

In summary, then, the three key strengths of CREs in their promotion of Universal Access are reach, credibility and well-developed structures. These strengths represent vital assets that are essential to strengthening multisectoral collaboration. From this we can make a finding that CREs represent vital assets with whom collaboration with other stakeholders is recommended in the interest of people infected and affected by HIV and AIDS in DRC

6.2.3 Findings concerning the strengths and weaknesses of current collaboration between Christian religious entities and other stakeholders

Finding 4: Christian religious entities in DRC are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths but a large number of weaknesses. (1) The main strengths are perceived to be the relationships that Christian religious entities have with their funding partners and particularly the Global Fund, relationships with government departments. (2) The main weaknesses are perceived to be the lack of relationship between and coordination of work amongst Christian religious entities, the different levels of knowledge and value systems between the partners, the difficulty of producing and administering a national policy in the midst of wider political crises, and a lack of government funding together with the vulnerability caused by reliance on external donors.

Through the desk review and the snowballing approach to the identification of participants for the workshop it was clear that CREs are involved in a range of collaborative partnerships. See 6.1.3 above and Appendix 5.6 for the selection of key collaborative stakeholders identified by advisors in DRC.

In a rough typology, these included: government bodies and structures, national AIDS coordinating mechanisms, international donors (a full range from large internationals to individuals), interfaith bodies or networks, national faith-based health networks (NFBHNs), denominational bodies, other NGOs, other CREs etc.³⁰⁵

This was confirmed in an exercise carried out with representatives from CREs in which they had to draw a 'spidergram' showing their relationships with one another, other faith-based organizations, government, and with donors. The exercise indicated a number of key issues:

- CREs have extensive relationships with a large number of external donors.
- Many CREs are funded by a number of different external donors.
- The relationships between CREs are not as strong as the relationships they each have with external donors.
- There is no strong relationship with a coordination body.
- There are no inter-faith relationships.
- Most CREs seem to have some kind of relationship with relevant government departments.
- Relationships with government departments are less significant than with external donors.
- There is no one government body channelling funds to CREs.

A. Perceptions of Christian religious entities about collaboration

In seeking to explore the perceptions of CREs about collaboration, time was spent exploring their understanding of government policy, government practice, and collaborative relationships with donors.

In the discussion on the spidergram exercise, participants felt that the strength of their collaboration lay in the fact that many of them operated using a common funding source, such as the Global Fund.

There are lots of funding interventions ... less collaboration between Christian organizations.

Despite this recognition, there was no real engagement in the discussion with the fragile nature of their operations, given their heavy reliance on this external funding. Some did, however, acknowledge their financial dependency on these external sources.

With regard to their relationships with government, they did feel that, despite not having a strong co-ordinating body, some collaboration did exist as a result of government policy. There are many government departments committed to mitigating the epidemic, such as PNLs (adopting a medical approach), PNMLS (adopting a multisectoral approach), MSL, PNTS, National Program of Blood Security and TB, PNT, Reproductive Health, PNSR.³⁰⁶

³⁰⁵ As noted in chapter 2, one of the limitations of this study, and this exercise in particular was the lack of focus on relationships with other NGOs.

³⁰⁶ See Appendix 1 for acronyms and abbreviations.

With regard to interfaith collaboration, there was recognition that while “we know each other, but we are not working together”. The Interfaith AIDS Council (CIC) was formed by the mainline churches, but it was felt that it “doesn’t really bring everyone together”.

CIC was formed, but there has been a problem of leadership ... there was a small group ... this should be the collaborative structure, but it is not working.

Arising out of the discussion, participants evaluated their own strengths and weaknesses as CREs. They felt their major strength lay in the fact that they have a broad community base and they are firmly part of the social structure of their society. CREs are seen to have credibility which enables them to mobilise resources and have a moral voice within their communities. They acknowledged “that the church is best placed to reach people”. However, participants also acknowledged their weaknesses. They felt that there is a lack of scientific knowledge about HIV and AIDS which leads to a lack of ownership of responsibility in mitigating the epidemic. Within their organizations there are inadequate material resources such as medical equipment and drugs, and in some cases an underutilization of resources. There was also recognition that there are divergent doctrinal and cultural practices, demonstrated in differing views on condom promotion and attitudes to the practices of polygamy and circumcision.

At the end of the discussion on the spidergram exercise, there was general consensus that there is a need for a national plan which includes a coordinated financial strategy that has been drawn up in a participatory manner. The participants expressed a desire for a multisectoral forum where these issues could be discussed in a more in-depth way.

Interaction with Government Policy

In trying to assess participant’s views on **government policy**, it became clear that while a policy exists, it was drawn up in the late 1990s and largely focuses on a medical multisectoral response. It is also not widely known or understood, hence the desire for a different and more participatory process to be established in order to draw up a more current and inclusive national plan.

The HIV and AIDS policy was distributed a long time ago, with the new tools and info we are getting the policy is outdated...it was before 2004 - around 1999.

Because it was outdated and other issues needed to be included, the distribution process was stopped. There is a new commission working on it, a new version which should come out at the end of 2008.

This new initiative is generally viewed positively as the following comments indicate.

Norms and regulations would give uniformity ...

This would be a unique framework of doing action, leading to co-ordination.

There were some reservations expressed, such as:

... there are legal questions that need to be addressed. Allocated resources need to be challenged ... you lose creativity with a national framework.

Most importantly, political will needs to be confirmed otherwise nothing will be implemented.

While a desire was expressed to be part of such an initiative, it appeared that participants were sceptical as to whether sufficient time and energy will be invested in making sure this National

Action Plan is implemented, given the overwhelming problems facing the health system in general in the DRC.

Interaction with Government Practice

In the discussion on **government practice**, participants felt that there was some emphasis on a multisectoral approach and that some training as well as the distribution of ART is taking place. These actions are viewed positively. However, concern was expressed that insufficient funding is being allocated to the HIV and AIDS epidemic. When probed about limited resources in the DRC given the enormity of the process of stabilising the society, there was general consensus that there is sufficient funding, but the issue is that of political will. In addition, allusions were made to corrupt use of funds which needed to be rooted out within government practice.

[I want to] stress that it is a problem of political will ... the senator can correct me ... we have a lot of resources in this country ... if there was a will we could do it ... we know where the money is going ...

This comment evoked heated debate.

A government should be responsible for issues arising in a country ... so government can have internal/external resources. The problem is how to make a fair distribution ... how can we make sure that the resources for HIV and AIDS are where they are needed. I do not agree that the country is wealthy ... but yes, potentially wealthy.

It is a problem of priority ... where do you start? Everything is a priority, that is the challenge ... a chicken and egg situation ... a question of how the little we have can be used efficiently.

In addition to government not allocating sufficient funding in order to mitigate the epidemic, it was also felt that there is insufficient engagement with NGOs and communities at a grassroots level.

Interaction with donors

In resuming the discussion on the interaction of CREs with **donors**, participants reiterated their appreciation for the extensive support offered by international agencies by way of funding and technical assistance. However, it was noted that as a result of programmes being heavily funded externally, this resulted in agendas being driven by the donors.

Funders are dictators, they tell you what to do rather than let you see what needs to be done.

There is no alignment between funding and priorities; they just withdraw the funding while the project is running.

Some also indicated that the heavy reliance on external funding rendered their programmes unsustainable in the long term. This was an important acknowledgment, as earlier in the spidergram discussion, they had not been willing to engage this matter.

Funding, more often than not, is given to a project for a limited period which makes long term planning difficult. This exacerbates the problem of a lack of ownership of the project by the local Christian Entity.

When funding dries up, churches stop their involvement, no ownership of programme.

It also appears that local, indigenous CREs find it difficult to access funds, while those that already have international links, such as the Catholics with Caritas or CAFOD, are at an advantage and directly benefit from these networks.

Many participants felt funding application procedures were complex which hindered access to funding. This is particularly true for CREs working in the rural areas.

The rules of funding are not well known, some institutions don't know how to access such funding.

In addition, monitoring and evaluation procedures are time consuming.

It is all very stressful, all the red colours (pointing to the donors on the spidergram) ... each organization has different forms, different M&E procedures, and different ways of reporting. At the end of the day we do not have time to do any work!

From the discussion, there appears to be competition between donors which hampers effective action in mitigating the epidemic.

There is a lot of competition between each other and funders ... they open the door and then keep it to themselves ... they want tangible results.

Funders want results for themselves ... there is competition between funders ... don't like [to give to organizations with] multiple funders.

There was also a feeling amongst participants that funding from large international agencies was not reaching grassroots communities.

[The] Global Fund recipient in the DRC is the UNDP ... they already have some funds and it goes to salaries of experts, rather than to the grassroots.

USAID, FNUAP etc take the money, even though they have their own money.

These comments either indicate ignorance on the part of the CREs, or that there is a lack of transparency as to how monies from the Global Fund are being used by donor agencies.

In summary, it is clear that CREs in DRC are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths but a large number of weaknesses. (1) The main strengths are perceived to be the relationships that CREs have with their funding partners and particularly the Global Fund, relationships with government departments. (2) The main weaknesses are perceived to be the lack of relationship between and coordination of work amongst CREs, the different levels of knowledge and value systems between the partners, the difficulty of producing and administering a national policy in the midst of wider political crises, and a lack of government funding together with the vulnerability caused by reliance on external donors.

6.2.4 Findings concerning the challenges and potential of collaborative partnerships between Christian religious entities and other stakeholders

Finding 5: Christian religious entities and their collaborative stakeholders see both challenges and potential in such partnerships. The challenges have to do with the fragile state of the country and of coordinating structures, the dependency syndrome with funders, the lack of knowledge about HIV and AIDS amongst Christian religious entities, and the conservative doctrinal emphases of certain churches. Yet it was also acknowledged that the potential for partnerships lies in the relationships that both government and CREs have with international donors, the recognition of mutual strengths, and a desire to work together.

As was noted at the beginning of the previous section, there are a number of existing structures and forums that already exist and offer enormous potential for strengthening collaboration. However, it is clear that existing co-ordinating structures are fragile in the DRC. Structures such as 'ABCS' were identified in one workshop as a key network for government and "all partners" to work within, but was not mentioned by the participants at the other workshop. On the other hand, the collaborative stakeholders assume that inter-faith work is happening through the Inter-faith Council, yet the participants from CREs acknowledged that this body is effectively not functioning and does not represent all interested parties.

Clearly while there is currently no effective multisectoral collaboration taking place, there are foundations on which to build in the future. The most important of these is the relationship that both CREs and government have with international donors. The challenge is to ensure that structures are in place that bring all three parties into relationship with one another.

In order to better understand future collaboration with CREs, it is important to assess what potential exists in such a relationship and what are some of the challenges that would need to be taken into account.

There is no doubt that collaborative stakeholders see CREs as crucial in mitigating the HIV and AIDS epidemic. They are seen to be deeply rooted in grassroots communities and therefore provide access to this important constituency. Because of their credibility in communities, they have the potential to mobilize large groups of people.

The church has the capacity to mobilize.

Within these communities, CREs have credibility and are also seen to have a moral voice. In addition, they have infrastructure which enables them to organize programmes in rural areas.

There is a perception among some collaborative stakeholders, however, that currently there is ignorance within a large number of the CREs with regard to HIV and AIDS knowledge. This is linked to a feeling that CREs do not currently have the resources to be strategically involved in mitigating the epidemic. As a result they do not 'own' HIV and AIDS work. However, there was no consensus on this matter, as others felt that the lack of ownership is simply related to a lack of knowledge.

I think it is mostly a lack of scientific information. When FBO leaders know how HIV and AIDS is spread, they might not consider adultery as the main way it is spread ... Therefore training of the trainers is important in order to pass on the information.

But, collaborative stakeholders acknowledged that the potential of CREs has not yet been harnessed. They also realise that if the assets of CREs are not harnessed, then this potential strength can turn into a weakness in collaborative efforts. For if CREs 'sit back' and do not get

involved, as some participants felt was the case, then huge groups of people will not be influenced.

In this country, certain church leaders speak, but there is little will [generally].

Having said all of this, it also became clear through the discussion that the perception of Christian Entity participants that collaborative stakeholders do not have much communication with grassroots communities is correct. Perhaps CREs are more involved in small, local community initiatives than these collaborative stakeholders are aware of.

Furthermore, some donor stakeholders admitted that, because of the dependency on funding, their relationship with CREs was often not a mutual one. Financial dependency prevents real partnership.

There is financial dependency of the Christian organizations ... we can't talk about partnership ... we pretend it is a partnership ... this is the ideal ... it is what it works but in reality it is not like that.

Financial dependency is really a threat, especially sustainability once the funds have stopped.

We pretend we want the partners to decide, but it is not so easy to practice what you preach.

A further key challenge relates to doctrinal differences amongst CREs and between CREs and their collaborative stakeholders. 'Revival churches' are considered mainline and have a large following in DRC. Thus, the extent to which they are involved in mitigating the epidemic becomes an important issue.

In this country, revival churches do not see HIV and AIDS as part of their mission. For them, HIV and AIDS is a medical or hospital problem, not a spiritual problem.

A further doctrinal issue relates to the promotion of condom use. This issue remains a source of contention amongst CREs and, as was noted earlier, there are divergent views regarding this matter. Some large CREs such as the Catholic church will not promote condom use in their prevention messages. This can be a source of conflict in collaborative efforts.

The discussion on condoms is outdated ... in terms of the Interfaith Council ... the entry point is that we agreed that HIV/AIDS is not a punishment from God, and then said HIV/AIDS is one of many challenges ... we won't promote condoms, only a way to preserve human life.

Collaborative stakeholders felt that the conservatism of CREs is deeper than the condom issue, as it relates to a particular kind of theology that leads to HIV and AIDS stigma and discrimination.

This perception of CREs as being unwilling to be involved in the HIV and AIDS epidemic through their conservative and dogmatic doctrinal beliefs, remains a key challenge to multisectoral collaboration.

A further challenge relates to perceptions of the role of government in mitigating the epidemic. As was noted earlier, CREs feel that government coordinating structures, such as PNLMS, are not functioning well. Monies from international donors drive the agendas rather than the national government. In addition, the National AIDS Plan is currently no longer relevant. On the other hand, collaborative stakeholders perceive CREs as not wanting to align themselves with

government policy, and some even suggested that they were ignorant of this policy. To a certain extent this ignorance was displayed in the CREs' workshop.

This situation highlights, yet again, the breakdown in communication between the three groups of collaborative stakeholders. This is despite a joint initiative between CIC (Interfaith Council), UNAIDS, CORDAID working on behalf of PNMLS (National Aids Council) and UNAIDS. This initiative sought to mobilize and share resources. A declaration was signed in December 2007 by these parties as well as leaders of CREs, including the Revival Churches.

In summary, clearly collaborative efforts are not sufficiently coordinated so as to maximise the enormous potential that lies within the key stakeholder groups namely, religious entities, Government, and international donors. Through discussions as to a way forward for more effective collaboration in the future, participants of both workshops indicated a desire to work towards this goal. CREs want to be in a mutual partnership with the other collaborative stakeholders and these stakeholders want to see CREs playing a more significant role in mitigating the epidemic.

Finding 6: There is an obvious commitment to strengthening the partnership between Christian religious entities and collaborative stakeholders from both sides. From the Christian religious entities there is a desire for greater participation in the decision making around the control of funds. From the collaborative stakeholders there is a desire that Christian religious entities be drawn into the National Plan, its policy formulation and implementation.

Despite the challenges noted in the previous finding, the researchers felt a desire expressed by both sides, for opportunities to improve collaboration.

A. Hopes for stronger collaboration: Christian religious entities

Issues of coordinating structures and the place of a National AIDS Plan was important to Christian Entity participants. However, of far more importance were the funding relationships. They felt for collaborative efforts to improve in the future, the contentious issues around donor engagement with CREs needed to be reassessed. Funding needed to be context-specific and include the recognition of Congolese expertise, if it is to reach the targeted grassroots communities.

B. Hopes for stronger collaboration: Collaborative stakeholders

Collaborative stakeholders also reflected on suggestions for a way forward in strengthening multisectoral collaboration.

Collaborative stakeholders, in addition, felt that funding issues were important, but for different reasons than Christian Entity participants. They felt that CREs needed to be far more accountable and transparent in their use of funds so that in the long term, their mitigation of the epidemic would be more effective. However, this view needs to be tempered by the fact that international donor agencies, such as UNAIDS, have enormous influence and control of agendas that it is crucial that this is acknowledged in any collaborative relationship with CREs.

On a positive note, one participant at the collaborative stakeholders' workshop summarised the way forward as follows,

There is a need for a National Plan with clear outputs, a platform to include all FBOs and educate the leaders, FBOs should be included in planning, a national co-ordinating body [needs to be put in place], and improved collaboration and co-ordination leading to mutual respect.

6.3 Recommendations arising from the research findings in DRC

6.3.1. For the attention of the Christian religious entities

- Assess effectiveness of the National Inter-faith AIDS Council (CIC) and restructure ensuring appropriate representation.
- Strengthen relationships with one another through establishing regular forums for dialogue and information sharing.
- Strengthen relationships with government stakeholders by inviting them to these faith-based forums.

6.3.2. For the attention of government

- Involve all collaborative stakeholders in the process of updating the National Action Plan.
- Plan strategic interventions that operate from the premise that HIV and AIDS is a development issue and not simply a medical issue.
- Involve religious entities in ensuring that HIV and AIDS information is reaching the grassroots communities.

6.3.3. For the attention of donors

- Establish a forum of representatives of all funding partners as a matter of urgency.
- Develop one set of reporting and monitoring and evaluating procedures.
- Work with government and CREs in establishing priorities for strategic interventions.

6.3.4. For the attention of all

- Prioritise the principles of the Three Ones as a way forward for collaborative efforts.
- Build on the existing agreement signed by all parties in December 2007.
- Establish regular regional forums for all collaborative stakeholders that enable ongoing dialogue, information sharing, and evaluation of strategic interventions.