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HEALTH IN FRAGILE STATES

COUNTRY CASE STUDY: DEMOCRATIC REPUBLIC OF THE CONGO

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HEALTH IN FRAGILE STATES

COUNTRY CASE STUDY: DEMOCRATIC REPUBLIC OF THE CONGO

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Abbreviations

ADF	African Development Fund
AfDB	African Development Bank
ARI	acute respiratory infection
BCZS	base centrale de la zone de santé
BPHS	Basic Package of Health Services
CDR	regional-level distribution centers
CHWs	community health workers
Cosas	health committees
DfID	Department for International Development
DOTS	Directly Observed Treatment, Short-Course
DPT3	diphtheria, pertussis, and tetanus
DRC	Democratic Republic of Congo
€	euro
ECC	Church of Christ of Congo
EC	European Community
ECHO	European Community Humanitarian Office
EPI	expanded program of immunization
EU	European Union
FDLR	Forces Démocratiques pour la Libération du Rwanda
FED9	9 th European Development Fund
FEDECAME	DRC federal agency
GAP	Global AIDS Program
GAVI	Global Alliance for Vaccines and Immunization
GDP	gross national product
GLIA	Great Lakes Initiative on HIV/AIDS
GRDC	Gouvernement de la République Démocratique du Congo
GTZ	Gesellschaft für Technische Zusammenarbeit (Corporation for Technical Cooperation)
HIPC	Heavily Indebted Poor Countries
HZ	health zone (<i>zone de santé</i>)
IMA	Interchurch Medical Assistance
INGO	international nongovernmental organization
IPRSP	Interim Poverty Reduction Strategy Papers

IRC	International Rescue Committee
MAP	Multisectoral AIDS Program
MICS	Multiple Indicator Cluster Surveys
MOH	Ministry of Health
MONUC	United Nations Mission in the Democratic Republic of Congo
MSF	Médecins Sans Frontières
NGO	nongovernmental organization
PARSS	Health Sector Rehabilitation Support Project
PATS	Programme d'Appui Transitoire au Secteur de la Santé
PHC	primary health care
PMPTR	Minimum Partnership Program for Transition and Recovery
PMURR	Emergency Multisectoral Rehabilitation and Reconstruction Project
PNAM	National Policy for Access to Essential Medicines
PRSP	Poverty Reduction Strategy Paper
PS-FED9	Programme Santé (Health Program)
PUSPRES	Programme d'urgence et de soutien au processus de réunification économique et sociale
RCD	Rassemblement Congolais pour la Démocratie
SANRU	Santé Rural
SWAp	sector-wide approach
TB	tuberculosis
U5MR	under-5 year mortality rate
UNOCHA	UN Office for Coordination of Humanitarian Assistance
USAID	United States Agency for International Development
WDI	World Development Indicators
WHO	World Health Organization
WHOSIS	World Health Organization Statistical Information System

All dollar amounts are in U.S. dollars (\$) unless otherwise noted.

Executive Summary

Analysis of Framework Conditions

Since 1994, conflict in the eastern part of the Democratic Republic of Congo (DRC) has created a major humanitarian crisis that significantly colors the way in which donor programs are conceived, developed, and implemented. Although a peace accord was signed, a transitional government put into place, and a constitution ratified, the central government's stability remains tenuous. Violence continues to have a major impact on mortality rates in the eastern part of the country, creating a mixed scenario in which humanitarian interventions and development programs must coexist.

In addition to political instability, which has been driven at various times by neighboring states and even rogue militias, other important drivers of fragility will have to be addressed if short-term gains in the social sector are to be sustained. Above all, these include abject poverty—it is estimated that up to 80 percent of the Congolese population lives on less than \$1 per day and parts of the country are essentially demonetized. Attention to jobs creation and income generation is essential. Moreover, the education system is in greater disrepair than the health system, creating a real risk that the next generation of Congolese will be illiterate.

Finally, a culture of predation and corruption prevails in the public and private commercial sectors. Progress in social sectors will be seriously impeded unless steps can be taken to heighten the level of confidence of both foreign investors and the Congolese population. Establishing the government's legitimacy first and then its effectiveness depend on demonstrating commitment and resolve to overcome these cultural factors.

The Health Sector

The DRC health system was once considered to be among the best on the African continent, but suffered a near total collapse between 1995 and 2001. Despite intense external support for health—currently estimated between \$2 and \$3 per capita per year—health parameters in the DRC remain among the worst in the world, making it clear that the road to recovery will be long. It is estimated that as much as 70 percent of the population has little or no access to health care. The humanitarian crisis is compelling and the need for health services throughout the country is great.

Innovative approaches to health sector programming have been instituted. The basis for reconstruction of the health system is the development of a Basic Package of Health Services (BPS), a step that has proven essential to providing policy coherence and uniformity of service delivery to an unguided and uncoordinated system. An agreement by both government and donors to focus development on the health zone—the unit from which primary health care services can be managed and delivered—has resulted in targeted support to much of the territory.

The engagement of the private sector and international and local nongovernmental organizations (NGOs) (including the traditionally strong church groups) has also been deemed essential. Rather than maintaining parallel private and public tracks for service delivery, attempts are being made to align the two by having the private sector manage health program implementation under the government's policy guidance. A promising mechanism is government contracting to private sector entities, sometimes on a competitive basis and sometimes with incentives based on achieving government-directed performance indicators. Another proposed

initiative is to establish a regular and sustained procurement of essential drugs at affordable and transparent prices through a decentralized network of purchasing agents.

Yet, health system management is weak. At this stage of re-development, the public health sector requires more technical assistance. Donors should work with the government to identify these needs and should place appropriate expatriate personnel, accountable to the Ministry of Health (MOH), at different levels of the health system.

Lessons Learned

A number of lessons have been learned in the early days of health system reconstruction in DRC. For one thing, donors should communicate better among themselves. In its current state, donor coordination consists of announcing plans and programs to each other. As is the case in many countries emerging from conflict, the country's health system has been *Balkanized*—there are Belgian-supported health zones, World Bank-supported health zones, USAID-supported health zones, and so on. In the future, a truly harmonized effort based on careful analysis of the rapidly changing situation will be required. Plans are in place to accomplish this.

Traditional developing country health programs should not be transplanted *in toto* to recovering geographical areas. Instead, transitional programs that address both health service delivery and drivers of fragility would be best. These would aim to increase the government's legitimacy as well as to improve the population's health status. Wherever possible, programs should cut across sectors to make the widest possible impact. Examples include the proposed multi-dimensional transitional programming designed by the United Nations Mission in the Democratic Republic of Congo (MONUC) and simultaneous programming in the health and conflict mitigation areas, as advocated by Corporation for Technical Cooperation (GTZ). Vertical programs, such as childhood vaccinations and disease-specific control programs, may contribute if they are highly visible and perceived by the population as being relevant to their most immediate needs.

Various forms of donor investment are being tried, including USAID's "state avoidance" strategies that establish contracts between the donor and contractor, World Bank "hedged" programs that establish management units in parallel to state entities, and the African Development Bank's on-budget lending. These will require careful independent evaluation to determine which, if any, outperforms the others.

Challenges

For most donors, the transition from emergency programming to development has proven difficult. Issues of financing, programming, and accountability must be resolved. The situation is complicated by continued unrest in parts of the country.

Concentrating on the health zones is sound policy, but carries with it the risk of excluding important health system constituents. In particular, the provincial (intermediate) level of the public health system remains seriously neglected. Due to the proliferation of directorates and special programs at the central level, as well as the donor community's interest in supporting management mechanisms that put private sector entities (for example, NGOs and churches) in the role of service providers, the provincial health authorities have been left without authority, and many are driven to support themselves in ways that are harmful to health system redevelopment. Plans to either support this level adequately or minimize its role should be further developed. The government has indicated a clear preference for the former and has requested additional donor financial and technical assistance at this level. Donors should approach provincial level reinforcement in a concerted fashion—just as the Basic Package of Health Services and a focus on the health zones are the first essential steps in harmonizing

donor action, so should the provision of technical assistance and financing to the provincial level be considered an essential element of harmonization and alignment.

Financing is a critical issue. According to the World Bank, donor aid to the health sector in DRC may soon reach \$200 million per year, or between \$3 and \$4 per capita. If the government increases its allocation to the health sector and Heavily Indebted Poor Countries (HIPC) debt forgiveness monies are used for health, public spending on health could reach as high as \$5 per capita. While this is more than what was available only a few years ago, it remains considerably short of the sums needed for substantial progress toward the health-related Millennium Development Goals to be made, even by the most conservative estimates. In the medium-term, recurrent costs, including salaries and drug procurement, may need to be borne by the donors. Given the state of impoverishment, the imposition of user fees and out-of-pocket expenditures for medicines should be avoided.

Although it makes sense to design programs for the short-term transitional period, a clear long-term vision for health sector development is required. Every program should be aligned with longer-term objectives to avoid the risk of once-off programs achieving fleeting success and making little substantive contribution to development. Without long-term objectives and, even more importantly, without guarantees of predictable long-term funding, the DRC health system will not be able to make real progress.

Summary

The major contributor to increased morbidity and mortality in the Democratic Republic of Congo is conflict, compounded by poverty and widespread corruption. Re-development of the country's health system should address these factors, in addition to developing strong disease prevention and treatment services. The rebuilding of destroyed facilities and reliable supply of those facilities with motivated personnel and appropriate medicines can contribute to an improved perception of government and, by extension, a lowered risk of the resumption of conflict.

The transitional process needs to be managed thoughtfully. Health programs should be designed with political and humanitarian objectives, and appropriate indicators for measuring progress towards both should be developed. Where possible, multi-sectoral programming (for example, health service delivery, income generation, and conflict mitigation) should be strongly considered.

Innovative management tools such as performance-based contracting have helped create potentially efficient public-private partnerships and should be continued. Increased technical assistance to the government, especially in management areas, should be provided. Adequate funding from both donors and government (to the extent possible) must be invested in the health system. Requiring household spending on health runs counter to poverty reduction principles and should be minimized.

Short-term or transitional programming is required immediately, but it is not too soon to plan for how the MOH and its donor partners can invest in and expand service delivery to achieve longer-term goals. It is a major strength that, despite the vastness of its territory, DRC demonstrated the ability to develop one of the strongest primary health care systems in Africa before conflict manifested itself in 1994. How it did so should be analyzed and, if appropriate, replicated.

1 Analysis of Framework Conditions

The fragility of the current situation in the Democratic Republic of the Congo is exemplified by the continued outbreaks of violence in the Kivus, in Ituri, and in northern Katanga. Politically, a group of Hutu rebels (*Forces Démocratiques pour la Libération du Rwanda* or FDLR) continues to destabilize the region, providing a degree of local legitimacy to the Rwanda-backed *Rassemblement Congolais pour la Démocratie* (RCD), which occupies a prominent place in the transition government. To help keep the peace, without which any hope for an improvement of the population's health status is illusory, MONUC currently has more than 16,000 troops (and an annual budget on the order of \$1 billion) in DRC. MONUC's initial mandate was to forcibly implement the 1999 ceasefire agreement; it is currently involved in disarmament, demobilization, and repatriation activities, in addition to supporting the transition to elections.

Economically, fragility in DRC is enhanced by warlords and rapacious public and private sector entities that continue unregulated extractive activities—a tradition begun by Leopold II that continues to the present time. One source describes the situation as a “food chain,” where those in power take a larger share of the resource pie while other, less powerful individuals, divide the leftovers, leaving the majority, those with no power whatsoever, with nothing.¹ A near total lack of transparency regarding the financial practices of those holding public positions, whether in government or as officers of state-owned or parastatal companies, results in important diversions of what should be public funds from, among other public functions, the development of the social sectors. Instead, whatever health and education services are provided depend largely on religious and other civil society institutions, rather than on state structures. In the eyes of many observers, this predation has become engrained within Congolese culture—and many assume that it will take a generation or more to reverse the current situation. According to the “2005 Global Corruption Report,” which ranked DRC 133rd out of 146 countries, “. . . reform of the public administrations will involve requiring certain officials to retire, carrying out a census of the workforce and eliminating fictitious employees, training officials, creating a civil service college, creating a school for judges and law officers, making the public servants' code of conduct more understandable to the general public, and increasing government officials' salaries.” Under these circumstances, delivering health services through a government-run health system will be a challenge for many years to come.

1.1 Nature of fragility

The present-day Democratic Republic of Congo (formerly the Belgian Congo and Zaire) was created as a distinct political administrative unit in 1885 by the Berlin Conference, which bestowed private title to the territory upon a private association headed by King Leopold II of Belgium. Leopold's basic interest in the land was the brutal extraction of large quantities of the country's enormous plant and mineral wealth, an activity that is estimated to have cost the lives of 10 million people. Eventually, the Belgian government took over administrative responsibilities, and the country remained a colony until 1960, when the outbreak of hostilities forced Belgium to grant the Congo independence. Internal conflict, including the attempted secession of Katanga Province, continued for five years, until Army Chief of Staff General Joseph-Desire Mobutu was able to seize power. Mobutu nationalized most of the Belgian and private extractive industry and, like Leopold before him, used his position for personal enrichment. He was a skillful political operator who was able to divert potential opposition, largely through the manipulation of rival factions, payoffs, and physical isolation (he is said to

¹ USAID/DRC, “Democratic Republic of Congo. Conflict Vulnerability Assessment,” August 2005, 24.

have allowed the road system to decay so that his enemies would be unable to reach Kinshasa).

Development in Congo was stifled both by a lack of will on the part of Mobutu and by the cessation of external economic aid at the end of the cold war. Despite its riches, the Zairian economy declined steadily through the 1980s. In 1994, the capture of Kigali by the Rwandan Patriotic Army in the wake of the genocide resulted in a large influx of both civilian refugees and armed militia from Rwanda to the east of Zaire, resulting in political destabilization of the area. A rebel force, led by Laurent Kabila and supported by neighboring Rwanda and Uganda, was able to overthrow Mobutu in May 1997. However, the conflict re-ignited and by 1999 the armed forces of five African countries were deployed on Congolese territory. In 1999, the belligerents signed a peace treaty in Lusaka that led to the putative withdrawal of foreign armies. To help enforce the terms of the treaty, MONUC was created in November 1999. Nevertheless, the government was short-lived—Kabila was assassinated in January 2001 and replaced by his son, Joseph. Relative chaos continued to reign throughout the eastern portions of the country, where “political” factions, the most important of which continued to be supported by external resources from Rwanda and Uganda, fought the weak central government and each other. The result was the near total destruction of the civic infrastructure and the entrapment of the local population. In total, this period of violence left more than three million people dead. Those who did not lose their lives lost their livelihoods and to a large degree, became dependent on the international humanitarian intervention that continues to this day.

In December 2002, some but not all of the warring parties entered into a peace agreement and, in June 2003, a transitional government was formed in Kinshasa. The transitional government, characterized by high-level representation of all the major contending political parties—there are four vice-presidents and 36 ministries, in addition to over 600 parliamentarians—will be in place pending elections that are to be held, if all goes well, sometime during the next few months. Although elections have been postponed several times, the promulgation of a new constitution in December 2005 has been widely hailed as a positive step forward.

Still, the weakness of the existing political institutions is a major source of continued state fragility. The successful completion of the transition to a democratically elected central government clearly represents a threat to those who will be called upon to surrender authority in some parts of the country. As part of the transition, most regional warlords have allowed their security forces to operate under a central command, at least to some degree, although the power that even the warlords can wield is often tenuous at best. At present, the various faction leaders in the eastern and northern parts of the country have adopted a wait-and-see approach; for the most part, they have agreed to at least a temporary cessation of overt hostilities, but they have clearly retained the option of re-asserting control within their respective areas. The reaction of those who are “losers” in the upcoming elections (when and, more importantly, if they are held) will determine the degree to which a central administration is able to provide security to the Congolese population.

1.2 Socio-Demographic and Cultural Context

The DRC population is about 60 million—the third largest in sub-Saharan Africa. The population pyramid is typical of a developing country in which HIV/AIDS has not taken a major toll. About 48 percent of the population is under 15 years and only 3.5 percent is over 60 years old. There are about 250 distinct ethnic groups. About 30 percent of the population is urban, but urban/rural separation is far more extensive than in most other countries because of the relatively recent destruction of what used to be a reasonably extensive road system and an inability, for security (piracy) and for financial reasons (extortion), to travel along the major waterways, especially the Congo River. Average life expectancy is not more than 45 years. The

UN Office for Coordination of Humanitarian Assistance (UNOCHA) reported that 1.6 million Congolese were displaced from their homes at the end of 2005, mostly due to the conflict in the east. Only 34.8 percent of children were enrolled in primary school, and school completion rates are exceedingly low for both sexes, but especially for girls (UNESCO and UNICEF 2005). Unless this situation is addressed, the next generation of Congolese will be largely illiterate.

Ethnicity is a surprisingly minor source of fragility in DRC. There are about 250 ethnic groups and over 200 distinct languages, of which Kikongo, Lingala, Tshiluba, and Swahili are recognized as “national languages” along with French. Tensions exist between Hema and Lendu in Ituri, and between Lubakat and Hema in Katanga, as well as in other areas, but many observers feel that these ethnic differences are not a root cause of conflict, but instead are frequently inflamed into rivalries by those seeking political advantage.

The most serious political conflict within the current transitional government has been between Kabila and the RCD, led by Azarias Ruberwa. The RCD is viewed by most outside of the Kivus as within the Rwandan sphere of influence. It is, itself, full of dissent between its Kinshasa representatives and those in the east who seek redress for claimed ethnic persecution (it is largely composed of Tutsis). Again, though, the dispute’s ethnic component is just one among many, the most important of which is a struggle between different factions to control the region’s vast mineral resources.

1.3 Economic Context

DRC is a resource-rich country. Within its borders are found the second largest rainforest in the world and unusual quantities of diamonds, gold, uranium, zinc, copper, coltan, and other minerals. Extraction industries account for 75 percent of export revenues and 25 percent of the gross national product (GDP). Yet mismanagement, corruption and conflict have crippled the formal economy. Annual per capita income has steadily declined since independence. The World Bank currently estimates that a majority of Congolese try to survive on less than \$0.20 per day, and 80 percent earn less than \$1/day. One-fourth of the population is food insecure (most consume less than two-thirds of minimum daily recommended calories), and only 20 percent have access to safe water.

In 2003, the estimated annual per capita GDP was \$673. Hyperinflation, which characterized the economy during the war years, has been reduced; inflation was 630 percent in 2000, 8.8 percent in 2001, and 4.5 percent in 2003. The exchange rate has also stabilized, and the economy has recently begun to show significant growth, reaching 7 percent in 2005. External debt is around \$12 billion (about 225% of annual GDP), but DRC became eligible for debt relief under the Heavily Indebted Poor Countries (HIPC) initiative in July 2003. Despite these positive signs, if one assumes a 5.3 percent average annual growth rate, DRC will not reach the level of annual per capita GDP it had in 1960 until the year 2060.

War has reshaped the economy. Exports, formerly a major source of revenue, have fallen to about 5 percent of GDP, while the proportion of the economy derived from the agriculture sector has increased from 30 percent in the 1980s to 54 percent in 2001. Still, rural agriculture is largely subsistence, due again, to a large degree, on the quasi-total lack of a transportation infrastructure that would allow produce to come to market.

The US dollar circulates widely in the east, while the CFA franc is common currency in the north. Some areas of the country remain essentially demonetized.

1.4 Quality of Governance, Institutions, and Policies

The Mobutu regime was characterized by state predation on a scale rarely seen. State actions combined with personal corruption effectively undermined any semblance of effective

governance in DRC prior to 1996. Subsequently, conflict, the rise to power of regional warlords and factions, and the progressive deterioration of the transport and communications infrastructure increasingly isolated large parts of the country from Kinshasa, removing them from the reach of a central administration and destroying even the possibility of national policy coherence. The creation of the existing transitional government was a major step forward, but the current situation is far from ideal or even good; belligerent groups, especially in the east, still have not ceded power to a centralized authority. Those parties that have joined the government are weakened by internal dissent. The transitional government itself is rendered relatively ineffective because of its inclusive nature; each major political party is represented at the vice-presidential level and the number of ministries has multiplied to accommodate the power-sharing needs of the many players involved. The next major step towards legitimate, if not effective, governance in DRC is elections, if these are held fairly and peacefully, and if those who lose cede power and authority to those who garner the will of the electorate, it is conceivable that a serious rehabilitation of the social sectors could be undertaken. Without successful elections and the formation of a viable and, hopefully, effective government, a return to instability and armed conflict is almost inevitable. It is important to note that all the efforts of the international community described in the rest of this case study, and especially in chapter III, need to be carefully considered in this context.

2 The Health Sector

Once considered a model for the continent, the DRC health system suffered a near total collapse between 1995 and 2001. High user fees, along with inadequate quality and availability of services, have made health care largely inaccessible for the poor. Preventable and easily treatable diseases, such as measles, malaria, diarrheal diseases and acute respiratory infections (ARIs), continue to claim a shockingly high number of lives. Even with increased health sector investment and external assistance over the last three years, health services remain out of reach for the majority of Congolese. Nonetheless, despite abysmal national health indicators, measured improvements have been observed in areas receiving the international community's targeted assistance.²

In addition, the public health policy framework is improving. Recent MOH policies and strategies, including the Minimum Package of Activities, provide a strong basis for donor harmonization. The current service delivery strategy focuses on revitalizing the decentralized health zone model for the delivery of essential health services, with particular attention to priority diseases such as malaria, pneumonia, diarrhea, vaccine-preventable diseases, and other conditions that jeopardize pregnant women and their newborn babies. HIV/AIDS and tuberculosis are also the subject of increased control efforts, as are other diseases of more local concern.

Health authorities have a long experience of working through public-private partnerships with churches and NGOs to co-manage health services at the district and health zone levels. Recent efforts to formalize partnerships with non-governmental actors, including strengthened accountability mechanisms such as performance-based contracts, could help to improve service provision quality and consistency. However, no matter how much more available services become, a far better understanding and response to demand-side factors and constraints will be critical for increasing their utilization, especially by the poor, rural, and disenfranchised population. The Congolese population has been exploited in every sector and has developed a natural aversion to all things governmental. Clearly the fee structure will have to be adapted; numerous studies have shown a clear inverse relationship between modifications of fees for health services and utilization rates. For this reason, the new World Bank Project has suggested offering free health services at facilities it supports. Still, most Congolese health authorities insist that some sort of charges need to be in place, if not to help support the salaries of health workers or the upkeep of facilities, then because of their deep-seated conviction that "free" equals "without value," and that people will hold the health system in higher regard if it they have to pay to use it. No data were found to support this contention.

Over and above the issue of money, though, are other considerations that can be summed up by the concept of "trust." There has been extensive writing on this subject (see Gilson et al. *Social Science and Medicine*). To increase utilization rates by instilling trust in the population that they will be well served and not taken advantage of, would be the equivalent of enhancing political stabilization by increasing government legitimacy. In this way, the health system may be able to make a measurable contribution to the attainment of the political objectives inherent in working in fragile states (see below). Initially, this can be done, perhaps, by just making an effort to rebuild and to re-supply local health facilities, and to ensure that health providers are present and seen to be working to assist their clients, not to fleece them. Eventually, improved quality of care will also figure in the equation. From the start, though, indicators of acceptance and trust of the health system on the part of the population it serves should be included in new health

² As demonstrated in NGO surveys and reports, for example, SANRU annual reports.

programs as a reflection of increased legitimacy and improved health sector governance (governance refers to both public and private sector management of health policy). There is not much evidence regarding the usefulness of this kind of indicator, and none on the relationship between “legitimate” health systems and political stabilization, but the idea is alluring and a post-conflict environment such as that of DRC provides an excellent opportunity for experimentation of this nature.

Sustained external assistance and increased spending by the Belgian government, including improved execution of the health sector budget and appropriate remuneration of health personnel, will be needed to augment delivery capacity. Nevertheless, even with the best of external partners, the DRC’s major challenge lies not only in shoring up basic services at existing facilities, in ensuring the expansion of coverage to all peripheral areas, particularly the most isolated and neglected rural zones, and in aggressively promoting their utilization, but also, to a large extent, on non-health sector efforts to consolidate the peace process and achieve an environment of political and economic stability within which the health sector can develop. As mentioned above, the extent to which improved health service delivery can contribute to the creation of this environment is unknown, and the fragility of DRC at this time seems to depend more on factors external to the health system.

2.1 Health System Organization and Infrastructure

Health System Organization

In 1981, the DRC adopted a progressive new health policy, with provision of primary health care (PHC) as its main strategy. A massive restructuring of the health system followed that included decentralizing the sector in 1986 into more than 300 health zones (HZ), the principal operational units. Within a short time, in large part due to strong backing from its principal donors, visionary technical assistance, and especially the dedication and exceedingly competent program implementation of Congolese staff, the DRC health system became one of the most admired in sub-Saharan Africa. In 2001, the system was re-divided into 515 health zones and has undergone continued expansion to allow the HZ boundaries to become aligned with political and administrative boundaries.

The health system is organized on three levels: central, intermediate (province-level) and peripheral (zone de santé/health zone, the equivalent of the district-level in most countries). At the national level, the MOH is responsible for overall sector policy, regulation, national programs, and hospitals. At the intermediate level, the 11 (expansion to 26 is planned) provincial units are charged with providing technical support and supervising the health zones. Each HZ is intended to cover an average population of 110,000 and includes one central HZ office (*base centrale de la zone de santé* - BCZS). The HZ is sub-divided into a variable number of *aires de santé* that consist of several health centers (clinics) and even more peripheral health posts that are responsible for providing a government-defined minimum services package. In addition, each HZ has a general referral hospital that offers a package of complementary services. In some cases, there may be an additional health referral center, depending on the zone size and the number and nature of the organizations providing health care within it.

Infrastructure and Health Facilities

The DRC has over 500 hospitals and more than 5,000 health facilities that are in varying states of functioning.³ Of these facilities, private institutions, churches, and NGOs operate more than

³ Government documents note the existence of 510 hospitals; a recent MSF report noted only about 400 hospitals and 5,000 health facilities.

half. Hospitals and other health facilities, in particular those under state management, are quite dilapidated; many structures in the most conflict-affected regions have been looted or abandoned and are no longer operational. The vast size of the territory and isolation of rural areas also leave a large proportion of the population out of reach of health services. A 2004 survey in Equateur Province found that 42.7 percent of households had to walk over eight hours to reach a health facility (World Bank 2005a). In 1998, there was just one hospital for 300,000 persons in urban areas and one hospital per 160,000 persons in rural areas, well above the respective standards of 150,000 and 100,000. Similarly, there was just one health center per 100,000 persons in urban areas and one health center per 60,000 persons in rural areas, in comparison with the respective standards of 20,000 and 15,000 (World Bank 2005b).

Human Resources

Years of conflict and mismanagement have left the country with few skilled health personnel; the majority of qualified workers are concentrated in Kinshasa and, to a lesser degree, in Bas-Congo. The current number of health care workers and staff postings is unknown. In 1998, DRC had only around 4.4 physicians per 100,000 persons and about 58 nurses per 100,000 persons. However, taking into consideration the disproportionate distribution of health personnel across urban and rural areas, there were only an estimated 1.8 physicians per 100,000 persons in rural areas in 1998. A World Bank/MOH study estimated that several provinces likely had less than one physician remaining per 100,000 persons in 2003 (World Bank 2005b). In addition, public sector health care workers are poorly and irregularly paid, unmotivated, and demoralized by ill-equipped facilities and a situation in which the gross lack of public resources has required them to demand remuneration from indigent patients. However, as mentioned elsewhere, a small “health professional production” enterprise has sprung up and the numbers of physicians and nurses, of questionable quality to be sure, may be on the rise.

Drug Supply and Management

The drug system is dysfunctional, with drug supply fragmented, inefficient, and costly. In the absence of a functioning centralized network, public pharmacies are frequently empty or only partially stocked. In recent years, private networks have covered about 20 percent of supply and distribution needs (African Development Bank 2004). Because hospitalized patients must procure their own medications and sometimes medical supplies to be treated, patients with means are sometimes left no choice but to buy drugs through the black market (Médecins Sans Frontières [MSF]-B 2005). There is an acute need for improved storage and distribution facilities for drugs at the national and provincial levels and for an improved pharmaceutical logistics and management information system (Keravec 2005).

Accordingly, a new National Policy for Access to Essential Medicines (PNAM) is under development, with the aim of centralizing the procurement for all essential medicines through a federal agency (FEDECAME). This complicated, but necessary, undertaking is a central target of assistance from the European Community. The new model relies on 40 regional-level distribution centers (CDR) located in strategic cities. The CDR are mixed status (private structures with a public mission), with the state playing a regulatory role. The main CDR clients are BCZS, hospitals, health centers, NGOs, faith-based organizations, and private health services. Nine CDR were operational as of September 2005 (Keravec 2005; World Bank 2005a). However, the project has run into strong objections from those who have a vested interest in maintaining the status quo, notably the pharmacist community.

The largest distributor of medicines in the conflict-affected areas of the east has been Association Régionale d'Approvisionnement en Médicaments Essentiels (ASRAMES), an NGO formed for that specific purpose. Although an NGO, ASRAMES in fact functions as a national

pharmaceutical purchasing and distribution agent might; it fills the needs of both government- and NGO-run health facilities throughout North Kivu. Based on its experience and its effectiveness, it would be interesting to see if the ASRAMES-developed system could be incorporated directly into whatever drug procurement system the government develops. The absorption of privately developed health system innovations implemented when governments are absent or exceptionally weak into a MOH of structure once it is (re) developed could be an interesting model to pursue.

2.2 Health Care Providers and Service Delivery

The DRC has an active civil society and a long tradition of public-private partnerships in the health sector. In recent years, largely non-state actors and private organizations have provided health service delivery. As will be discussed later, major bilateral and multilateral partners such as the European Union (EU), the World Bank, the African Development Bank (AfDB), Belgian Cooperation, and USAID have channelled resources to numerous NGO and sectarian partners, with a focus on providing a core package of key interventions at the health zone level. Many of the not-for-profit private sector, church organizations, and NGOs have been providing health services in the Congo for 20 to 30 years or more. The U.K. Department for International Development (DfID) has said that the “Catholic Church is probably the most significant civil society actor in the Democratic Republic of Congo,” as it has a level of access and influence that is challenged only by the central government, and has maintained a presence throughout the conflict.

In the 1980s, donors provided substantial assistance to the health sector, helping to create health zones and put in place a structure of operational partnerships between the Gouvernement de la République Démocratique du Congo (GRDC), churches, and local NGOs. Notable interventions during this time included USAID’s Santé Rural (SANRU), a series of projects run by the Church of Christ of Congo (ECC) / Interchurch Medical Assistance (IMA), which sought to reinforce the capacity of some 200 health zones for the management of essential primary health care from 1981 to 1991, and Santé pour Tous, a Belgian-supported project that delivered primary health care in urban areas. During the early 1980s, faith-based organizations and NGOs co-managed as many as 78 percent of existing health zones (Kintaudi and Baer 2005).

With the health system’s near total collapse in the late 1990s, church organizations and NGOs again became the principal health care providers at the district and peripheral levels, with the private sector running most of the surviving structures and services. Today, sectarian groups direct about one-third of health facilities, and in many health zones, the church manages the only hospital of recourse (World Bank 2005b).

The EU’s Programme d’Appui Transitoire au Secteur de la Santé (PATS) (1994–2005) provided direct support for existing health services, with the aim of stabilizing remaining structures and retaining health personnel to prevent further degradation. Through contracts with 42 partner organizations, the project sought to preserve peripheral services and the health zone delivery model in the absence of government institutions. In the first PATS (1994–98), there was no convention between the government and the European Community (EC), but in PATS II, emphasis was placed on formalizing contractual relationships between the MOH and civil society partners (Delamalle 2004).

The prevailing donor model of providing support to the HZ level has continued since major bilateral development assistance resumed in 2001. The common strategy of external partners has been to focus on basic health service provision, in accordance with the Minimum Package of [Health Sector] Activities developed by health officials of the then-divided DRC in Nairobi, using international and national NGOs or sectarian organizations to conduct assistance

programs at the health zone level, where service provision through the public sector was precluded by violence and insecurity. External agencies have traditionally targeted selected health zones for service delivery support. For example, since reinstating the SANRU program in 2001, USAID has provided assistance to 81 health zones. The EC's Programme Santé (PS-FED9, the successor to PATS) now supports health services in four provinces. Coopération Belge concentrates its support on health zones in Bas-Congo and Kisangani. The African Development Bank supports health sector development in Province-Orientale. Through its Health Sector Rehabilitation Support Project (PARSS), The World Bank is supporting essential health services in 83 health zones.

Humanitarian interventions in the east, while involving a somewhat different set of actors, are intended to support the same Minimum Package of Activities, demonstrating an unusual degree of harmonization of effort, but essentially always through NGOs. Different national MSF branches, for example, have supported delivery in more than 30 health zones, while International Rescue Committee (IRC), Action Contre la Faim, and many other agencies are "responsible for" other zones.

Although adherence, at least in principle, to a common Minimum Package may allow for a relatively smooth transition from humanitarian to development programming from a policy standpoint, the very different administrative procedures that exist with donor agencies in regard to humanitarian interventions versus longer-term programming will undoubtedly cause problems in DRC, as they have in many other countries. Even within the non-conflict areas, the participation of such a diverse array of actors has also resulted in the development of a variety of different management systems. Finally, despite the many partners providing support at the peripheral level, assistance has not been equitably distributed, creating some "well-off" health zones, while others are virtually destitute and offer few if any services to the population in their catchment zones.

Recent MOH/not-for-profit private sector engagements have sought to more clearly define contractual parameters. One of the key principles in the PARSS (World Bank) model is the use of performance-based contracts between the MOH and implementing partner agencies, including independent external evaluation of partner agencies' performances.

An informal for-profit private sector also exists, particularly in areas where the population has some purchasing power, such as in the cities or around the mines. For the most part, the for-profit private sector is restricted to the sale of medications and does not offer care (MSF-B 2005).

2.3 Financing and Financial Management

The 2005 health sector budget was about \$86.5 million, representing 4.45 percent of the total GRDC budget and approximately \$1.3 per person (GRDC 2005). Actual 2005 spending was considerably less, with only 48 percent of the 2005 allocation discharged, equivalent to just \$0.62 per capita. The rate of budget execution was highest for drugs and supplies (119%) and public health services, including vaccination (90%), and the least for other health operating expenses, including health worker salaries (32%) (GRDC 2005). There has also been geographic disparity in health sector disbursements, with spending concentrated in Kinshasa (World Bank 2005a).

Private expenditure on health is extraordinarily high, with households continuing to bear the brunt of health care costs in out-of-pocket expenditures. The withdrawal of external assistance

and the total nonfunding of the health sector in the late 1990s through 2002⁴ led to high cost recovery fees, essentially supporting health services on the backs of the poor.

Table 2.1 Health Expenditures

Indicator	1998	1999	2000	2001	2002
Total expenditure on health as a percent of GDP	3.7	3.1	3.7	3.5	4.1
External (donor) resources for health as percent of total expenditure on health	6.7	3.7	4.9	16.7	28.4
Private expenditure on health as percent of total expenditure on health	90.1	92.8	92.6	81.8	69.8
Out-of-pocket expenditure as percent of private expenditure on health	100	100	100	100	100

Source: World Health Organization Statistical Information System (WHOSIS).

External development assistance returned in 2002, with large health sector support commitments from the World Bank, the EU, and other donors. External assistance is being used to support recurrent costs for the provision of basic health services, along with strengthening disease-specific control programs. Government spending remains low.

Table 2.2 Major Projects Supporting the Health System Strategy

Project	Total	Target Population	Length
Health Sector Rehabilitation Support Project (PARSS) – World Bank	\$150 Mil	83 HZ	4 years (12/2005–12/2009)
EC Programme Santé – PIN 9 ^{ème} FED	€ 80 Mill	4 provinces	5 years (2003–07)
Programme d'urgence et de soutien au processus de réunification économique et sociale (PUSPRES)	\$20 Mill	3 cities	2 years
AfDB	\$40 Mil	1 province	5 years (09/04–10/09)
USAID ^a	\$40 Mil	80 HZ	4 years (2004–08)
DGCD (indirect bilateral aid) ^b	\$29 Mil	61 HZ & 4 provinces	6 years
DGCD (direct bilateral aid) ^b	€ 30 Mil	DS & 6 Dir/Progr.	5 years
Global Fund – Tuberculosis (Round 5) ^c	\$36.2 Mil	11 provinces	5 years (2006–10)
Global Fund – Tuberculosis (Round 2)	\$7.6 Mil	11 provinces	3 years (08/03–07/06)
Global Fund – Malaria ^c	\$53.9 Mil	156 HZ	5 years (10/04–09/09)
Global Fund – HIV/AIDS ^b	\$113.6 Mil	11 provinces	5 years (10/04–09/09)
Great Lakes Initiative on HIV/AIDS (GLIA) ^d – WB	\$20 Mil	5 provinces	4 years (2005–09)
Multisectoral AIDS Program (MAP) – WB ^e	\$35 Mil	11 provinces	5 years (2005–10)
PDDS/POR (Government)	\$35 Mil	26 HZ, 3 DS	5 years
GAVI	\$49 Mil	EPI	5 years (2003–07)

Sources: Gouvernement de la République Démocratique du Congo Ministère de la Santé Publique 2005; Global Fund; GAVI; World Bank “Active Projects” 2006; AfDB 2006.

Note: € = Euro.

- This reflects USAID assistance targeted towards providing the minimum package of services in specific health zones (roughly \$9-10 million per year). USAID spends an average of \$18-20 million a year on health, with an additional annual contribution of \$7 million from OFDA.
- These figures taken from the Annual Review of the DRC MOH. The DGCD website states that they spend an average of € 10 million annually on health in the DRC.

⁴ From 2000–02, less than 1 percent of the total budget was devoted to the health sector (GRDC 2005).

- c. Expected funding over 5-year lifetime of grant: \$14.6 million for TB, \$24.9 million for malaria and \$34.8 million for HIV/AIDS have been approved for the first two years; \$21.4 million for HIV/AIDS and \$20 million for malaria have been disbursed to date.
- d. Not all funds target the DRC.
- e. Total grant amount is \$102 million, allocated across multiple sectors; \$35 million of this amount directly supports the health sector strategy.

2.4 Stewardship

Government policy has focused on primary health care provision, with the development of the health zones as the principal strategy for delivering essential health services. In 2001, the government adopted a new national health policy reaffirming these objectives and its commitment to a decentralized system. The MOH has subsequently defined standards for the functioning of health zone facilities and the contents of the minimum package of activities.

The November 2004 Minimum Partnership Program for Transition and Recovery (PMPTR) presented donors with a strategic framework and government-identified priority actions for the health system's reconstruction and rehabilitation. Health sector objectives concentrated on the revitalization of the 515 HZ and capacity building at all levels of the health system, with the aim of putting the country on track towards achieving the Millennium Development Goals. An interim Poverty Reduction Strategy Paper (PRSP) was also prepared in February 2002.

While government resource allocation for the health sector has been paltry to date, policy documents have called for substantial increases to achieve the overall goals of improved utilization and access to essential PHC for the poor. The interim PRSP called for a minimum allocation of 15 percent of the national budget to the health sector, with increased spending to target, among other things, HZ rehabilitation, especially in rural areas; strengthening of national and local capacity for combating priority diseases; and ensuring the regular supply of essential medicines. However, given the DRC's global reconstruction needs, it is unlikely that such a lofty objective will ever be attained.

The MOH has 42 specialized programs (only some of which are operational) targeting priority diseases and areas, including malaria, tuberculosis, HIV/AIDS, expanded program of immunization (EPI), reproductive health, and nutrition. The programs are charged with setting care standards, and coordinating and monitoring activities at the national level. Specialized program activities are to be integrated at all levels of the health system and for all types of care. While there is some rationale for the inclusion of each of these programs within the MOH structure, more refined prioritization is probably indicated at this stage of reconstruction—the propagation of vertical programs appears inconsistent with the GDRC's ability of to develop a coherent policy framework and to pursue its principal objective of ensuring primary health care services for the entire population.

As noted above, in many areas, especially those supported by the World Bank and the EU, the GDRC has introduced partnership contracts with international nongovernmental organizations (INGOs) for the provision of essential services and has placed a new emphasis on the monitoring and evaluation of implementing partners.

2.5 Community Engagement

Research on demand-side initiatives is lacking. As noted above, the DRC has an active civil society, with a tradition of church and NGO-managed health facilities. With communities shouldering the bulk of health care costs over the last decade, those facilities that continued to function did so largely thanks to private sector and community support.

The health policy calls for the participation of communities through health committees (Cosas) and for the mobilization and training of communities in the care, maintenance, and rehabilitation of facilities. The MOH has adopted a strategy based on the training of community health workers (CHWs) and the creation of community extension units. The CHW role is to sensitize the local population on health issues, to contribute to finding context-appropriate solutions, to promote appropriate care-seeking behaviors, and to help foster an effective partnership between the health center and community members. Projects have sought to support training, the operation of community extension units and health committees, and to provide institutional support to grassroots associations and NGOs (AfDB 2004). For example, the World Bank health sector rehabilitation project supports the training of volunteer CHWs to assist with treatment of diarrhea and pneumonia, promotion of family planning, and obstetric referral at the community level.

While outreach and community-based services have been weak, “benefiting only those persons who live in close proximity to health centers,” the new focus on measurement of health outputs, including community involvement, should help to foster increased community outreach and accountability on the part of service providers (USAID 2004; World Bank 2005a).

2.6 Trends in Health Service Outputs and Outcomes

Available DRC health data are of poor quality, are not up-to-date, and do not provide a full picture of the country’s health status. There are considerable regional and rural-urban disparities, as well as variations across assisted and unassisted health zones. Reported indicators for antenatal care, skilled birth attendance, tuberculosis detection, and DOTS (directly observed treatment, short-course) completion seem surprising and inconsistent with other utilization data and the generally poor rate of contact between the health system and the population.⁵ Data commonly reported by the World Bank, the World Health Organization (WHO), and UNICEF are provided below, but they should be interpreted with caution.

Health Service Outputs

Utilization is poor across all health services, with a large proportion of the population never accessing the formal health sector. At the height of the conflict in June 2001, a joint WHO-UNICEF mission estimated that more than 70 percent of the population had little or no access to health care.⁶ More recent studies have concluded that 50–60 percent of the sick do not seek consultation (World Bank 2005b). High user fees, limited geographic coverage, inadequate interventions, drug unavailability, and poor quality of care have kept utilization low overall, with the poor most adversely affected. Where services are available, the population’s limited financial capacity has frequently been too great a barrier to accessing care. A World Bank/MOH study showed differential utilization rates across all income levels, with demand strongly associated with household income and, presumably, cost of care (World Bank 2005b).

Immunization coverage remains poor despite significant vaccination campaigns and the EPI restructuring in 2000. The second round of the Multiple Indicator Cluster Survey (MICS2) in 2001 documented EPI coverage of 53 percent for BCG (Bacillus Calmette-Guérin), 48 percent for measles, 42 percent for polio, and 30 percent for DPT3 (diphtheria, pertussis, and tetanus). At most, 23 percent of children were estimated to have complete vaccinations. More recent

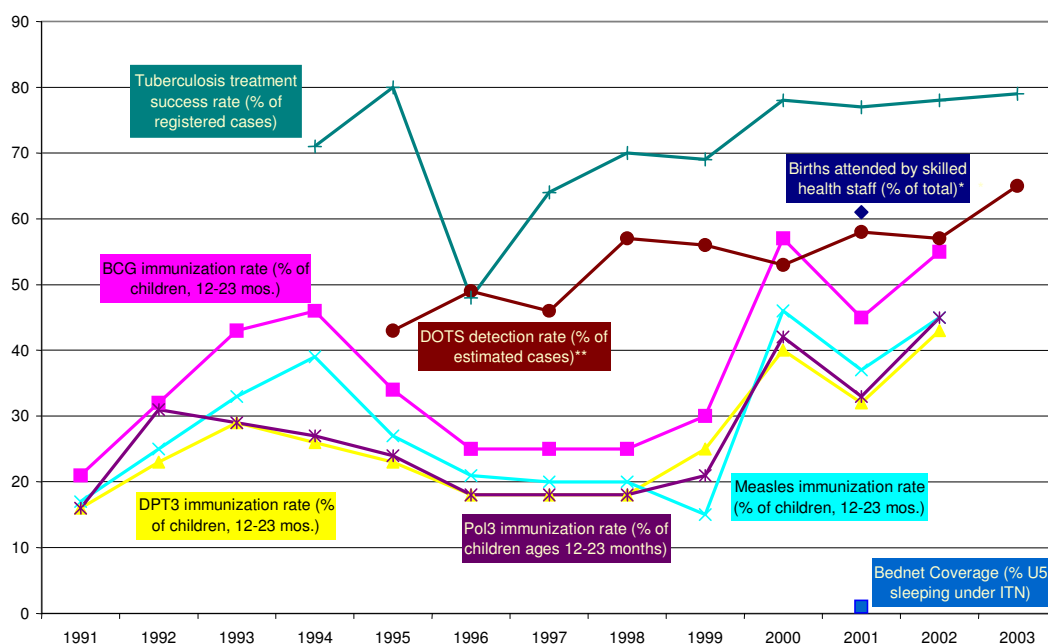
⁵ The National Tuberculosis (TB) Program estimated a 2002 TB case detection rate of 52 percent, with about 70 percent of the population having access to anti-TB drugs (World Bank 2005b).

⁶ Joint mission, OMS-UNICEF, June 2001.

estimates for 2005 suggest that DPT3 coverage is about 61 percent nationally and measles coverage is about 62 percent, with rates varying by region and health zone (USAID 2006).

According to the Food and Agriculture Organization (FAO), 71 percent of the population is undernourished (FAO 2005). A 2001 national nutrition survey estimated 38.2 percent of children under five are moderately to severely malnourished, with a breakdown of 28.9 percent in urban areas and 42.6 percent for rural areas.

Figure 2.1: DRC Health Service Outputs



Sources: DOTS detection and treatment (WHO 2006). All other data are from World Bank (2005c).

* Available data for births attended by skilled health staff vary. World Development Indicators (WDI) reports 61 percent (as charted), while the 2002 Interim Poverty Reduction Strategy Papers notes that 65–85 percent of births are unattended; other sources report 42.7 percent of births were attended in 2001.

** DOTS detection rate is based on uncertain estimates of TB incidence (WHO 2006).

Health Outcomes

Mortality rates remain above emergency thresholds in several areas of the country. A 2005 MSF study documented rates ranging from 1.8 to 3.4 deaths per 10,000 persons per day in four of five surveyed health zones, some of which were not conflict-affected. The main causes of morbidity and mortality are communicable diseases such as malaria, acute respiratory infections, and diarrheal diseases, with malnutrition and HIV/AIDS also weighing heavily in the household burden.

The DRC has one of the worst maternal mortality ratios in the world, with 1,289 deaths per 100,000 live births. The infant mortality rate and under-five mortality rate are also well above sub-Saharan averages. The 2003 Lancet series on Child Survival lists DRC with the fifth most annual childhood deaths of all countries in the world (484,000) and with the ninth worst under-5 year mortality rate (U5MR) (205/1000 births). The most recent UNICEF (MICS) estimates cover 2003 and part of 2004 and estimate the U5MR at 259 per 1000 live births, with still higher rates in rural areas (World Bank 2005b).

Table 2.3 Health Outcomes

Indicator	2000	2001	2002	2003
Infant mortality rate, both sexes (per 1,000 live births)	127.0 ^a			
Under-five mortality rate, both sexes (per 1,000 live births)	211.8	213		259
Maternal mortality ratio (per 100,000 live births) ^b		1289		
Number of adults and children living with HIV				1.1 million
HIV prevalence among 15-49-year-olds (%)	4.3			4.2

Sources: WHOSIS; UNICEF MICS2; World Bank Development Indicators Database; IPRSP; UNAIDS; Black 2003.

- a. According to a 2000 IRC report, this rate was actually much higher: 200/1000 live births.
- b. MOH reported maternal mortality rate estimates vary from 905/100,000 in Ituri (1999) to as high as 1,837/100,000 births nationally in 1998/1999; 2,000/100,000 births in Kinshasa and up to 3,000/100,000 in Kivu (2001).

3 The Role of International Development Partners

3.1 Inventory of Key Actors

As is the case with many countries emerging from conflict, DRC has recently become relatively popular among the donors. The World Bank and European Commission are the largest of the multilateral donors in the health sector. The leading bilateral donors include the United States, which is in the process of issuing a contract for its third five-year health service delivery project, SANRU (Santé Rurale), Belgium, Canada, and Germany. The United Kingdom is rapidly expanding its programs in DRC, but remains a modest investor in the health sector for the time being.

PARSS is the principal World Bank health project in DRC. Approved in September 2005, the four-year grant provides \$150 million in IDA assistance, aimed primarily at ensuring access to, and promoting the use of, the MOH's Minimum Package of Activities in 83 health zones. The project will target a population of approximately 9.4 million (about \$15 per capita for the targeted population, about \$2.5 per capita of the national population, over a period of four years). The selection of targeted health zones was made both on the basis of perceived and documented need and through discussion with government officials and other donors. The bulk of the grant, \$104 million, is devoted to service delivery, to be implemented via performance-based contracts awarded on a competitive basis to NGOs. The MOH level of involvement in contracts is to be determined, although increased MOH control over the contracting is expected, in comparison to its predecessor project, the Emergency Multisectoral Rehabilitation and Reconstruction Project (PMURR), in which the MOH was more or less excluded from the process. An independently contracted entity will evaluate the performance of the NGOs. Because achieving health status improvement is the principal goal, the implementing partners (NGOs) are accorded a great deal of discretion, including, to some extent, fee-for-service structures and health worker remuneration. In addition, greater financial transparency and better incentives to all levels of the health system are supported.

PARSS also devotes \$30 million specifically to malaria control activities in the same health zones. This will cover intermittent presumptive treatment for pregnant women and artemisinin combination therapy, to the extent possible, in addition to the distribution of long-lasting, insecticide-impregnated bed nets and technical assistance. This component will support the national Roll Back Malaria plan and is being implemented in coordination with the Global Fund. A third component allocates \$12 million to strengthen the oversight and evidence-based management of the health system.

PMURR included a three-year \$44 million health subcomponent in support of 67 health zones. An extension to PMURR was approved at the end of 2005, and the World Bank will continue to provide additional financing of \$5.4 million for the health sector under a supplemental IDA credit.

The European Commission 2005 Global Plan for DRC amounted to € 38 million, of which €15.5 million was designated for primary health care in 87 zones, serving a population of 8 million (almost \$ 2 per capita targeted population, about \$ 0.25 per capita for the national population). Under the 9th European Development Fund (FED9, 2003–07), the EC is currently supporting a € 80 million five-year health program. The program builds off of PATS I and II, implemented from 1992 to 2005, and focuses on the same central themes of access to services, essential drug availability, and sector financing. At the national level, the program provides support to the MOH to strengthen stewardship, drug supply, and the health information system. Support is also provided for targeted health zones in four provinces: Nord Kivu, Province Orientale, Kasai Oriental, and Kasai Occidental. Implementation began in the first half of 2006. Also this year, the European Community Humanitarian Office (ECHO) began handing over humanitarian

programs in areas formerly affected by conflict (Equateur, East and West Kasai, and Katanga), to focus on achieving an objective of equitable access to the Minimum Package of Activities in those areas still deemed to be affected by conflict or at greatest risk of a reprise of hostilities (Ituri, North and South Kivu, and Northern Katanga).

The African Development Bank began funding a five-year \$39.6 million health care project in September 2004, focusing on communicable disease control in formerly conflict-affected areas of eastern DRC. It is funded at a level of \$39.6 million, of which \$28.8 million is an African Development Fund (ADF) loan, \$7.2 million is ADF grant support, and \$3.6 million is a government contribution.

Multilaterals and global health partnerships are also supporting specific disease control programs. The Global Fund to Fight AIDS, Tuberculosis, and Malaria has approved grants worth a total of \$82 million over two years (phase 1), with requested funding over the five-year lifetime of grants totaling \$211 million. Of these grants, \$48.3 million has been disbursed to date; \$21.4 million targets HIV/AIDS prevention and care, \$20 million for malaria control, and \$6.9 million for tuberculosis control

In addition to the Global Fund, there are three projects supporting HIV/AIDS control in DRC. The World Bank MAP began in 2005 and is scheduled to disburse \$102 million in escalating amounts through FY 2010. About \$35 million of this grant directly supports the health sector strategy. Its four components are to mainstream HIV/AIDS activities in all public sector programming, to support HIV/AIDS control activities by public and private entities, to transfer responsibility for HIV/AIDS control to the DRC government, and to organize a National Coordination Unit for the overall implementation of the other three components. The DRC is also one of six countries receiving grant assistance as part of the GLIA, a \$20 million supplemental Work Bank project.

The U.S. Centers for Disease Control and Prevention opened a Global AIDS Program (GAP) office in DRC in 2002 focused on three areas: monitoring the epidemic, strengthening PMTCT services, and improving national health care capacity. Core GAP funding for FY 2004 was \$1.8 million. Over 16,000 people have received counseling and/or treatment at GAP sites and about 4,800 Congolese staff were trained in laboratory techniques.

The Global Alliance for Vaccines and Immunization (GAVI) has committed \$49.1 million to DRC from 2003–07. The government's objectives for GAVI funding were to improve the EPI infrastructure and to introduce new antigens (hepatitis B, yellow fever, and *hemophilus influenzae* type b). However, funding for hepatitis B and Hib was denied. Available funding is for yellow fever vaccine (\$12 million), injection safety (\$3.2 million), and reinforcement of immunization services (\$31.4 million). In addition, in keeping with its New Delhi declaration of December 2005, GAVI in DRC has stated that it intends to strengthen and maintain the capacity of the health system to vaccinate and to provide other appropriate health services.

Among the bilateral agencies, USAID has provided an annual average of \$18–22 million towards health sector programming in recent years; \$22.4 million was allocated for health in FY 2005, of which \$9.4 million was to support implementation of the Minimum Package in 81 health zones in rural areas. Child survival funding also supported national-level initiatives in immunization and nutrition-related activities. Family planning services received \$4.8 million in 11 new rural health zones and four new urban areas. And \$8.2 million was dedicated to HIV/AIDS, TB, and malaria control activities.

It is worth noting that in FY 2006, USAID implemented a new “fragile states strategy.” Implementation took the form of a drastic shift in the geographic focus of USAID's efforts in the health sector. Support that had been ongoing to health zones in the western part of the country

(Bas-Congo) was terminated and funding will be diverted, albeit through similar programs, to health zones in the formerly conflict-affected zones of the east. In these areas, USAID will not only strengthen the ability of the health zones to provide services, but will also, indirectly, strengthen provincial-level supervision. In addition to about \$20 million for health system strengthening, USAID's Office of Foreign Disaster Assistance will also provide about \$7 million for emergency programs in 2006.

Since 2001, the Belgian Development Cooperation has provided an annual average of €10 million in direct bilateral assistance for the health sector. The Belgian Cooperation provided €10.1 million for the health sector in 2004, primarily in the form of technical assistance directly to the MOH and support to health facilities in Bas-Congo. A total of 44 projects were funded in 2004. Additional indirect bilateral support is provided through co-financing of NGO-led health projects. Recently, Belgium, assisted by USAID, took over the reins of the donor health interest group.

Other bilateral donors, notably Canada, Germany, and the United Kingdom have significant, but smaller, investments in the health sector in the emergency/humanitarian side, the development side, or both.

The final paragraph of this section is devoted to the UN (MONUC) proposed program in DRC, although only a small portion of it is devoted to health. The MONUC program is a bit distinct from other donor programs in that it is specifically aimed at providing a demonstrable "peace dividend" to help stabilize the peace process and, hopefully, to contribute to the legitimization of whatever government takes power after elections. Accordingly, the MONUC program, which is not yet funded, consists of six components: small arms control; rural development and recovery (aiming to increase agricultural production); social services (education and health – intended to provide a "rapid and massive" scaling-up of service delivery in areas at highest risk of renewed conflict and where social indicators are at their lowest); enforcing the rule of law; improving government coordination; and instituting "national reconciliation" processes. All these components are to be implemented simultaneously in 200 communities to create an "irreversible dynamic of change." In essence, this program is intended to "fast-track" the Poverty Reduction Strategy and to show tangible gains within two years. By MONUC's admission, the program wasn't "sold" to potential funders as well as it might have been and its future remains uncertain.

3.2 Harmonization and Alignment Approaches

The donor representatives in DRC are in general agreement that harmonization of their efforts remains far from optimal. If it can be said that "cooperation"—that is, the sharing of information regarding their individual programs—must precede serious attempts to harmonize policies and actions, then the DRC donor community is at an early stage of cooperation. At present, there are plans to transform what have been irregular donor meetings at which plans were announced into regular thoughtful deliberations as to how to best work together and with the transitional, and eventually permanent, government to ensure that both health service delivery and institutional strengthening programs are implemented in a consistent manner. As mentioned above, Belgium and the United States have recently assumed the co-chairmanship of the donor health interest group and intend to infuse it with new energy and a more substantive agenda. Under their leadership, DRC is a pilot country for implementing the Principles of International Engagement in Fragile States.

3.3 Dealing with Key Trade-Offs: Saving Lives versus Building Capacity

One major challenge to the DRC and its development partners is to successfully negotiate the transition from a situation of conflict and an essentially non-functional state, where health services are delivered through private organizations supported by international donors, to one

where building the state's legitimacy and effectiveness becomes the primary concern. There is an obvious trade-off here, as indicated by the title of this section and discussed at length in the World Bank's "World Development Report of 1994": humanitarian interventions that bypass any state machinery and where accountability is strictly between the provider and the recipient of services are more likely to be more effective in the short-term than development programs that require major state involvement with all of the bureaucracy that that implies. Paradoxically, most health sector actors agree that saving more lives in the short-term is not a substitute for long-term development that, almost by definition, would be accompanied by a less effective health system and higher morbidity and mortality rates in the longer-term.

Several large donors to the DRC, including USAID, the EC, and the UK's DfID, have struggled with this situation in many countries and admit that they have not yet been able to ensure this transition in an entirely satisfactory manner. In fact, part of the problem may be exactly what is unfolding in DRC; most donors, whether they have been directly involved in providing humanitarian assistance or not, seem to be shifting from emergency programs to development programs without designing or implementing the kind of programs that might be most useful in a transitional period. Repeating what has been said above, there is not much experience in the health sector with what might be called transitional programming. In summary, what would be required, at first, is a clear long-term vision of what the health system should become and a commitment on the part of the donors (and government) to realize that vision. Initially, programming might consist of short-term activities, selected on the basis of their ability to contribute both toward the re-development of the health system and toward the process of state building (enhancing the government's legitimacy, then its effectiveness). Again, the selection of appropriate indicators to ensure that both of these objectives are met ("what gets measured gets done"), an emphasis on the monitoring of these indicators, and periodic evaluations of both components of this kind of programming are essential.

An exception to this might be the proposed MONUC program described above. MONUC personnel have said that, unlike what seems to be the case with some of the donors, the "UN is not interested in state building" during the two-year period during which its program would be implemented. Instead, it is far more interested in consolidating the peace process, in ensuring fair and representative elections, and in creating a political environment within which a new government could effectively deliver health services.

While the impact that conflict in DR Congo has had on the health system is clear, its impact on the health of the population may be less well understood. A recent IRC nationwide survey conducted (Coghlan *et al.* 2006) showed that both crude mortality and under-5 year mortality rates were far higher in health zones where incidents of armed violence had been reported than in those that were in relative peace (deaths are reported per 1,000 population per month) as shown in table 3.1, below.

Table 3.1 Health Zones and Violence

	Crude mortality	Under-5 mortality
HZs reporting violence	3.0	6.4
HZs not reporting violence	1.7	3.1

Source: Coghlan *et al.* 2006, 47.

The point is that improved service delivery may not be the solution to the health problems of the population—more antibiotics, oral rehydration therapy, and antimalarials would undoubtedly help to some degree, at least temporarily, but the underlying causes of mortality in DR Congo may not be diseases; instead, they may be conflict, political instability, and abject poverty. The

IRC survey authors stated more starkly that their analysis suggested “if the effects of violence were removed, all-cause mortality could fall to almost normal rates.”

The implications for donor support, including health sector support, if one believes this data and agrees with this conclusion (and there is no obvious reason not to) are important. While conflict mitigation and prevention are important contributors to health, improved health service delivery may not, in and of itself, make an important contribution to arriving at and maintaining an effective peace agreement during the transition period. Actions such as shifting existing health programs to areas most susceptible to a resumption of hostilities may make some sense, but there is little, if any, evidence to suggest that they would help. If they do, the shifting of resources from areas that are in need of major financial and technical assistance to those into which large sums of money have already been invested by the humanitarian divisions of the major donors might work against the equity and poverty reduction principles that most of those same donors believe in (see 4.3, below).

On the other hand, it seems clear that taking steps to help a fledgling government deliver social services to its population in the longer-term, may contribute to its legitimacy. But complex emergencies are bound to have complex solutions. Donor harmonization is essential. Unfortunately, it has not yet been achieved in the health sector in DRC and, to a large extent, the level of investment in health programs, their geographic focus, and the appropriate implementation mechanisms, are still largely up in the air. The strong tradition of effective primary health care in DRC and the vastly improved (but somewhat unrealistic at times) policy framework established by the MOH are factors of which advantage should be taken. There is real potential for the state, with its strong private sector partners, to become an effective provider of health services in the future if the peace holds and the political transition is successfully negotiated, if the level of donor investment is adequate, and if corruption can be controlled.

4 Summary, Lessons Learned, and Recommendations

4.1 Fragility and Health Service Delivery

The Democratic Republic of Congo presents a very complicated picture for donors at the present time. It is a resource-rich country that had one of the most developed health systems in sub-Saharan Africa as recently as 20 years ago. Its health system was considerably strengthened in the period following independence, and its primary health care model centered around peripheral health zones is one about which much was written. Subsequent government mismanagement and neglect resulted in progressive impoverishment. The withdrawal of foreign assistance combined with the economy's collapse resulted in the physical deterioration of health facilities, defections of health personnel, increasing corruption, and an interruption of health services. Paradoxically, the health sector remained among the strongest of DRC's social sectors, largely due to the support of civil society, and especially of the religious organizations throughout the country.

Since 1994, conflict in the eastern part of the country, strongly influenced by foreign actors, has created a major humanitarian crisis that still significantly colors the way in which donor programs are conceived, developed, and implemented. Although a peace accord has been signed, a transitional government put in place, and a constitution ratified, the stability of the central government remains tenuous at best. Unlike the cases of other countries emerging from conflict, such as Sierra Leone, East Timor and even, albeit to a lesser extent, Afghanistan, its legitimacy has not yet been established, and its effectiveness in securing its borders, in dealing with foreign powers, in managing the economy, and in ensuring the delivery of social services to the population is highly questionable. Violence continues to have a major impact on mortality rates in the eastern part of the country, creating a mixed scenario in which humanitarian interventions and development programs must co-exist, a situation which is difficult to address for the donors, which continue to represent by far the most important source of health sector financing.

4.2 Health Sector Adaptations

The DRC MOH has taken a number of measures to address the situation that it faces. One of the most important of these was the development of a Basic Package of Health Services (BPHS) that is intended not only to guide the activities of peripheral health facilities, managed by the Bureau Central de la Zone de Santé, and encompassing the range of facilities from the Hôpital Général de Référence (district-level hospital) to the poste de santé, but also to provide guidance to the donors as to what kinds of health programs they should support. The BPHS development was a political and a technical event in that it brought together, for the first time since hostilities broke out, health authorities working under the jurisdiction of all of the important armed political factions at the time. This is important in that it suggests that at least a small role for the health sector is possible in forging and possibly in maintaining the fragile peace.

In general, though, "health in fragile states" is a donor concept, not a local one. It is fair to say that the MOH has not, at least not consciously, considered analyzing or specifically addressing the causes of fragility within its borders. Its role within an even weak government structure is to deliver health services to the population. The degree to which it is able to do so may have an impact on the overall level of legitimacy which the population accords to the government, but there is little evidence in general and none in DRC to suggest that even major improvements in health services delivery will be singularly important to the consolidation of the peace process or to a successful passage from transitional government to a more stable political environment.

Still, it makes sense to maximize the health system's effectiveness even if its contribution to the state-building process is minor. Good governance within the relatively well-supported (by the donors) health sector might serve as a model for other social sectors. Given the vastness of DRC and its strong tradition of relatively decentralized health system management, as well as the seemingly insurmountable problems of communications and logistics, it makes sense for the MOH to devolve authority towards the periphery. The donors seem to agree, and most recent proposals aim to strengthen the zones de santé.

However, in terms of health system structure, one crucial level of the system, the provincial level, remains seriously neglected. Because of the proliferation of directorates and special programs organized at the Kinshasa-level and the interest of the donor community in supporting humanitarian interventions that essentially put private sector entities (NGOs, churches, and so on) in the role of service providers, the provincial health authorities have been left without authority or capacity. Where provincial health teams continue to function, it is largely due to predatory practices that include making peripheral level personnel, who are capable of charging fees for services, pay for "supervisory" visits.

This is a situation which needs attention from both DRC and donor officials. In fact, the recently promulgated Strategy for Strengthening the Health System of the MOH goes so far as to suggest that the "center of negotiation" for donor assistance to the health sector should be shifted from central to provincial level and that the nature of donor assistance should change from primarily support to vertical programs to "Province-level SWAps" (sector-wide approaches). This kind of decentralization that devolves not only the responsibility for executing health sector programs, but also the authority to allocate funding for them to the provincial level would represent a radical shift in the balance of health sector power in DRC and would significantly alter the way donors would have to do business with the government. Nevertheless, donors might see this proposed MOH strategy as another opportunity to harmonize their aid and to align their policies with those of the Ministry. Just as the BPHS and a strong and focused concentration on the Health Zones helped ensure that donors would be working in the same direction, and in accordance with MOH strategy, so could the provision of technical assistance and consideration of the provincial level funding problems be seen as a second phase of harmonized effort.

4.3 Accessibility, Availability, Acceptability, and Quality of Services to Marginalized Groups

With the possible exception of those health zones currently covered by humanitarian assistance and those that receive significant support from donors, both accessibility and utilization of health services are severely limited. Even with the external support it has received (currently on the order of \$2-3 per capita per year for health) DRC health parameters remain among the worst in the world. It is estimated that as much as 70 percent of the population has no or little access to health care.⁷

As is the case with most post-conflict countries in which health system rehabilitation is in an early phase, the DRC health system has been "balkanized"—there are "Belgian-supported health zones," "World Bank-supported health zones," "USAID-supported health zones," and so on. Nevertheless, coverage has been less than uniform and far less than complete. The MOH has a reasonable idea of which health zones are currently receiving coverage, but there continues to be some overlap and a substantial number of "unsupported" zones. Certain parts of

⁷ World Bank, "Project Appraisal Document," Health Sector Rehabilitation Support Project, June 23, 2005, 4.

the country are particularly underserved. There are gross disparities regarding the distribution of health facilities, their maintenance and state of functioning, and the number of health care personnel. In regard to human resources, most sources cite a gross lack of both physicians and nurses, but some informed sources say that because of the income-generating potential of service delivery, the health professions have become quite popular and large numbers of “physicians” are being trained. There are as many as 35 medical schools in DRC at present, and last year 1,550 physicians were trained in Kinshasa and Lumbumbashi alone. Although this seems scandalous at first, perhaps these “diploma mills” could be put to good use—if they could at least provide competent training in the BPHS, national health policy could become all the more widely implemented. On the other hand, the gross poor distribution of human resources, with health professionals concentrated in urban areas, needs to be urgently addressed.

Even where there is access to and availability of health services, utilization rates are pathetically low. Although other factors might be involved, including the very low quality of care offered by poorly trained and unmotivated providers, most attribute this dismal situation to the cost of services to the consumer. Because health worker salaries are not paid by the state, and because drug supply is spotty at best, all costs are passed on to the user. The cost of emergency procedures, such as Cesarean section, may be exorbitant—\$60 or more in areas where 80 percent or more of the population earns less than \$0.20 per day. Paying for health care can, in fact, be a cause of poverty. Several studies have shown close correlations between user fees and utilization rates, with the latter increasing as fees are lowered and decreasing when they are raised (see Dijkzeul and Lynch, *Journal of Global Public Health*, vol 1, number 2, June 2006). There is a strong case, especially in the immediate post-conflict period, for providing health services free of charge to the population and even for strongly subsidizing the cost of drugs. Whether or not this is done will depend on the donors; if costs are not borne by the consumer, the only two other sources are the government and foreign assistance. The GDRC has been requested to, and should, devote a substantial proportion of available HPIC funds to health system re-development, but until a permanent government is put in place, and until it adopts public health as a high priority, the burden of funding the social sectors is likely to fall largely on the donors.

The point of this discussion is that extreme poverty in DRC is undoubtedly a contributor to fragility—no government will be able to achieve legitimacy without improvement of the household level economic situation. Nevertheless, the MOH, as well as some (but not all) of the major donors, have been supportive of continued user fees, claiming that free services would be mistrusted and undervalued. This requires further study. In addition, as discussed in section 2.3, above, cost is not the only deterrent to health system utilization. Fundamental issues of (mis-) trust must also be analyzed and corrected in an effort to improve health sector governance.

The issue of marginalized groups is worthy of comment. It is usually felt that considerations of equity should be of the highest priority for donors in post-conflict settings.⁸ However, the argument could be made that addressing the potential causes of resumed hostilities in a post-conflict setting might be most important, even when this means prioritizing services to those who have already benefited most, not least. For example, in DRC, considerable donor assistance has been provided to re-establish and reinforce health services in the conflict-affected areas. Humanitarian assistance funding is not only more than what it might be, on a per capita basis, for development, but also it is freer of encumbering conditionalities. But regardless of the potential inequity, it might be more important, to pursue an effective fragile states strategy where state building is a crucial element, to continue to preferentially fund areas in the eastern

⁸ See, for example, E. Pavignani, “Health Service Delivery in Post-Conflict States,” November 2005, 22.

part of the country, where the risk of renewed conflict remains greatest. This has been USAID's rationale for shifting its health sector programming from health zones that are still in great need of assistance to those in the east. Providing the population living there with a "peace dividend" in the form of rebuilt or rehabilitated health facilities, a constant supply of drugs and other commodities, and motivated hard-working health officers may contribute to consolidating the peace process more than trying to provide relatively higher-quality services to traditionally vulnerable, but, to be harsh, less strategically important groups (women, children, and so on) or to other underfunded geographical areas. And, as suggested by the data presented at the end of the previous chapter, consolidating the peace process may be more beneficial to the population's overall health than trying to provide even appropriate health services through traditional mechanisms in an unstable political environment.

Finally, a word is in order about funding levels. According to the World Bank (op. cit.), donor aid to the DRC health sector may soon be on the order of \$200 million per year, or between \$3-4 per capita per year. If the GDRC increases its health sector allocation and/or if HPIC debt forgiveness monies are used for health, public spending on health might reach as high as \$5 per capita. While this is considerably more than what was available only a few years ago, it remains woefully short of the sums estimated by even the most conservative estimates that would be needed for substantial progress to be made toward the health-related Millennium Development Goals. When we add in the air transport costs for all commodities (the inter-city road system is non-functional) and the high costs of doing business because of the deep-seated culture of corruption that will take years to redress, the effective value of this funding is considerably reduced. From any viewpoint, expectations of the DRC health system must be modest.

4.4 Adaptations by International Development Partners

As mentioned above, donors are in the process of making adaptations to a changing situation in DRC. Most donor programs have two central elements: providing assistance to the health zones that are the equivalent of what is called in most countries the "district level," and technical assistance to the central-level directorates and/or vertical programs such as AIDS control, malaria control, EPI, and so on. This technical assistance has proven to be quite valuable and, if it is acceptable to the Ministry, the donors should consider more assistance at this level, specifically in the area of health systems management (human resource development, health care financing, health information systems, and so on). A discussion of the relative lack of support to the provincial level was discussed above. Some donors have made mention of limited support to this level in their more recent project proposals and, as discussed above, the MOH has made strengthening the provincial level a principal plank of its newly proposed strategy for strengthening the national health system.

For the most part, as of yet the donors have not made major efforts to harmonize their programs or to align their policies and procedures, although there is increasing contact between them and promises of major progress in this regard, under the donor health interest group's new leadership. The complexities of the DRC situation require thoughtful consideration and analysis by each donor of what is happening in the health sector as a whole. Superficial coordination, in the form of periodic public announcements of new programs or modifications to old programs, or making investment and/or programmatic decisions without meaningful consultation with the others and with the MOH will only lead to an even more complex environment in the long run. The results of inadequate consultation were seen recently when one major donor shifted the geographic focus of its support into areas already funded by other donors, leaving some needy health zones without external support. The lack of consultation created considerable rancor and may result in delayed implementation of health programs in some areas.

The adaptations that most development partners have made to date have to do with various forms of protecting their investments. In the transitional period, hedging investments to reduce risk seems reasonable. Different forms of lending are being used, and several examples are presented very briefly here; the assessments presented are partly those of a highly placed government official:

The African Development Bank project (about \$36 million to 28 health zones in Province Orientale) is that the government favors because it does not put intermediate structures between the MOH and the health zones. Funds flow from the donor to the government and the latter executes the project in accordance with its usual procedures.

Belgian Cooperation health support is also entirely consistent with government priorities and desired procedures because it is designed in close consultation with the Ministry. In fact, a long-term technical assistant sits in the Department of Evaluation and Planning, and a close technical and financial relationship has been formed between the donor and national authorities.

A third favored project of the government is that of the European Union (FED9). Although there are problems with certain aspects of the program, for the most part it takes a long-term developmental perspective. The health zones that the EU is supporting were carefully chosen on the basis of their ability to effectively implement health service delivery programs. Importantly, at least for the MOH, the FED9 project does not interpose management structures between the Ministry and the peripheral level—it is clear about working in a way that allows the Ministry to assert and fulfill its stewardship role of the health sector.

The World Bank PARSS project, in contrast, despite its numerous excellent technical and management features, has perhaps not made enough progress in this regard, although the level of corruption that exists in DRC and the relatively heavy bureaucracy that pervades the central level of administration provides considerable justification for its design. The Bank's first large health project, a \$50 million component of the \$450 million PMURR that provided support to 67 health zones covering a population of about 8.5 million, was designed during a time when war was raging in the eastern part of the country. Project funds were controlled outside of the MOH and were dispensed to a large extent on the basis of performance-based contracting with NGOs that ultimately are responsible for the execution of tasks that ranged from reconstruction and rehabilitation of health facilities through hands-on delivery of primary health care services. The World Bank's fiduciary agent established the contracts with the NGOs without the Ministry's involvement. There were reasons for this arrangement, but the context is rapidly evolving. Some of the MOH management concerns are being addressed by the PARSS, which is basically a next-generation follow-on to PMURR, but the relationship between the MOH and the new PARSS Project Management Unit remains somewhat unclear, especially insofar as the Ministry's ability to oversee the work of the contracted NGOs is concerned.

Finally, the USAID project has had the least MOH involvement. Funds will flow directly from USAID to its implementing contractor, and the line of accountability between the latter and the Ministry is weak. Negotiations over the health zones to be supported were not amicable, although progress is being made in regard to the coverage level to be provided. At least part of the problem stems from the way in which USAID has chosen to implement its new fragile states strategy. In essence, the USAID mission has retained its health program design, but has decided to implement that program in geographical areas that it deems to be most susceptible to a resumption of conflict. That is, there has been no real attempt to redesign the project to address underlying causes of fragility; it remains a fairly conventional and traditional primary health care support project. There has only been a shift of the geographical areas (health zones) to be covered (see above).

4.5 Conclusions

1. The biggest and most immediate threat to establishing the ability of the DRC MOH's ability to effectively lead and manage a health system capable of delivering appropriate services to its population is a political one. While many components of donor assistance have been designed with the intention of consolidating the peace process, the health sector basically consists of two kinds of programs: continuing humanitarian assistance in conflict-affected (or formerly conflict-affected) health zones and longer-term efforts to develop a routinely functioning health system. Although there is little evidence to suggest that health sector programs can make a substantial contribution to state building, there is also little to the contrary. It seems logical for both donors and MOH officials to find some middle ground: to implement health programs that are most likely to contribute to better governance, to increase the legitimacy of whatever government comes to power after the elections (now rescheduled to end-July), and to contribute to an effective transition from years of autocratic or chaotic rule to a stable, even representative state.

Business as usual in both the humanitarian and development components of donor assistance is unlikely to make a more than temporary contribution to either improving governance or improving the population's health status. The content of donor programming in the health sector needs to be adapted to the current context—it needs to both improve the population's health status and to contribute to better governance, in the hope that the latter will, in turn, reduce the risk of a return to conflict (perhaps the most important risk factor for crude and even childhood mortality) and increase the possibility of economic recovery.

The degree to which health programs can contribute to stability and peace is not clear. It stands to reason, though, that the more health services become a part of comprehensive local recovery efforts, including jobs creation and other livelihoods-oriented activities, the more likely they are to succeed. For this reason, post-conflict health programs in DRC should be designed to include more multi-sectoral elements. Examples include the multi-dimensional transitional programming designed (but poorly "sold" to donors) by MONUC and the GTZ ideas (not described above) to program simultaneously in the health and conflict mitigation areas. Other examples, such as allowing palm oil production at hospital facilities to offset costs, rather than passing them off on the health care consumer (thereby driving down utilization rates) are also possible. This is a time when considerable creativity is required. Program performance indicators best suited to the context, not drawn from traditional health programs implemented in very different contexts, should be developed and carefully monitored.

2. The donors are essential players in the recovery of DRC's health system—neither the population, through out-of-pocket expenditures, nor the transitional government can be counted on at this time to prioritize the social sectors. To develop and implement efficient and effective health programs, the harmonization and alignment principles that the OECD enunciated should be put into practice in a meaningful way. The donor community in DR Congo has been coordinating by sharing information about bilateral (or multilateral) programs that have been designed without full consultation and/or analysis by the entire donor group and the MOH. At times, even this coordination has been inadequate to avoid miscommunication and resulting hard feelings. The reinvigoration of the donor health sector interest group holds promise for a sorely needed "merging of the minds" around a number of outstanding issues, including the potentially competitive relationship between MOH and NGOs/contractors as to who should be most responsible for service delivery, support to the provincial health system level, the level and

provenance of technical assistance to the central level, drug procurement, and health systems management, to name but a few.

The private sector's role, and especially that of the NGOs, is also crucial. A large proportion of health services in DRC have always been delivered through the private sector, especially through secular NGOs and church organizations. These civil society elements must be accorded an important role in health service delivery, but they should also be asked to contribute to the state-building process, rather than compete with it. The MOH has shown strong leadership in developing the Basic Package of Health Services and formulating plans to decentralize management to the provincial level.

Donors and the private sector can help by being constructive and facilitating followers of the Ministry's lead, fragile as it may be. Additional technical assistance, especially help in continuing to formulate a strong policy framework and to provide management help at the provincial level, might be useful. Performance-based contracting schemes, championed by the World Bank in DRC, may be a constructive way to bring about an alignment of private sector health service delivery with government-directed policies. These and other experimental arrangements intended to strengthen the health sector partnership by clarifying the roles of each of the partners should be encouraged and carefully monitored.

3. Finally, funding levels should be reviewed and longer-term expectations for the DRC health system should be commensurate with these, with the availability, present and future, of human resources, and with the level of political stability. For the medium-term future, recurrent costs, including salaries and drugs procurement, may need to be borne, at least partially, by the donors, although government should be encouraged to shift whatever resources it can from HIPC funds, for example, into the social sectors. Short-term or transitional programming is required currently, as mentioned above, but it is not too soon to plan for how the MOH and its donor partners can invest and expand service delivery to achieve its longer-term vision. The fact that DRC has demonstrated an ability to develop one of the strongest primary health care systems in Africa despite the vastness of its territory, before interrupted by years of conflict is a major strength—how it did so should be analyzed and, if appropriate, replicated.

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