



HIV/AIDS HEALTH PROFILE

HIV and AIDS Estimates	
Total Population*	61.5 million (mid-2007)
Estimated Population Living with HIV/AIDS**	1 million [560,000-1.5 million] (end 2005)
Adult HIV Prevalence**	3.2% [1.8-4.9%] (end 2005)
HIV Prevalence in Most-At-Risk Populations**	Sex Workers (Kinshasa): 22.2% (2002)
Percentage of HIV-Infected People Receiving Antiretroviral Therapy***	8.6% (end 2006)

*Institut National de la Statistique **UNAIDS ***DR Congo National AIDS Program 2006

The Democratic Republic of the Congo (DR Congo) was one of the first African countries to recognize HIV/AIDS, when it started registering cases in 1983. The DR Congo faces a generalized epidemic that appears to have reached its peak in the 1990s, when life expectancy had dropped 9 percent. By the end of 2005, UNAIDS estimated that 1 million people were living with HIV/AIDS in the DR Congo, which had an adult HIV prevalence of 3.2 percent. The main mode of HIV transmission is heterosexual activity, which accounts for 87 percent of cases. According to the 2006 DR Congo Antenatal Care (ANC) Surveillance Survey, HIV prevalence is highest among men and women aged 15 to 24 and women attending antenatal clinics (3.6 percent among pregnant women aged 15 to 24

years old). HIV prevalence among antenatal clinic attendees in Kinshasa, the capital, has been relatively stable (3.8 percent in 1995 and 3.6 percent in 2006). However, in the second largest city, Lumbumbashi, the prevalence rose from 4.7 percent in 1997 to 5.4 percent in 2006. Prevalence among antenatal clinic attendees is also high in Kisangani, Matadi, and Tshikapa (4.1, 4.1, and 5.2 percent, respectively). The 2006 ANC Survey also found that HIV prevalence was the same in rural and urban areas (4.2 percent).

Because many regions in the DR Congo are difficult to reach, data about the HIV/AIDS epidemic are incomplete. Nonetheless, available data show that decades of conflict have exacerbated the country's epidemic. For instance, HIV prevalence among women who have suffered sexual violence in areas of armed conflict may be as high as 20 percent, according to UNAIDS. This is primarily due to the use of sexual violence as a weapon of war; 67 women are raped every day. HIV prevalence remains high in some rural areas (6.9 percent in Lodja, for example) that were at the front line of the 1998 war. Approximately 90 percent of the DR Congo's estimated 2.17 million internally displaced persons live in the eastern part of the country, where surveys have shown that HIV prevalence is five times greater than the national average. Children are a particularly vulnerable group because they are infected through mother-to-child transmission and are also affected by the loss of a parent to AIDS. According to UNAIDS, 120,000 children under the age of 15 are infected with HIV.

Several factors fuel the spread of HIV/AIDS in the DR Congo, including movement of large numbers of refugees and soldiers, scarcity and high cost of safe blood transfusions in rural areas, a lack of counseling, few HIV testing sites, high levels of untreated sexually transmitted infections (STIs) among sex workers and their clients, and low availability of condoms outside Kinshasa and one or two provincial capitals. The low percentages of men and women who know their HIV status (9.5 and 10.6 percent, respectively) are also fueling the epidemic, according to a 2005 survey cited by UNAIDS. Consecutive wars have made it extremely difficult to conduct effective and sustainable HIV/AIDS prevention activities. Accurate and updated HIV data for planning should be available soon from the DR Congo's first Demographic and Health Survey, which was conducted in 2007 and included questions about HIV testing and HIV-related behaviors.

In addition, the DR Congo ranks 11th among the world's 22 high-burden tuberculosis (TB) countries. The estimated incidence of TB was 173 cases per 100,000 population in 2006, according to the World Health Organization. HIV prevalence in adult-incident TB patients is estimated to be 17 percent.

National Response

The National AIDS Control Program, established in 1987 within the Ministry of Health (MOH), provides leadership in the health sector for HIV/AIDS control. The National Multisector AIDS Commission (PNMLS) was established within the Office of the President in 2004. The MOH leads the Commission, which has members from the Ministries of Finance, Education, Planning, and Public Works, as well as from donors, the private sector, and civil society. The PNMLS coordinates a multisector response to the HIV epidemic.



Currently in a process of national reconstruction, the Government of the DR Congo has named AIDS control a priority in its Poverty Reduction Strategy Paper but lacks the necessary infrastructure and resources. Therefore, HIV/AIDS activities have resumed since the 1998 war but only to a limited extent. According to the National HIV/AIDS Strategic Framework for 1999–2008, the DR Congo favors prevention, care, and advocacy activities that highlight community participation, human rights, ethics, and the needs of people living with HIV/AIDS (PLWHA). To implement this strategy nationwide, the Government solicits participation from all development partners, including the private sector and faith-based and nongovernmental organizations (FBOs/NGOs).

The DR Congo is a member of the Great Lakes Initiative on AIDS (GLIA), along with Burundi, Kenya, Rwanda, Tanzania, and Uganda. Launched in 1999 with UNAIDS support, GLIA has been an independent legal organization since 2004 and serves as a forum for its members to address the key role that migration and displacement play in the transmission of HIV in the subregion. GLIA partners include the six GLIA governments, United Nations organizations, bilateral and multilateral donors, FBOs/NGOs, and the private sector.

In 2004, the World Bank approved a \$102 million grant to support implementation of the National Strategic Framework and provide resources to improve service delivery mechanisms. The following year, the Global Fund to Fight AIDS, Tuberculosis and Malaria disbursed \$46.7 million in funding to the DR Congo for the first phase of a third-round grant of \$113.65 million to support an HIV/AIDS prevention and care project. The project targets at-risk populations (men in uniform, sex workers, truck drivers, prison populations, and youth), PLWHA, and HIV-positive mothers and their newborns to achieve four objectives:

- Mobilize community leaders to join the fight against HIV/AIDS and other STIs
- Prevent transmission of HIV within at-risk populations and the general population
- Improve the quality of life for HIV-infected and -affected individuals
- Enhance the quality of information management in relation to the epidemic

The Government was subsequently awarded \$71.4 million for HIV round seven to support the five-year program from 2008–2012. The U.S. Government provides one-third of the Global Fund's total contributions, and the DR Congo is currently the second Vice President of the Coordinating Country Mechanism.

USAID Support

Through the U.S. Agency for International Development (USAID), the DR Congo in fiscal year 2008 received \$10.61 million for essential HIV/AIDS programs and services. USAID programs in the DR Congo are implemented in partnership with the U.S. President's Emergency Plan for AIDS Relief (Emergency Plan/PEPFAR). The Emergency Plan is the largest commitment ever by any nation for an international health initiative dedicated to a single disease. To date, the U.S. has committed \$18.8 billion to the fight against the global HIV/AIDS pandemic, exceeding its original commitment of \$15 billion over five years.

Reauthorized on July 30, 2008, the U.S. is continuing its commitment to global AIDS in the amount of \$39 billion for HIV/AIDS bilateral programs and contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Working in partnership with host nations, the initiative will support antiretroviral treatment for at least 3 million people, prevention of 12 million new HIV infections, and care and support for 12 million people, including 5 million orphans and vulnerable children.

Since the 1980s, the U.S. Government has worked with the DR Congo's MOH to develop HIV/AIDS programming. USAID currently supports activities that contribute to the reduction of HIV prevalence while increasing access to quality HIV/AIDS prevention, care, and support. USAID-supported interventions include implementing behavior change communications (148,145 individuals targeted with community outreach that promoted HIV/AIDS prevention through abstinence and/or being faithful) and promoting social marketing of condoms (8,106,863 condoms distributed during 2007 in Bukavu, Lubumbashi, and Matadi cities). USAID supported voluntary counseling and testing (VCT) (43,704 individuals in 13 VCT sites during 2007) using community, mobile, and health facility-based strategies. Strategies for prevention of mother-to-child transmission were integrated as part of a health care package of services in the 57 USAID-supported health zones, and care and support were provided to HIV-infected and -affected individuals (support for palliative care to 3,211 PLWHA in 2007). USAID also promoted blood safety, ensuring universal precautions, and strengthened the Government's capacity to improve its leadership

in provision of services, especially for orphans and vulnerable children (OVC). USAID collaborated with the Ministry of Social Affairs to reach 6,275 OVC with services in 2007.

In 2006, USAID/DR Congo's HIV/AIDS program aligned some of its activities in the east of the DR Congo (Bukavu) with SafeTStop, the regional ROADS HIV program, to stem and mitigate the consequences of HIV/AIDS in vulnerable populations along the East Africa Transport Corridor, which includes eight countries (Burundi, Rwanda, Uganda, Kenya, Tanzania, Djibouti, Southern Sudan, and eastern DR Congo). After a rapid participatory assessment conducted in Bukavu to evaluate community needs, the DR Congo program introduced the cluster model to community-based organizations. The cluster model in Bukavu brings together 73 low-income women's associations, 25 youth associations, and seven transport associations to develop a common vision and unified front in the fight against HIV/AIDS. Through the clusters, the project's goal was to reach more than 20,000 in-school youth; 15,000 out-of-school youth; 24,000 low-income women; 500 OVC; 3,500 drivers; and 12,000 passengers.

Through the Global Development Alliance (GDA), USAID/DR Congo took the opportunity to offer HIV prevention, care, treatment, and laboratory support to people in Matadi, Katanga, and 57 rural health zones by leveraging resources with private companies, including mining companies. In 2007, 838 people received counseling and testing, and seven people initiated antiretroviral therapy (ART) through one of the GDA programs located in Matadi.

Also, in 2006, USAID, PEPFAR, the United Nations Development Program, and the Global Fund launched a project to provide comprehensive HIV/AIDS prevention, care, and treatment at three DR Congo Government hospitals in Bukavu, Matadi, and Lubumbashi. As of October 2006, 456 people had initiated ART at these three hospitals, where USAID is leveraging resources with the Global Fund, and around 4,800 individuals had received counseling and testing, including 580 registered TB patients.

Important Links and Contacts

USAID/DR Congo

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Web site: <http://eastafrica.usaid.gov/en/Country.1005.aspx>

USAID HIV/AIDS Web site for the DR Congo: http://www.usaid.gov/our_work/global_health/aids/Countries/africa/congo.html

For more information, see USAID's HIV/AIDS Web site: http://www.usaid.gov/our_work/global_health/aids

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