IMPROVING HEALTH SYSTEM EFFICIENCY

# DEMOCRATIC REPUBLIC OF THE CONGO

## Improving aid coordination in the health sector

Hyppolite Kalambay Ntembwa
Wim Van Lerberghe

Health Systems
Governance & Financing

World Health Organization

# IMPROVING HEALTH SYSTEM EFFICIENCY

## DEMOCRATIC REPUBLIC OF THE CONGO

### Improving aid coordination in the health sector

Hyppolite Kalambay Ntembwa
Wim Van Lerberghe

Health Systems
Governance & Financing

World Health Organization

WHO/HIS/HGF/CaseStudy/15.4
© World Health Organization 2015

All rights reserved. Publications of the World Health Organization are available on the WHO website (www.who.int) or can be purchased from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int).

Requests for permission to reproduce or translate WHO publications –whether for sale or for non-commercial distribution– should be addressed to WHO Press through the WHO website (www.who.int/about/licensing/copyright_form/en/index.html).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

The named authors alone are responsible for the views expressed in this publication.

**ACKNOWLEDGEMENTS**

This report is produced under technical guidance of Joseph Kutzin, Coordinator for Health Financing Policy in WHO Geneva in collaboration with the Health Research for Action (hera). The lead author of this report is Hyppolite Kalambay Ntembwa, Director, Department of Studies and Planning, Ministry of Health, DRC. Wim Van Lerberghe is the co-author of the report and Josef Decosas provided editorial support on behalf of hera. Technical comments were provided by Winnie Yip, Oxford University's Blavatnik School of Government, Laurent Musango, Tarcisse Elongo, WHO, AFRO, Dorjsuren Bayarsaikhan, and Justine Hsu, WHO Geneva. The views presented in the report are not necessarily the views of WHO. Kay Bond edited the report. Cover design and layout services were provided by Fokion Kopanaris and Revekka Vital. Funding from the EU–WHO Partnership for Universal Health Coverage and the Bill & Melinda Gates Foundation towards preparation of this report is gratefully acknowledged.

Original graph of the cover by Paprika, France
Design and layout by CommonSense / Fokion Kopanaris & Revekka Vital, Greece

# CONTENTS

# ABBREVIATIONS

| | |
|---|---|
| CAG | Management Support Unit, *Cellule d'Appui à la Gestion* |
| CCM | Country Coordination Mechanism of the Global Fund |
| CDR | Regional Distribution Centre, *Centre de Distribution Régional* |
| CNP-SS | National Health Sector Steering Committee, *Comité National de Pilotage du Secteur de la Santé* |
| DFID | United Kingdom Department for International Development |
| DRC | Democratic Republic of the Congo |
| ECDS | District Health Management Team, *Équipe Cadre de District Sanitaire* |
| GDP | Gross Domestic Product |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| HRH | Human Resources for Health |
| HSSS | Health System Strengthening Strategy, *Stratégie de Renforcement du Système de Santé (SRSS)* |
| MOH | Ministry of Health |
| PNDS | National Health Sector Development Plan |
| SNAME | National System for Supply of Generic and Essential Medicines, *Système National d'Approvisionnement en Médicaments Essentiels* |
| WHO | World Health Organization |

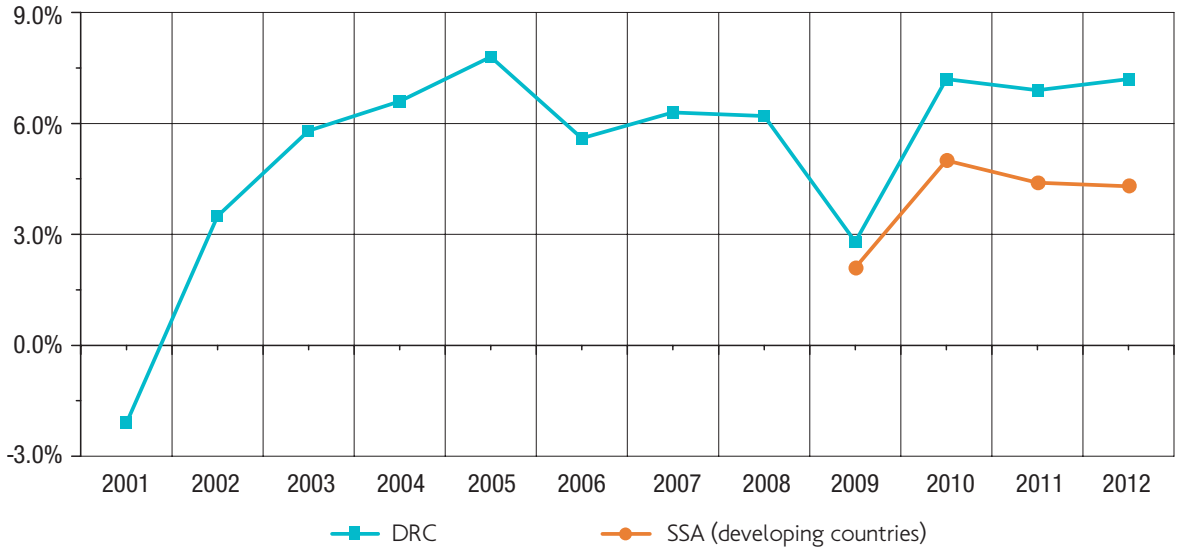
# 1 NATIONAL CONTEXT AND HEALTH CHALLENGES

## 1.1 Political changes and economic development

After more than three decades of autocratic rule and more than a decade of social unrest and armed conflict, the Democratic Republic of the Congo (DRC) adopted a Constitution that enshrined a highly decentralized state. Democratic general elections were held for the first time in 2006 and again in 2011. Parliaments and governments were established in each of the 11 provinces and at the national level.

These political changes came at a time of considerable progress in terms of economic growth and macro-economic stability. Between 2008 and 2012, gross domestic product (GDP) grew at an average rate of 6.1% per year (Fig. 1). Inflation fell to less than 10% in 2010 and stood at 2.7% at the end of 2012. After the global economic crisis of 2009, the DRC achieved growth rates that were consistently higher than the average for sub-Saharan Africa. Investments in the extractive industries and the effects of dynamic growth in agriculture, construction and trade resulted in economic growth of 7.2% in 2010 and again in 2012. Structural reforms that enabled the country to attract more foreign capital contributed to a new dynamism in the Congolese economy. The cancellation of 90% of the external debt in 2010 as part of the Heavily Indebted Poor Countries initiative expanded fiscal space and gave the State more means to carry out its policy of reconstruction.

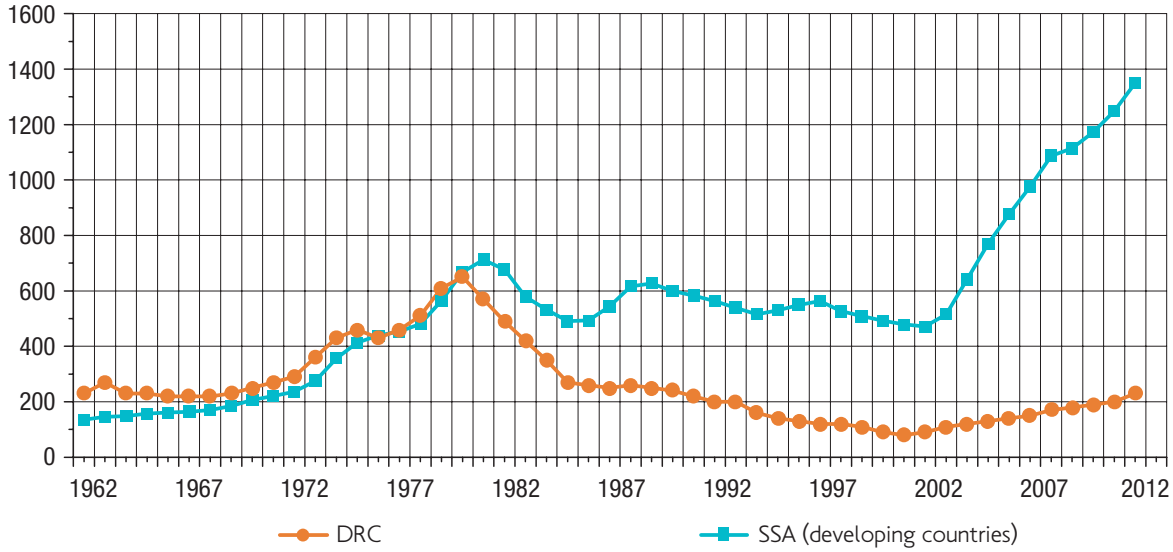
**Fig. 1. Annual growth of gross domestic product, 2001–2012**




DRC: Democratic Republic of the Congo; SSA: sub-Saharan Africa.
*Source:* World Bank. GDP growth (annual %) 2015, http://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG/.

Despite positive growth, however, gross national income (GNI) per capita has remained low compared with the average in sub-Saharan Africa (Fig. 2). The lowest levels of US$ 80–90 were recorded between 2000 and 2002 during the time of armed conflict. Since then there has been a gradual recovery, although poverty remains pervasive.

## Fig. 2. Per capita gross national income in current US$, 1962–2012

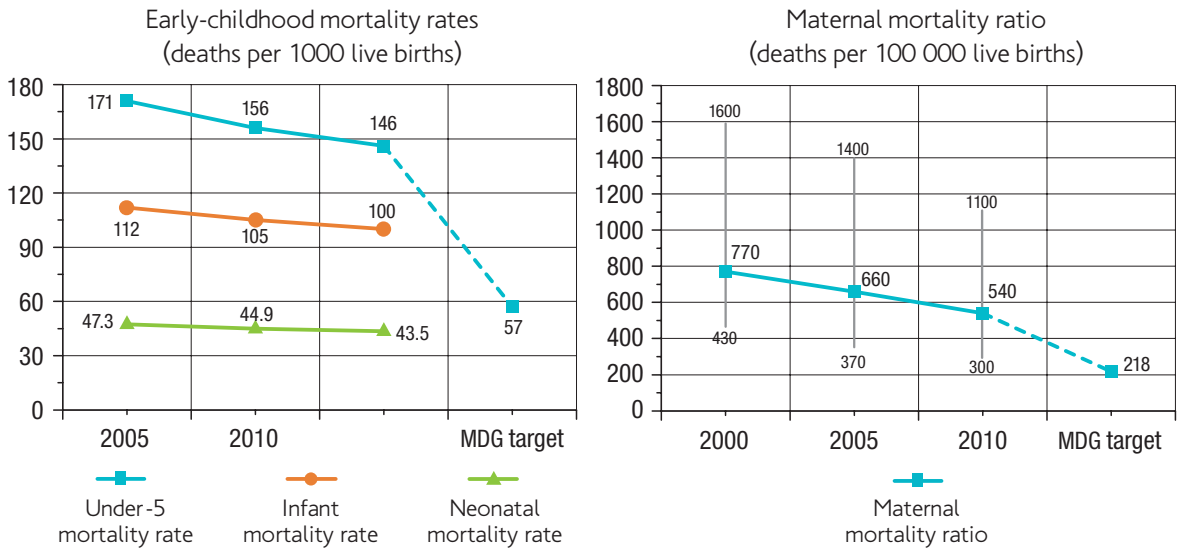



DRC: Democratic Republic of the Congo; SSA: sub-Saharan Africa.
*Source:* World Bank. GNI per capita, Atlas method (current US$), http://data.worldbank.org/indicator/NY.GNP.PCAP.CD.

### 1.2 Health status and organization of the health sector

The health status of the population is alarming. The seven principal causes of disability-adjusted life years (DALY) lost are malaria, diarrhoeal diseases, protein-energy malnutrition, lower respiratory tract infections, HIV, preterm birth complications and tuberculosis. Non-communicable diseases associated with epidemiological transitions account for 21% of the national burden of disease, although this proportion is rising *(1)*. Mental health and the consequences of violence are major public health challenges. Maternal and child health indicators have shown signs of improvement since the beginning of the century (Fig. 3), albeit at an insufficient rate to attain the targets of the Millennium Development Goals (MDG).

## Fig. 3. Progress in maternal and child health indicators

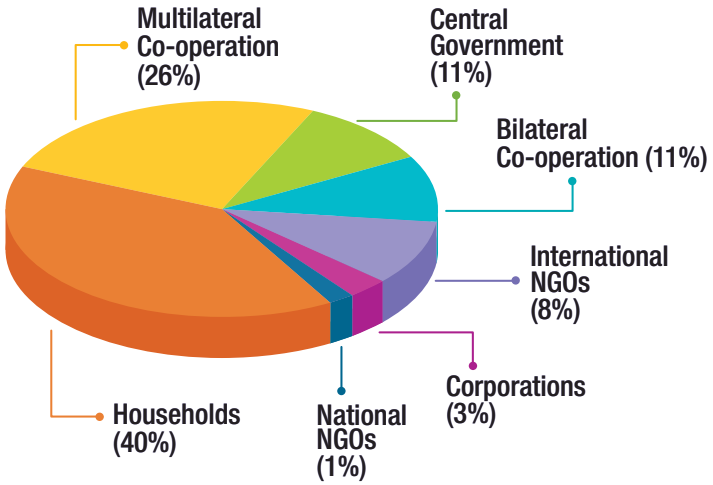



MDG: Millennium Development Goal.
*Sources:* WHO Global Health Observatory Data Repository (http://apps.who.int/gho/data/node.main and http://www.childinfo.org/mortality_neonatalcountrydata.php for neonatal mortality rate).

The health system of the DRC is organized in three levels. At the implementation level there are 516 health districts, where a district team manages a network of health centres and a district hospital. Districts typically cover a population of 100 000 to 200 000. The intermediate level, responsible for technical and logistic support, is managed by provincial health departments, the number of which has recently increased from 11 to 26. The central level has a normative role.

Expenditure on health in the DRC is low at US$ 12–13 per capita per year between 2008 and 2012. Total health expenditures was US$ 876 million in 2009, declining to US$ 830 million in 2010, with a partial recovery to US$ 843 million in 2012 *(2)*. Households are the largest contributors to total health expenditure, closely followed by multilateral aid. Central government contributes 11% (Fig. 4).

**Fig. 4. Health expenditure by financing source, 2011**




NGO: nongovernmental organization.
*Source:* National Health Accounts 2011 *(2)*.

The proportion of health in the national budget has ranged between 4% and 5%, far below the commitments made in 2001 in Abuja *(3)*. The budget execution has remained low at 50–60% per year. However, in absolute terms the budget has been growing, and in 2014 the percentage attributed to health increased to 7.8%.

The process of revitalizing the health sector in the DRC started in 2005 with the adoption of the Health System Strengthening Strategy (HSSS) *(4)*. The strategy was developed by key national actors following extensive discussions and analyses of the history and political economy of the health sector and the health status of the population. It provides a framework for reforms to overcome inefficiencies in the sector and the marginalization of national policy-making in a context of dependency on external aid.

### 1.3 Root causes of a dysfunctional health system

To a large extent, inefficiencies in the DRC health sector find their origin in the collapse of the state and the economy after three decades of non-governance. The DRC became fragile with weak national leadership. GDP dropped from US$ 450 per capita in the 1970s to US$ 50 in 2001. More than 70% of the population, including health workers, were impoverished. In the health sector, two further elements compounded this bleak picture. First, government public funding withered as of 1990. Health financing became almost totally dependent on out-of-pocket payments and external aid, the latter essentially based on humanitarian assistance. Second, with no public funding and weak national leadership, regulation of the health sector evaporated. It was clear to all involved that the system was broken.

Donors reacted by creating projects in search of rapid results and data to document them. This led to multiple donor coordination mechanisms and project management units and, critically, a duplication and waste of resources for supervision, training, multiple technical assistance, etc. It also created a huge burden on the time of staff at district and health facility level to attend training seminars, respond to supervision visits and write reports. Health workers were left with little time to provide real health care, with consequent frustrations and erosion of professional identities. Logistics fragmented and the multiplication of supply chains resulted in stock-outs in some health centres and hospitals, and excess supplies in others, who had to watch medicines and health products expire. The lack of coordination and the parallel systems suffocated the national procurement system and a number of regional distribution centres went bankrupt.

As government funding of the health sector disappeared, a system of reverse financial flows developed: part of the user fees collected by health facilities was channelled to the district offices and from there to the intermediate and national administrative and governance levels. These funds were meant to finance activities, but were also used to pay salaries. Over the years, this system of informal taxation became standard practice and a way to assure the financial survival of individuals and institutions. It was augmented with income from a variety of other channels, such as the sale of permits and authorizations to the private sector, fines and local taxes. This system motivated the health authorities to multiply private for-profit service delivery points as sources of informal taxation. In Lukula District in Bas-Congo, for example, 120 units were created instead of the 18 envisaged in the health coverage plan.

Humanitarian assistance became one of the few operating economic sectors and, with rare employment opportunities, the profession of health worker became comparatively attractive. This created a thriving business of private nursing and medical schools. From 3 public medical faculties in the 1980s, the number rose to more than 30 public and private universities in 2005, all still functioning. The number of nursing schools increased from 219 to 362 in the same period. This led to an oversupply of health workers, with spectacular overstaffing in urban public health services.

Not surprisingly, the quality of services deteriorated rapidly, health indicators were at unacceptable levels (in 2001, the maternal mortality rate was 1287 per 100 000 live births and the infant mortality rate 213 per 1000 live births), while the institutional memory of a country that had been a pioneer in developing the health district model in Africa started to disappear.

It is against this background that in 2005 a set of reforms were launched. Before reviewing these, it is useful to provide more details on the specific inefficiencies that characterized the DRC health system during the first decade of the 2000s.

# 2 SPECIFIC INEFFICIENCIES IN THE DRC HEALTH SYSTEM

Since the 1990s, the health system in the DRC has been characterized by the inefficient use of international as well as domestic resources (state budget and household contributions). The inefficiencies took different forms: disproportionate management costs; waste, duplication and ineffectiveness because of fragmented services and programmes; organizational and managerial inefficiencies; unproductive deployment of the workforce; and duplication of supply chains for medicines and health products. Their causes, consequences and the reforms put in place to overcome them are summarized in the Annex.

## 2.1 Disproportionate management costs

Between 2006 and 2012, 195 projects and programmes in the health sector had external financing. Five international financing partners accounted for 81% of external assistance to the health sector in 2007–2008: The Global Fund to Fight AIDS, Tuberculosis and Malaria (20%), the Government of Belgium (19%), the World Bank (16%), the United States Government (14%), and the European Union (12%). Other partners included United Nations agencies, GAVI and several countries through their bilateral development agencies *(5)*.

**Box 1. Duplication of effort in Ikela health district.**

In Equateur Province, the Ikela health district is about 1000 km from the capital Mbandaka. It is only accessible by river boat. The district is supported by the provincial health department and by a partner organization. Both travel to the district by boat. It is not uncommon for the boats to cross on the river, one going to the district, the other coming back. At an average fuel consumption of 5000 litres a supervision/management visit to Ikela costs US$ 10 000–15 000.

The large number of projects and programmes generated high management costs. For example, the management cost and international technical assistance of the health programme under the 9th European Development Fund between 2006 and 2009 amounted to €30.5 million, 38% of the total programme budget of €80 million. To put this in perspective, in 2013 the Government spent a similar amount – €30 million – to purchase equipment that fully equipped 660 health centres and 132 district hospitals.

Most international projects implemented prior to 2006 established long-term technical assistance positions, often combined with management units at both the national and provincial level. International technical assistants deployed to the district level recruited local staff, primarily for logistic functions, and worked in parallel to the structures of the Ministry of Health (MOH). Additional short-term technical assistance was mobilized for specific tasks, all of which was paid from project resources. Many of the project management or technical assistance units duplicated the technical support to health districts provided by the provincial health departments.

**Box 2. Humanitarian aid in South Kivu, 2012.**

A large portion of international financial support to DRC is earmarked for humanitarian assistance. Much of it is invested in the health sector, especially in the east of the country, which has a history of non-alignment with the national health system. South Kivu, for example, is one of the provinces most severely affected by conflict. Taking humanitarian aid into consideration, the health system in South Kivu is the best funded in the country.

In 2005, at least 15 management units existed at the national level, each with its own administrative procedures and coordination mechanisms. This multiplicity was a significant source of inefficiency and ineffectiveness. It prevented synergies and complementarity among programmes funded from different sources. Even programmes funded from a single source established separate coordinating mechanisms per project: one international health programme, for example, had seven different local coordination bodies.

Paradoxically, the multiplication of coordination structures came with a lack of transparency: the managers of health services supported by the projects were often unaware of what resources were available to implement their activities. This was further complicated by the large proportion of international health sector support provided through humanitarian aid channels (Table 1) that was implemented outside the national or provincial planning framework. These factors contributed to the fragmentation of operational planning at the peripheral level, resulting in an average 12 operational plans per health district per year.

**Table 1. Development assistance for health and humanitarian sectors**

| Year | Assistance for health (million US$) | % of development assistance | Humanitarian assistance (million US$) | % of development assistance |
|---|---|---|---|---|
| **2005** | 196.65 | 8.0 | 384.94 | 15.5 |
| **2006** | 191.38 | 7.7 | 403.70 | 16.2 |
| **2007** | 202.76 | 13.3 | 370.78 | 24.4 |
| **2008** | 388.75 | 20.1 | 508.29 | 26.4 |
| **2009** | 375.75 | 14.3 | 550.01 | 20.9 |

*Source:* Organisation for Economic Co-operation and Development (www.ocde.org/fr/statistiques/).

## 2.2 Waste, duplication and ineffectiveness as a result of fragmentation

Health districts in the DRC are intended to be led by district management teams of about five polyvalent professionals who are responsible for the development and operation of all district health services, including the district hospital and the health centres. They share the responsibilities of supervision, follow-up and support of health facilities in the district.

**Box 3. Maldistribution of aid in health areas.**

In 2010 the Vanga District Health Management Team in Bandundu Province, which already had vehicles for supervision, received seven motorcycles from different partners who were responding to different national coordination and management units. The neighbouring district, meanwhile, had no means of transport for supervision. In order to comply with the instructions from the programmes and their funding partners, a district doctor had to return to his office to change bikes to supervise the activities of another specialized programme in the same health area.

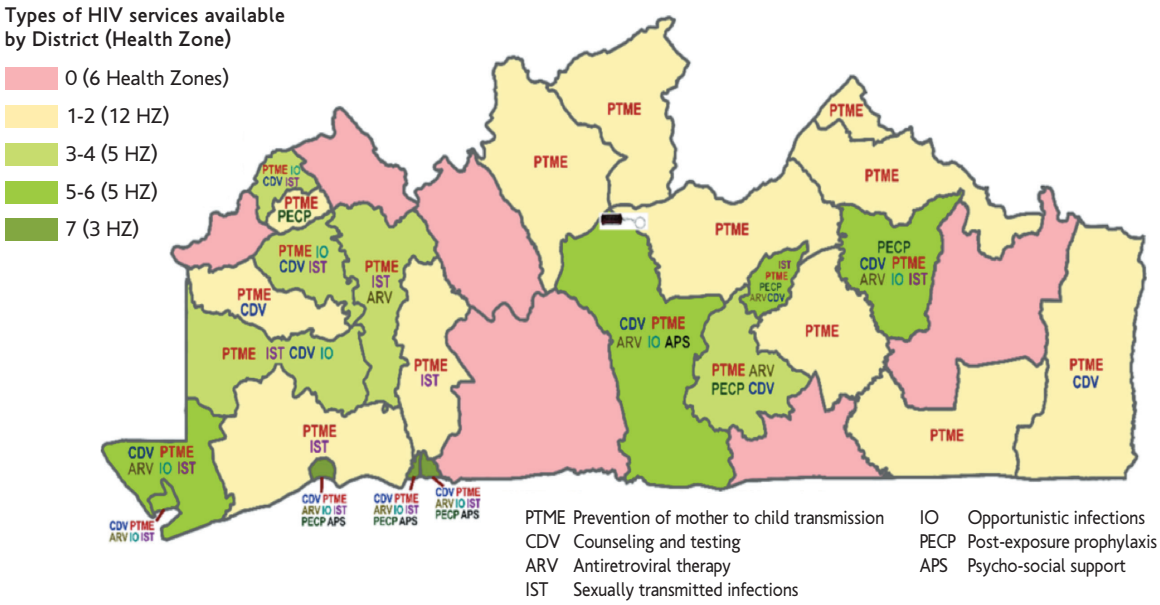
The multiplication of externally funded disease control programmes resulted in a gradual replacement of the small polyvalent teams with larger management teams and their respective staff. Some district management teams had up to 18 members, each representing a different programme with its own resources and operations. They were most often paid directly by the programme they represented or by partners funding the programme. Some managed two programmes with separate resource envelopes and clear instructions to use them only for activities related to the earmarked programme. For example, a health district team may have received a set of motorcycles to supervise immunization activities, another set for the HIV programme, and yet others for tuberculosis or malaria.

This fragmentation also affected the intermediate level (the provincial health department). Coordination mechanisms for specialized programmes multiplied as external resources became available. Each provincial programme representative managed his or her own human, financial and material resources through a contract signed with each source of funding. In Kinshasa province, for example, there were still 33 such

contracts in 2014. No functional coordination existed between the different programmes, even if they were housed in the same building. Each implemented training and supervision activities for district staff without regard for the plans of others, which posed an enormous burden on their time. The nurse of the Mkungu Lengi Health Centre in Lukula Health District in the Bas-Congo, for instance, received an average 35 follow-up or supervision visits from district staff per month. Requests for operational plans and activity reports proliferated. Nurses in most of the country's health centres spent up to 60% of their time filling in monthly report forms.

Fragmentation was even observed within disease control programmes. For example, prior to 2006 HIV activities were scattered across districts without coordination. One district would build its capacity for HIV counselling and testing with no capacity to initiate or monitor treatment, while another district could provide treatment but had no counselling or testing programme. Only three out of 31 districts in the Bas-Congo province could offer a comprehensive package of all seven components (Fig. 5). Patients had to travel from one district to another to access such a package of prevention and care.

**Fig. 5. Distribution of HIV services by intervention in Bas-Congo, 2008**




*Source:* National HIV/AIDS Programme, 2008 *(6)*.

## 2.3 Organizational and managerial inefficiencies

In theory, health care at the district level is delivered on two levels. The primary level is assured by health centres, or integrated health centres offering first-contact services outlined in the basic service package. The secondary level is assured by the district hospital, which provides technical support to the primary level, and hospitalization and reference services as defined in the package of complementary services.

The growth of special programmes and external funding in the 1990s affected the role of the district hospital. It now had to compete for human, financial and technical resources with health centres that received these resources directly from global health initiatives. The running costs for a district hospital and a health centre (including HIV services) were estimated at US$ 1 200 000 and US$ 91 300 per year respectively – assuming each would play its expected role in the system. However, instead of focusing on hospitalization and referral services, district hospitals started offering first-contact services, thus competing with health centres. This shift disrupted the system of referrals and led to a deterioration in the quality of second-line health services at the hospitals. Meanwhile, health centres delivered special programme services rather than integrated primary health care and referral. This wasted scarce resources and fuelled the frustrations of both medical staff and patients.

**Box 4. The value of training.**

In 2003, the malaria programme financed by the Global Fund allocated US$ 5 million for the training of community volunteers. The same volunteers were targeted for training on HIV by other health partners. It was not uncommon for senior staff at the Ministry of Health to receive air tickets from different partners for three different training courses held simultaneously across the country.

The disruption was aggravated by the proportion of staff time in these facilities taken up by in-service training, usually organized by special programmes without overall planning or coordination. A physician could spend up to 120 days per year in such training workshops, with no assurance that the knowledge and skills transmitted would ever be used; or the time spent in training activities seen as an opportunity cost for service provision.

All this was compounded by inadequate and inappropriate national management practices. For example, in 2006 central government funds were invested in the purchase of medical equipment and supplies. A first batch for 100 district hospitals arrived in 2008, coinciding with the end of the first round of presidential elections. The supplies were given to parliamentarians to deliver to health districts in their constituencies. An inventory in 2009 showed that some equipment never arrived; some equipment was delivered to health facilities that had no qualified staff to operate it, e.g. ultrasound equipment to health centres without obstetric staff; and some items were separated rendering them inoperational, such as X-ray machines and electricity generators *(7)*.

## 2.4 Inefficient workforce deployment

The overabundance of human resources for health (HRH) in urban hospitals and health centres affects both the efficiency and effectiveness of the health system. This was caused by the explosive development of private training institutions and the freeze on retirement of health staff in the public sector. The national norms for staffing a health centre covering 10 000 inhabitants prescribe 7 health workers (5 nurses and 2 non-professional staff), and 5–10 medical doctors and 30 nurses for a 100-bed district hospital for 100 000–200 000 inhabitants. In actual fact, many urban health centres have more than 30 nurses for about 5 outpatients a day. In Mont Ngafula II District Hospital (22 beds), there are 15 medical doctors: each works one day a week because of the small number of outpatients, but all receive a full government salary. Phantom staff and staff eligible for retirement constitute up to 30% of the workforce in some urban facilities, and in those where the workload is low because of competition from the thriving unregulated private sector, staff no longer show up for work but continue to draw their salary.

## 2.5 Duplication of supply chains

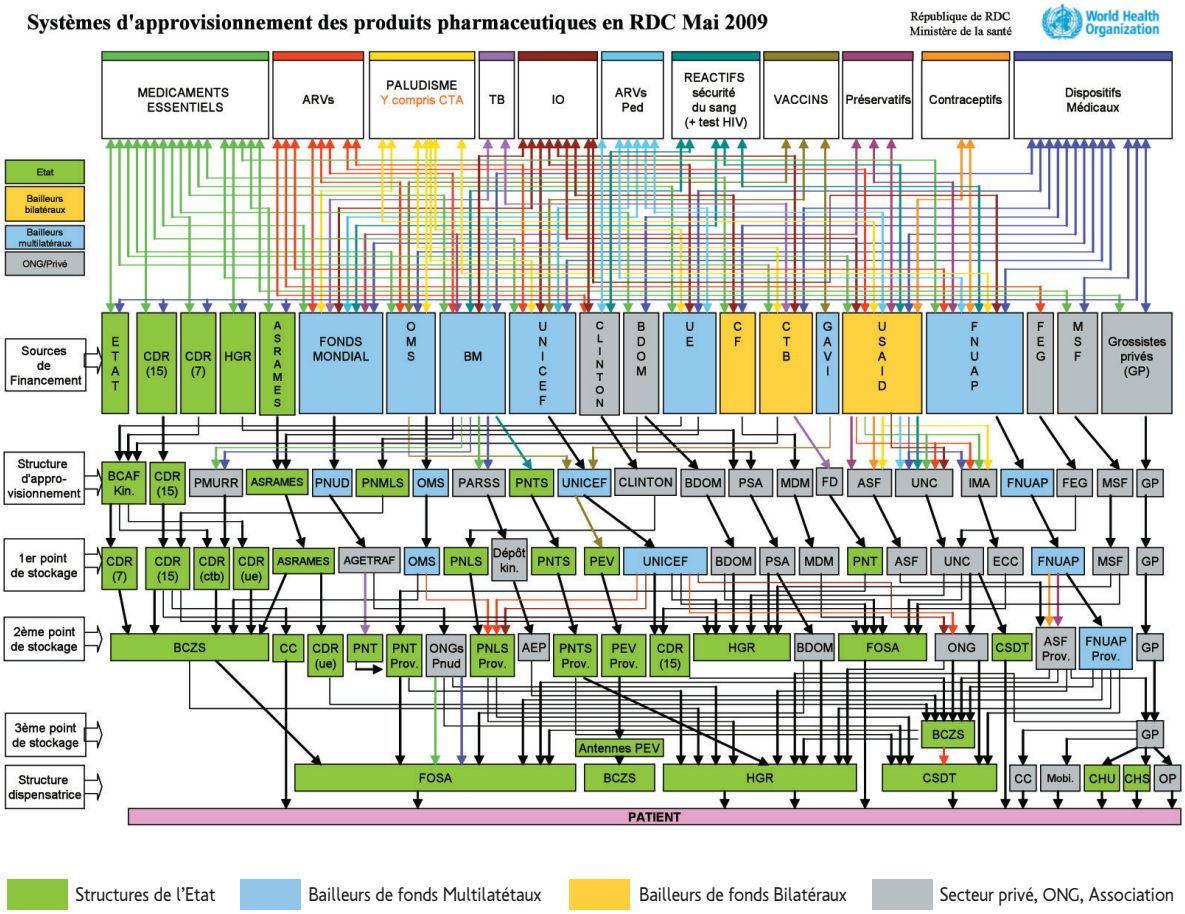
Procurement and supply systems for essential medicines in the public sector were established according to the logic of external financing with little involvement of the Government. Bottlenecks in supply and unequal access have fostered an increase of supply circuits in all provinces of the country. Medicines supplied through these parallel supply chains (and those used by the public sector) included counterfeit and expired products, or were simply unnecessary or ineffective. Moreover, neither the quality nor the uninterrupted supply of essential medicines was assured. Since a prescription in the DRC includes on average seven different medicines, and households have to buy them on the market, this has inflated private out-of-pocket expenditure on health.

In 2009, the MOH, with support from the World Health Organization (WHO) and the European Union, documented the complexity of the public sector supply system *(8)*. It listed 99 distribution channels, with 85% of partners in the health system using their own procurement agencies, warehouses and distribution systems (Fig. 6).

This generated duplication and waste of resources. Public sector capacity to manage the supply system at the district and provincial level was low; these structures were largely bypassed, as was the national body

within the MOH responsible for the supply of quality controlled generic and essential medicines (SNAME). The magnitude of the distortion created is illustrated by a grant mobilized by the Government in 2008 of US$ 656 million from the Global Fund for five years. US$ 346 million (53%) were allocated to medicines and health products, but through parallel systems. At this time, the National Supply System turnover was US$ 16 million, 20 times less than the amount mobilized from the Global Fund. In such a context it is difficult to build a sustainable national purchasing and supply system.

## Fig. 6. Supply chain for medicines and health products in the DRC, 2009




*Source:* Programme National d'Approvisionnement en Médicaments Essentiels, 2010.

# 3

# REFORM FRAMEWORK: FROM HEALTH SYSTEM STRENGTHENING TO A HEALTH SECTOR DEVELOPMENT PLAN

The Government started to address inefficiencies in the health sector in 2005 when it formulated its Health System Strengthening Strategy (HSSS). This comprised a set of reforms that soon became the health component of the larger poverty reduction and growth strategy *(9)*. At this stage the reforms were only a statement of intent, outlining the main axes to be put into place. While the structures and measures established were a direct consequence of this framework, they were influenced by events of the moment, rather than a "grand design" (Fig. 7).

**Fig. 7. Sequence of the response to overcome inefficiencies**


The Health System Strengthening Strategy resulted from the frustrations of a group of Congolese decision-makers in the health sector – within the MOH and importantly from civil society and aid agencies – with the deterioration of the sector. It also reflected their commitment to a vision for the future of the national health system. They managed to obtain the engagement of a large core within the Congolese health system, followed by that of development partners, and finally the political arena.

The HSSS was primarily a re-appropriation of health policy and governance by the MOH from external agencies that had been setting these policies over previous years. Of critical importance was the explicit inclusion within the HSSS of guidelines on managing external aid. The HSSS has since become the framework for implementation of the Paris Declaration in the health sector in the DRC *(10)*.

In 2010, a five-year national health sector development plan was elaborated aligned with the orientations of the HSSS *(11)*. Its six pillars are:

1. **Developing health districts**. This pillar is the strategic axis of the HSSS and involves: strengthening leadership at the health district level; streamlining operations of the district hospital; improving health coverage of the integrated health centre; integrating the two levels of health services provided in the district; and improving the quality of care and the participation of the community. In line with assuring the continuity of care, this pillar forms the basis for developing secondary and tertiary referral services and ensuring the pre- and in-service training of lower level health staff.

2. **Strengthening governance and leadership in the health sector**. This pillar includes: a reform of the health sector, including decentralization and management; reform of the national health information system as a tool for decision-making; health system research to improve process control and standardization; and measures to counteract corruption and the deterioration of values. At the peripheral level, this pillar focuses primarily on the deployment of integrated district health management teams.

3. **Developing human resources for health** including reforms in: pre-service training of secondary level health professionals; university-level training of professionals in collaboration with the Ministry of Higher Education; in-service training to reduce fragmentation and improve effectiveness and efficiency; and career management and staff retention.

4. **Reforming the pharmaceutical sector** to tackle issues that cannot be addressed at the district level. Issues include: parallel medicine supply channels that weaken the national system; lack of Government ownership of the national procurement and supply management system; regulation of medicines and supplies; quality assurance of medicines entering the country; and improvement of local production.

5. **Reforming health financing**. This pillar focuses on the rational unification of existing funding sources; an increase in the state budget allocated to health and its rational use for the benefit of the population; the establishment of "basket funding" at the provincial level for better coordination and allocation of resources; reduced fragmentation of international aid and its impact on services and health system at the peripheral level; the creation of a sector-wide approach and a Department for Financial Administration in the MOH; and the development of mechanisms for universal access to health care.

6. **Strengthening intra- and inter-sector collaboration** comprising: cooperation for a better regulated private for-profit and non-profit sector of health providers to improve rapidly the supply and quality of health care; and government cohesion and support to efforts to strengthen the health sector as a prerequisite for building links to other sectors and including a perspective on health in all national policies.

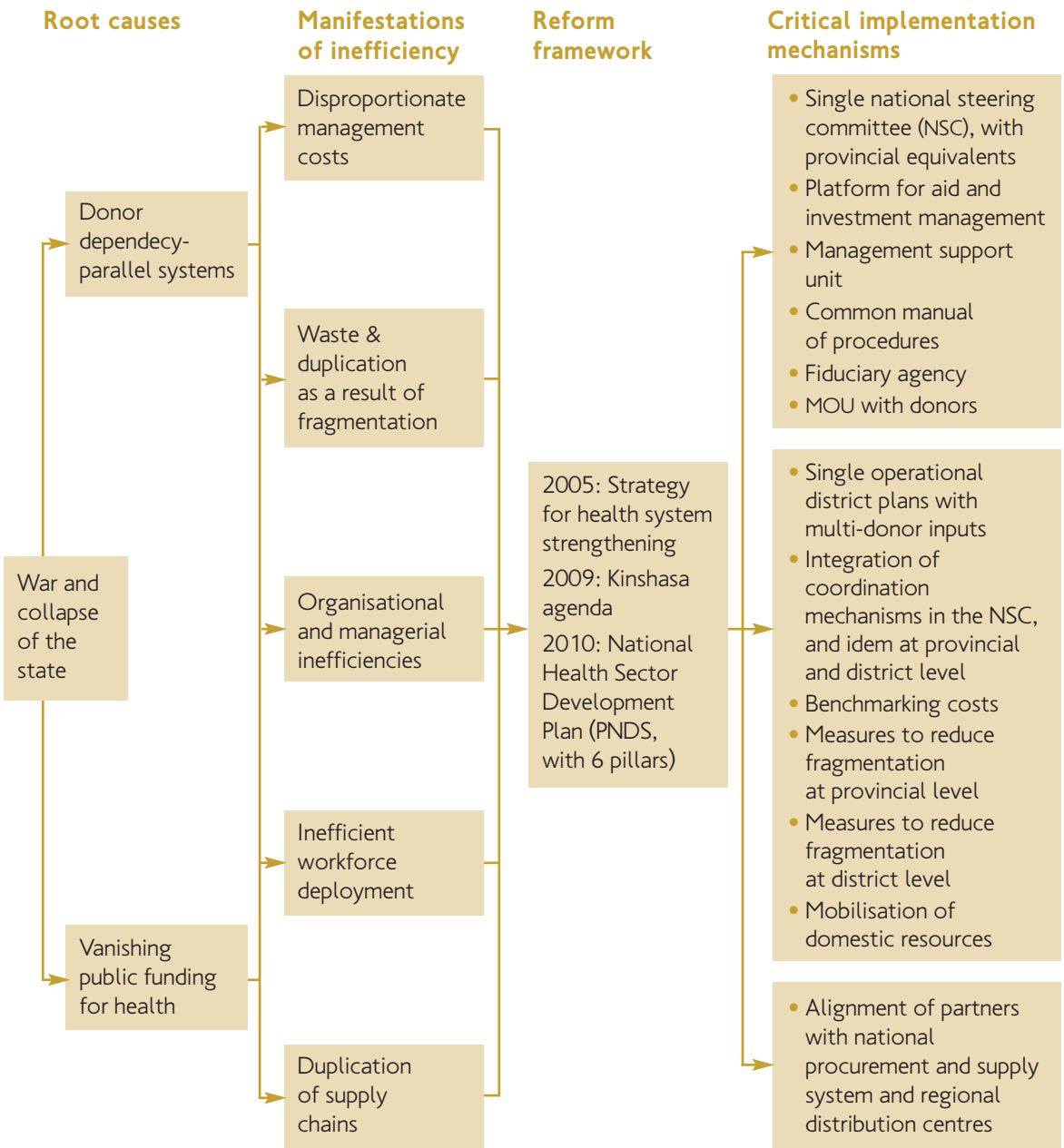
In 2009, the DRC hosted a forum on aid effectiveness and adopted the 'Kinshasa Agenda' *(12)*, the following principles of which are relevant to implementing the Paris Declaration:

- Reaffirmation of the government's central role in channelling international assistance, and its commitment to results-based management of public affairs;
- Commitment of government and development partners to rationalize the institutional framework for international assistance and to reinforce the institutional capacity of the public sector;
- Commitment of government and development partners to reduce fragmentation and increase the transparency of international development assistance;
- The commitment by government and development partners to use and strengthen national structures and procedures to implement development assistance.

# 4 IMPLEMENTING THE REFORMS

While consensus was built around the reform framework, concrete measures were needed to transform it into practice. Fig. 8 describes the implementation mechanisms adopted to address the inefficiencies and systemic problems. Activities targeted issues simultaneously, and were adapted as obstacles were encountered.

**Fig. 8. Implementing the reforms**



## 4.1 Reducing management costs and fragmentation

A key concern of the HSSS was to establish a new working relationship between the health sector and its external partners. This was critical because of the political and operational weight of the partners and the marginalization of domestic actors in the health sector.

In 2006 the Government set the scene to translate the HSSS's concerns into practice: international health sector partners made a formal commitment to align themselves with the HSSS. This commitment, generated by the impetus of the HSSS, was reinforced by the global discussions around the Paris Declaration on aid effectiveness. This commitment, and the collaboration of partner agencies, made it possible for the MOH to take three steps that had a critical impact on overcoming inefficiencies in the health sector.

The first step was the creation, in 2007, of a single coordinating mechanism to implement the health sector strategy. This national health sector steering committee (CNP-SS) became part of the national policy dialogue on all issues concerning the health sector and was later extended to the provinces through provincial steering committees.

The second, in 2009, was the establishment by the Ministry of Planning of the Platform for Aid and Investment Management. The platform assembles data from technical and financial partners (multilateral, United Nations agencies and bilateral development cooperation agencies) and ministries, including their departments and specialized agencies, in order to increase the transparency of international assistance, manage external resources and regain control of planning for national targets.

Lastly, the MOH initiated the health financing reform to improve the effectiveness and efficiency of the deployment of international assistance and domestic resources. The reform includes proposals to strengthen the Studies and Planning Department of the Ministry of Health and to establish a Department for Administration and Finances. Transitional structures were designed to improve resource management and generate best practices that could, in a later phase, become permanent structures in line with the public finance law. This led to:

- The establishment of a management support unit responsible for scheduling payments and supporting the MOH in preparing funding applications on the basis of operational plans approved by national steering committee or its technical sub-committees. At the provincial level, approval of operational plans is the responsibility of provincial steering committee, and at the peripheral level, the District Health Board.
- The agreement, by government and development partners, on a common manual of management procedures (*13*).
- The establishment of joint financial management through the contracting of a fiduciary agency, AGEFIN. In 2011, CAG-AGEFIN started to manage the health sector grants of GAVI, the Global Fund and the European Union. AGEFIN is a private company that assures, through its network in the provinces, that payments are made to projects and accounted for in a transparent manner.

This process was supported by a memorandum of understanding signed by the MOH and development partners, which foresaw that implementation of reforms would proceed in a gradual manner. Operationally, each source of funding (domestic and external) was expected to adopt progressively the reform areas of projects, programmes and plans in the country.

Implementation of this system in 2009 reduced management costs and improved the complementarity of funding sources. To date, three financing partners have joined the new mechanism, representing more than 30% of external funding to the health sector. According to forecasts, this should rise to over 50% in 2015.

Management costs of internationally funded projects have decreased from an average of 28% in 2005 to 9% in 2011. This corresponds to savings of more than US$ 56 million between 2009 and 2014, equivalent to a four-year GAVI grant (2007-2011) for health system strengthening.

In 2012 and 2014 two other development partners – the Belgian Cooperation and the World Bank – aligned their cooperation with the health financing reform. The latter became the main channel for international aid to the health sector in the country.

Implementation, however, faced a number of unexpected obstacles. First, some partners insisted on having administrative and technical staff that would respond to them directly. This fragmented the management unit, with HIV, tuberculosis, malaria and health system strengthening project managers working in parallel with MOH direction and programmes with the same responsibilities. The duplications and frustrations generated were compounded by a growing number of technical, financial and procurement activities of partner staff in the management unit.

External audits and evaluations of the management unit were conducted in 2012 and 2013, both of which demonstrated general mismanagement and conflicts of interest. To address this, three functions are currently being split: the management unit will only be responsible for financial management; technical responsibilities will return to programmes and departments; and a procurement unit will be put in place.

## 4.2 Increasing and aligning resources at peripheral level

Prior to the HSSS and subsequent reforms, coordination mechanisms for international projects were numerous. There were 15 just at the national level. Little communication existed among them and decisions taken by one coordination committee were not known by another. As a consequence, district management teams had to submit up to 12 different operational plans each year to partners or special programmes.

**Box 5. Misallocation of resources.**
The District Hospital of Maluku II District on the outskirts of Kinshasa received a new X-ray machine in 2008. In 2013, the machine was still not unpacked as the hospital had no suitable place to install it. The partner who provided the machine responded to a different coordinating body than the partner who supported the development of the district.

To resolve this situation, coordination and planning in the health sector was restructured along three main axes: consolidating coordination mechanisms; benchmarking operating costs of a health district; and establishing single multi-donor annual operational plans at each level of the health system. All external partners in the health sector are now aligned with the restructured coordination and planning, and are providing technical and financial support for its implementation.

### 4.2.1 Consolidating coordination mechanisms in the health sector

All national coordination mechanisms in the health sector are integrated in the National Health Sector Steering Committee established in 2007. The one exception – the Country Coordination Mechanism (CCM) of the Global Fund – is under negotiation for closer collaboration and possible fusion.

Provincial steering committees replaced the multiple coordination mechanisms at provincial level. The CCM has no representation in the provinces.

At the district level the district management boards, many of which were ineffective, have become a fora for dialogue between stakeholders and provide a framework for coordination of plans and activities. This has made it possible to enter all resources at the provincial and district levels into unified operational plans, including resources from Global Fund grants, with the aim of preventing duplication of activities at the service level.

### 4.2.2 Benchmarking the costs of the health district

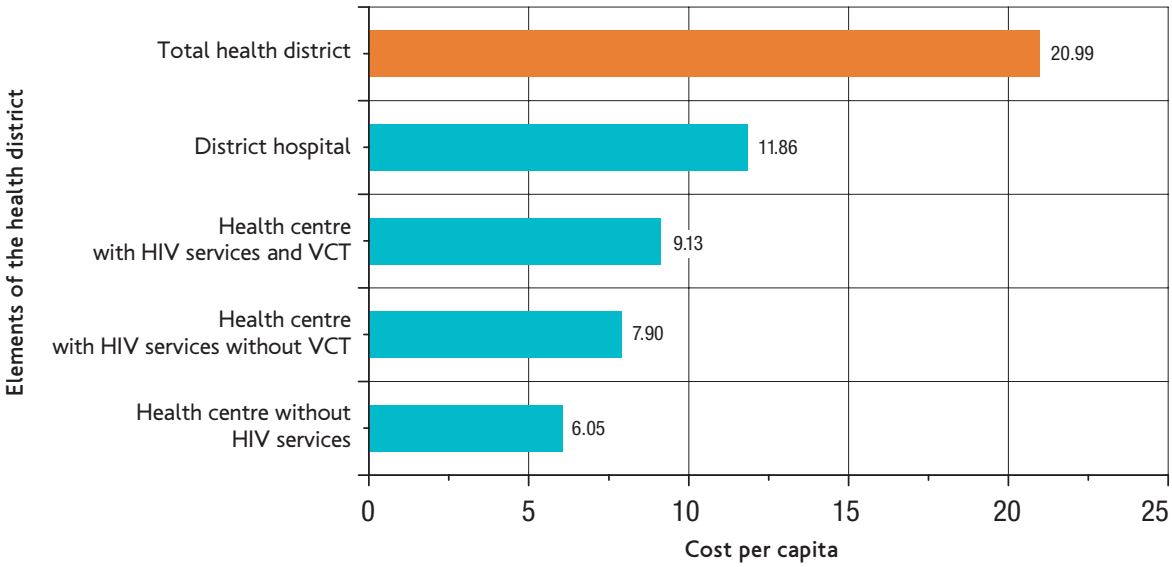
In order to develop coordinated, realistic and complementary plans for multi-donor funding of health facilities and institutions, the MOH conducted a modelling study to benchmark the minimum cost for the operation of a health district.

The benchmark was based on an average health district with a population of 100 000, 10 health centres, a 100-bed district hospital and a district health management team of five polyvalent professionals. Under the

model, HIV services are provided in two health centres and at the district hospital. Services at the district hospital include voluntary counselling and testing, antiretroviral treatment and the prevention of HIV transmission from mother to child. The costing does not include major infrastructure investment, the provision of large equipment, or mass campaigns such as the distribution of bednets or mass treatment for onchocerciasis. The model estimates the total operating cost of a district health system at US$ 21 per inhabitant per year (Fig. 9).

This benchmark facilitated discussions with external partners on the financing of services. It introduced the notion of a critical mass of funding that would allow proper functioning and a sustainable system.

**Fig. 9. Modelled recurrent per capita cost of a health district, in US$**




VCT: voluntary counselling and testing.
*Source*: Direction d'Etudes et Planification, Ministère de la Santé Publique, 2010 *(14, 15)*.

### 4.2.3 Establishing single operational plans with multi-donor inputs

Starting in 2011, the first year of implementation of the national health development plan 2011–2015, the planning process was significantly restructured. Multiple operational plans initiated by partners and special programmes at the district level were replaced by a single operational multi-donor plan. Departments and programmes of the MOH at central level continued to develop their plans, but no longer included activities implemented by health districts. District plans were then developed and validated with the participation of all stakeholders at the district level.

During the last quarter of each year the national, provincial and district coordinating committees meet to launch the planning process for the following year. During this meeting, health sector partners communicate the amount of funding available for projects, programmes and support to services in the provinces and districts where they are active. This information is collated in a financial information sheet that is made available to all stakeholders and published on the MOH website. This process:

- makes available financial information for planning and thereby reduces the lack of transparency that characterized project management in the past;
- prepares the ground for complementarity among different funding sources and reduces the risk of duplication;
- allows budget holders (districts, provinces, departments, special programmes, etc.) to verify the financial resources available for operational planning; and
- improves the monitoring of use of financial resources per source, for instance of disbursements against commitments.

The impact of this change in the planning process is illustrated in South Kivu Province. From 2011 to 2012, total resources for health sector planning in the province increased by 30% from US$ 40.8 million to US$ 53 million. The largest proportion of this increase was attributable to better information about available resources. In 2010, the districts in South Kivu had little information about available resources and therefore generally under-planned their budget, while in 2011, two of the 34 districts had at least 75% of required resources to deliver basic health services according to national standards. In 2012, this number increased to six out of 34. Further increases are anticipated after implementation of the reform.

In many cases, the establishment of a single multi-donor annual operational plan is just the beginning. The next important step is to assure that within this plan there is a shift from juxtaposed to integrated activities.

### 4.3 Reducing fragmentation and duplication at provincial level

While coordination mechanisms and single multi-donor operational plans significantly reduced fragmentation and duplication at provincial level, they had to be complemented by a change in operating mechanisms. A study was conducted in North Kivu and Kasaï Oriental to adapt the structure and functions of the provincial health divisions to support districts rather than acting primarily as a relay for special programmes. The study identified five core areas of need: *i)* technical support to districts including the management of medical resources such as drugs and vaccines; *ii)* management of non-medical resources (human, material and financial); *iii)* management of health information; *iv)* support to research and communication; and *v)* inspection, supervision and control.

These areas of work are gradually replacing the current fragmented operations of provincial health divisions. The reform, adopted by all stakeholders with support from all technical and financial partners, is being rolled out across the country. The Government and partners provide the financial resources for its implementation.

In terms of efficiency and effectiveness, the reform allows the pooling of financial resources that were otherwise managed separately by provincial offices of special programmes, and thereby significantly reduces fragmentation and duplication of interventions. In addition, increased coordinated management of technical support (monitoring, evaluation, supervision) is afforded to the peripheral level, as well as integrated and coordinated in-service training for staff, reducing the time spent in training workshops of different partners and special programmes. Finally, there is increased accountability of provincial health divisions in the organization and implementation of health services in the districts under their responsibility. A single contract with all funding sources has replaced previous multiple contracts.

### 4.4 Streamlining governance and operations at district level

A number of districts had already started implementing HSSS reforms in 2005 and 2006 with support from health sector partners. This made it possible to experiment, validate and build confidence. Decentralization and the reform of district level planning, governance and ways of working accelerated in subsequent years, and was consolidated in the national health development plan 2011–2015. This includes a programme to redefine the roles and functions of district hospitals and health centres.

The district level reforms aim:

- to ensure that the district hospital plays its role as a reference health facility and does not compete with health centres for the provision of first-level health services;
- to focus services on people and communities rather than the interests of special programmes; *(16)*
- to re-establish a system of continuity of care through referral and counter-referral between the district hospital and the health centres;
- to re-align the distribution of health facilities with the district health service coverage plan.

These changes in structure and governance complemented demand-side interventions in a move towards universal coverage, i.e. to reduce financial barriers to access and lay the foundations for a pre-payment

system to avoid catastrophic out-of-pocket expenditures *(17)*. The following interventions were put in place as they directly affect service delivery, both at health centres and district hospitals:

- establish consolidated computerized medical records to replace the numerous registers and report forms required by special programmes;
- reorganize the patient itinerary within the district hospital;
- establish rational practices for laboratory and radiological examinations, and medical prescriptions;
- coordinate the services offered under the two levels of care, the basic service package available at health centres, and the complementary service package provided by district hospitals;
- establish the routine use of clinical decision flowcharts in health centres;
- secure the continuous supply of essential medicines;
- create demonstration health centres to provide opportunities for internships for integrated in-service training of health centre staff;
- match the workforce of district hospitals and health centres to the workload: assign the most competent staff to each position, upgrade knowledge and skills, and encourage remuneration and motivation that assure the continuous delivery of quality services.

These efforts are beginning to have an impact on the service delivery. However, while national standards stipulate that each health area of 10 000 inhabitants should be covered by one integrated health centre, in practice, some have up to 15 first-contact health facilities. Most often these are private for-profit clinics that provide health services of unknown quality, increasing the cost of health care to the population and delaying necessary hospital referrals. This phenomenon is most pronounced in large urban areas, but is also present in some economically active rural locations.

**Box 6. Reducing substandard facilities.**

In Makungu Lengi, Bas-Congo Province, the "suffocation strategy" resulted in closure of 80% substandard and unregulated commercial health-care providers between 2008 and 2010. Use of the integrated health centre increased from 0.3 visits for curative care per person per year in 2008 to 0.5 in 2010. Monthly revenues of the health centre, raised by flat-rate user fees, increased from an average US$ 900 per month to US$1700. Similar results were reported from Kabondo District in Kisangani, where 60% of unregulated private facilities closed within two years as their users switched to attending integrated health centres.

Forced closure of sub-standard and unlicensed establishments has proven difficult because of weak regulatory powers of district health management teams and economic interests in the clinics of senior district or provincial health executives. Encouraging results were achieved through a strategy of "suffocation", which consisted of providing targeted technical, financial and logistic support to a promising facility and upgrading it to the status of an integrated health centre, thereby undermining the client base of substandard facilities in the area.

The reform package has also influenced human resources for health. As previously noted, an important challenge was overstaffing due to the non-retirement of government officials and the overproduction of graduates. A discussion of the specific actions undertaken to address these challenges is beyond the scope of this case study. It is, however, important to note that progress will only be sustained through alignment of international assistance, without which fragmentation and inefficiencies will continue.

Data on four district hospitals in the city of Kisangani and in the Bas-Congo province illustrate what is possible when the reforms are implemented and supported by external partners present in the area *(18)*. Hospital staffing levels were brought in line with national standards, and the reorganization made funds available for remuneration of the remaining staff, increasing motivation for productivity and continuity of service (Tables 2 and 3).

**Table 2. Reorganizing human resources in district hospitals in Kisangani and Bas-Congo**

| District hospital | Beds | Initial staff | Current staff | Redeployed | Retired |
|---|---|---|---|---|---|
| Boma (Bas-Congo) | 200 | 225 | 114 | 49 | 62 |
| Lukula (Bas-Congo) | 100 | 98 | 55 | 23 | 20 |
| Makiso (Kisangani) | 168 | 226 | 112 | 26 | 88 |
| Kabondo (Kisangani) | 160 | 85 | 88 | 0 | 0 |

*Source:* Direction d'Etudes et Planification, Ministère de la Santé Publique, 2010.

**Table 3. Evolution of monthly salary of staff by occupational category**

| Staff category | Salary (in euro) | |
|---|---|---|
| | Before rationalization | After rationalization |
| Physician | 50 | 230 |
| Administrator/Manager | 25 | 110 |
| Nurse A1 | 20 | 90 |
| Nurse A2 | 15 | 75 |
| Nurse A3 | 10 | 65 |
| Administrative Assistant | 10 | 70 |
| Driver | n/a | 50 |

A1: French Baccalauréat level plus 3; A2: Baccalauréat; A3: pre-Baccalauréat.
*Source:* Direction d'Etudes et Planification, Ministère de la Santé Publique, 2010.

A further area where the reform package is showing results is that of reducing fragmentation of district governance and financing. Decentralization entrusted the central level with normative and regulatory functions, while primary level care became the exclusive jurisdiction of the provinces. This resulted in a system in which health districts implement the health system strengthening strategy rather than special programme activities. They can pool all available resources (human, financial and material) and deploy them to implement the district health plan. For example, the district health management team now has the full and sole responsibility to plan, organize and carry out immunization activities, while the national immunization programme concentrates on ensuring standardized inputs for vaccination. The composition of the district health management teams (ECDS) has been modified to reflect this redefinition of responsibilities. Each ECDS member works at the district hospital and is responsible for a set number of integrated health centres and their preventive and curative activities. District representatives of special programmes are no longer members of the ECDS. These changes have the support of all health sector partners and have been initiated in all provinces of the country.

### 4.5 Mobilizing domestic resources for health

Each year, the national health sector steering committee calls a meeting for a preliminary assessment of expenditures in the preceding year. The results are summarized in a published report and posted on the MOH website. Table 4 is an example of available data on international assistance to health in 2012 *(19)*.

**Table 4. Commitments and expenditures of international contributions to health, 2012**

| International partner projects and programme funding in health districts | Total funding in 2012 (US$) | | % of distribution compared to total committed and cash | |
|---|---|---|---|---|
| | Resources committed | Resources disbursed | % of global commitment | % of disbursement |
| Total project and programme funding | 417 164 273 | 348 575 920 | 100 | 84 |
| 1. Development of health districts and continuity of care | 344 786 748 | 302 354 431 | 83 | 88 |
| 1.1 Improving health coverage | 16 806 641 | 16 432 793 | 4 | 5 |
| 1.2 Improving the quality of services | 2 519 764 | 1 995 918 | 1 | 1 |
| 1.3 Efficient functioning of health-care services, human resources and health map | 0 | 0 | 0 | 0 |
| 1.4 Mass campaigns | 316 545 426 | 277 383 377 | 76 | 80 |
| 1.5 Contingency of emergencies and disasters to outbreak response | 198 952 | 48 693 | 0 | 0 |
| 1.6 Promotion of community participation in health action | 1 160 651 | 771 707 | 0 | 0 |
| 1.7 Promotion of health services | 7 555 313 | 5 721 943 | 2 | 2 |
| 2. Development of human resources for health | 8 425 907 | 5 879 677 | 2 | 2 |
| 3. Drug reform sector | 8 148 957 | 5 879 677 | 2 | 2 |
| 4. Reform of funding | 4 668 859 | 2 899 271 | 1 | 1 |
| 5. Improving and upgrading health equipment and infrastructure | 29 814 825 | 18 165 051 | 7 | 5 |
| 6. Improving health information systems | 5 114 927 | 1 289 639 | 1 | 0 |
| 7. Building leadership and governance | 16 204 050 | 12 108 174 | 4 | 3 |

*Source:* Direction d'Etudes et Planification, Ministère de la Santé Publique, 2013.

This kind of information makes it possible to put health sector financing distortions clearly on the table for discussion with all stakeholders – national and international. Table 4 shows that in 2012, 80% of international support to health programming at the district level was invested in mass campaigns (bednets, vitamin A, mebendazole, etc.) Investment in sustainable health service delivery and the quality of services was limited, and the enormous investment gap for health service infrastructure in the country was largely ignored.[1]

More comprehensive information, channelled through a credible structure such as the national health sector steering committee, made it possible to lobby for a review of the Government health budget. Over the past years the proportion of the national budget allocated to health has been 4–5%; about 60% of this budget was earmarked for staff salaries and only 20% on interventions. The proportion allocated to health gradually increased to 7.8% in 2014.

In 2012, a Government public finance reform discovered many instances of payroll duplication and fictitious personnel lists. The savings realized were reinvested in social sectors, including US$ 80 million in the health sector. For example, funds were used to replace equipment in hospitals and health centres, renovate health facilities using the procurement services of the United Nations Children's Fund (UNICEF), procure and distribute medicines, and to support health sector reform. Partners such as GAVI and the Global Fund invested in these reforms. The share of domestic public funds invested in the health sector increased significantly compared with international assistance, from 34% in 2011 to 71% in 2013 *(20)*.

1 One thousand and five hundred of the 8000 health centres in the country comply with national standards. Most of the 424 district hospitals were built before independence and require extensive renovation and renewal of equipment.

### 4.6 Streamlining the procurement and distribution of essential medicines

One action to address inefficiencies in the procurement and distribution of essential medicines was government appropriation of the national procurement and supply system. Grouped procurement reduced the number of costly distribution channels and the purchase of medicines of uncertain quality from private suppliers. The number of users of SNAME, launched in 2002, has grown and currently includes the Belgian Technical Cooperation, South Korean Cooperation, European Union, GAVI and the Global Fund. The latter recently joined SNAME to procure and distribute medicines and supplies to the public sector. This has greatly increased the turnover of SNAME and promoted expansion of its distribution networks.

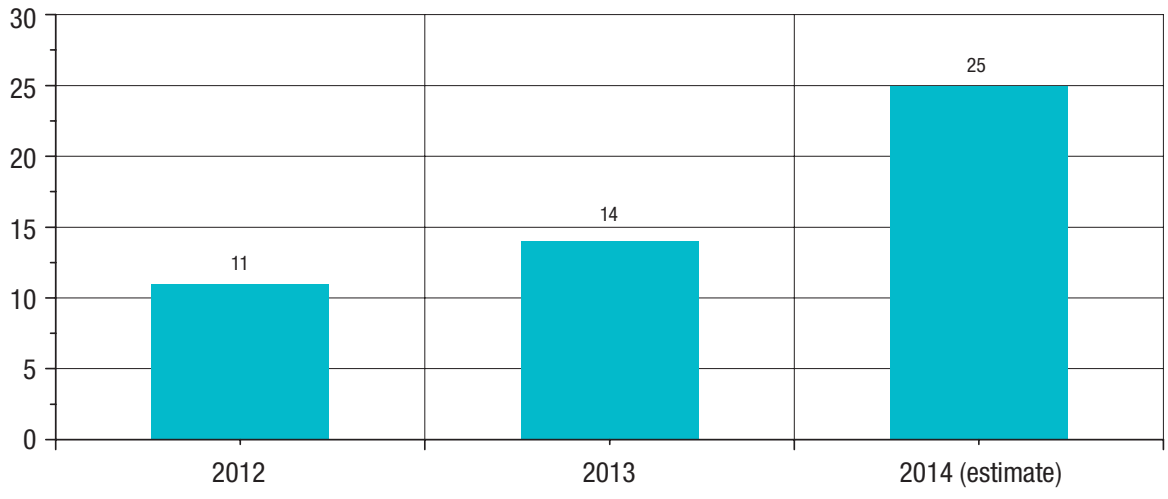
In 2006, seven regional distribution centres out of a planned 25 were active. Following the alignment of development partners, the number increased to 16 in 2010 and two more are scheduled to open. Between 2005 and 2013 the proportion of health districts supplied by regional distribution centres (CDR) increased from 28% to 75% (386 of the country's 516 health districts).

In parallel to partners who fully contracted the procurement and supply management to SNAME, some have maintained their own procurement mechanisms but use the SNAME network of regional distribution centres. These include USAID, the World Bank and the Global Fund for medicines procured by nongovernmental grant recipients.

In 2013, the Government injected US$ 3 million into the procurement and supply system of SNAME from resources recovered through the public sector reform. These funds contributed to building a stock of essential medicines for the supply chain and to improving the availability of drugs at the service level.

Historically, the Government spent approximately US$ 5 million per year on the procurement of medicines other than vaccines. However, the distribution and supply channels for these medicines were inefficient, and the drugs rarely reached the health facilities *(8)*. Shifting this volume of procurement to SNAME was considered a more sustainable way to ensure quality medicines at the service level (Fig. 10).

**Fig. 10. Business volume of SNAME in million US$**




*Source:* Direction d'Etudes et Planification, Ministère de la Santé Publique, 2014.

To improve the efficiency of procurement and distribution systems, the Government established a policy of pooling resources. Equateur and Bandundu are neighbouring provinces, each with its regional distribution centre (CDR). The CDR of Equateur and its development partners aligned with the national policy and established a system to pool resources for the transport of medicines.

Equateur and Bandundu have several transportation axes, two of which are compared here:

- Bwamanda-Mobay-Mbongo, 393 km from the CDR (CAMENE) of Equateur
- Bandundu-Bokoro-Oshwe, 380 km from the CDR (CAMEBAND) of Bandundu.

The cost of transportation per kilometre is almost the same in the two provinces, i.e. US$ 4.5 in Bandundu and US$ 4.0 in Equateur.

Pooled resources via CAMENE consist of a single large truck to transport drugs to all health districts, namely Karawa at 156 km; Businga at 238 km; Gbadolite at 368 km and Mobay-Mbongo at 393 km from CAMENE. The principle of pooling is as follows: the first health district on the axis pays for the number of kilometres that separates it from CAMENE. The second health district pays for the kilometres that separate it from the first health district, and so on. Thus, the Mobay-Mbonge health district pays only for 25 kilometers that separates it from the Gbadolite health district. Thus, the total amount is US$ 200 for the round trip of the truck.

In Bandundu Province, each health district organizes the transport of its own medicines and other health products from CAMEBAND. The Oshwe health district, located 380 km from CAMEBAND, pays almost US$ 3 500 on such transport. A four supply trips per year, Oshwe pays almost US$ 14 000 to transport its drugs and other health products, almost a third of its turnover for these products. This contrasts starkly with the transport costs of the Mobay-Mbongo health district, which is at an equivalent distance from CAMENE.

The pooling experience of CAMENE is being scaled up in the country. While some provinces are more advanced than others, it is estimated that when all CDRs have set up the transport pooling policy, the SNAME will save more than US$ 3.5 million each year.

# 5 CHALLENGES AND OPPORTUNITIES

## 5.1 Turning words into action

The joint declaration of alignment to the HSSS issued by the donor group in 2006 created a strong dynamic. However, international investments in health in the DRC often remain earmarked and come with implementation strategies and guidelines that are inflexible and may conflict with national priorities. Many partner agencies are committed to strengthening district health systems, but pressure for quick and visible results has led to earmarking for stand-alone mass campaigns, missing opportunities to build an effective and sustainable system. Thus, the operational plans of some provinces and districts continue to be challenged by predefined and unintegrated health interventions that, however well intended, negatively affect the efficiency and effectiveness of their operations.

Partner commitments to ensure that resources reach the district level are welcome. However, in the long run, some of these contributions would better be directed towards institutional support to health system structures (a department, programme, provincial health division, health district, hospital or health centre), rather than to specified activities. This would enable the district health management team to pursue its institutional task of building a sustainable system in the district.

## 5.2 Leading by example

Since 2012, the reforms have gained momentum and the Government has taken greater ownership of the sector strategy, particularly through the investment of funds recovered through the public sector reform in equipment for the health services. The Government will need to seize the opportunities offered by fewer armed conflicts and the growth of the economy to continue such investments. The increase in domestic resources in the health sector will also give the Government greater leverage when negotiating the alignment of assistance provided by international partners. However, its pace in implementing sector and national reforms has been slow, and it has not consistently taken the priorities of the health system strengthening strategy into account in its budget. This is a waste of domestic resources and limits the ability to influence partner agency behaviour.

## 5.3 Moving forward

The health financing reform remains fragile. In part, this fragility is caused by the corporate interests of partners who joined the common financial management mechanism. A critical example is the management support group (CAG). This transitional structure put in place by the Government to overcome fragmentation has rather become a forum where programme managers for malaria, tuberculosis, HIV, and health system strengthening promote the specific interests of their funding sources. Their accountability to the structures of the MOH is poorly defined and has thereby created a structural conflict of responsibility within the Ministry. This threatens to reverse the progress made to overcome the fragmentation and duplication that long plagued the health sector in the DRC. The technical responsibilities of the CAG should be returned to departments of the MOH that have an intrinsic mandate to strengthen the health system.

To do this, the MOH and its partners should instruct the fiduciary agent (AGEFIN) to identify the activities needed to build the financial management capacity of the Ministry structures, giving real authority to the future Department of Administrative and Financial Affairs. A road map should set out the mandate and milestones of AGEFIN, and define the conditions for the handover of responsibilities of the agent and its provincial network to the MOH structures that are being put in place at the national and provincial level.

**Box 7. Persistent duplication of efforts.**
In 2013, the health system support programme funded by DFID approved the procurement of 58 vehicles for the supervision of health districts. Most of these districts received a shipment of the same type of vehicles from Global Fund grant. These funds could have been allocated to another priority area of health system strengthening.

In addition to a road map, a solution must be found to bring the country coordinating mechanism of the Global Fund – the sole remaining parallel coordination mechanism – under the umbrella of the national health sector coordinating committee. If that is achieved, another important source of duplication in the health sector will be resolved.

### 5.4 Overcoming political obstacles to human resource reforms

The problems of human resources for health in the DRC are well known. It is difficult, however, to devise a political strategy to overcome the serious obstacles to address them. HRH reforms require the simultaneous involvement of several ministries and departments (health, higher education, public service, budget, finance, and decentralization), a challenge in itself. Reforms of institutions of higher education are highly political, as many of them were established by politicians seeking electoral support. Consolidating health science colleges and universities is therefore an agenda that elicits strong political opposition. Authorities are understandably reluctant to make decisions that could result in a popular revolt. Finally, the Government does not currently have sufficient funds to pay the retirement benefits of all civil servants which, as mentioned earlier, is causing severe disruption in health facilities.

### 5.5 Stepping up efforts on essential medicines

Multiple parallel procurement and supply systems for essential medicines continue to waste resources in the health sector. Efforts under way to align and create ownership of a national drug supply policy will make the system more efficient and effective, but major challenges remain.

A great amount of domestic and international public funds feed the parallel supply circuits. When the contributions of the Global Fund, the World Bank and USAID are taken into account, parallel systems channel 10 to 15 times more funds than the national system for the supply of generic and essential medicines. As in other sectors, this creates a vicious circle: financial partners expect a certain level of performance from the national system before funding the supply of medicines; at the same time the national system cannot improve its performance if it does not have access to these funds.

Concurrent to encouraging partner agencies to use national structures is the need to accelerate the coordination of suppliers: this is critical to prevent health districts stimulating new parallel channels at the provincial level by sub-beneficiaries of the Global Fund, local implementing agencies of World Bank grants, or coordination units of special programmes. Finally, the distribution of free or highly subsidized medicines by some partners has often led to the same product expiring on the shelves of regional distribution centres. The challenge is to regulate the distribution of free drugs, or at least to use the stocks in the national pharmaceutical supply system.

# 6 CONCLUSIONS AND LESSONS LEARNT

The Democratic Republic of the Congo Government formulated a comprehensive health system strengthening strategy (HSSS) in 2005 as a wide-ranging reform package under its strategy for growth and poverty reduction. The HSSS was a key element in reclaiming political leadership and governance of the health sector. External technical and financial partners aligned themselves with the HSSS strategy in 2006. This triggered a dynamic of change on the ground that enjoys growing support, including in the political arena outside the health sector.

The reforms guided by the HSSS helped improve efficiency and effectiveness in the health sector, generating better health with the available financial resources. The reforms, which are still being implemented, target health financing; partner and sector coordination; service delivery at district level; public financing and government ownership of the sector strategy; the pharmaceutical sector; and the organic framework of the Ministry.

Key in sustaining the reforms has been the establishment of a set of transitional structures: a management support unit to replace the multiple and fragmented coordination structures; a common procedure manual agreed upon by government, domestic and international partners; and a fiduciary agency with a country-wide network to manage health sector donor funds. This is estimated to have saved US$ 56 million between 2009 and 2014.

Reforms of the processes and systems for sector planning reduced the myriad of annual plans to a single multi-donor annual operational plan for each level and structure of the health system. It increased transparency in the management and allocation of resources and reduced duplication. Greater transparency and planning security enabled some provinces to increase their available operational budget by 30%.

The reform of health services at district level is part of a wider effort to revitalize primary health care in the country. In this way, the health district is the implementation unit of the sector strategy, the district hospital is the central structure for the organization of care, and a network of integrated health centres serve as first-contact and entry points into the care system. These reforms are also allowing the defragmentation of services provided at the health district level, and are having an impact on all other levels of the health system.

The public finance reform allowed the Government to make substantial savings on wages by eliminating double payments and payments to fictitious employees. The resources made available were invested in health infrastructure and equipment.

Government investment in the public procurement and supply system for generic and essential medicines (SNAME) – and its increased use by international development partners – has reduced the number of parallel supply channels and improved the availability of medicines in peripheral health facilities. The proportion of health districts supplied by the regional distribution centres of SNAME increased rapidly from 28% in 2005 to 75% in 2013, while its business volume grew from US$ 11 million in 2012 to an estimated US$ 25 million in 2014.

Numerous challenges remain to improve efficiency and the effective use of resources. Some commitments by health partners to aid alignment remain declarations of intent. Several technical and financial partners are still reluctant to align with the health financing reform, either because their governments have not yet

approved the guidelines, or because they expect further progress on the current reforms. Efforts to align the Country Coordination Mechanism of the Global Fund with the unified sector coordination committee are at a standstill. This situation continues to duplicate resource allocation in the sector.

Appropriation of the strategy by government structures beyond the health sector, in particular by the Ministry of Finance, has accelerated in recent years. The next step is to use the medium-term expenditure frameworks to orient the health sector budget towards supporting the HSSS.

There is major potential for improving efficiency and the effectiveness use of domestic resources and international assistance for health. The Government must increasingly fund the health sector strategy from domestic resources, which would accelerate the alignment of technical and financial partners with the health reforms. All stakeholders – including the Global Fund – must agree on a road map to unify coordination mechanisms at national level. The stakeholders at central level – national and international – should draw lessons from the way the comprehensive policy dialogue at district level has improved operations. This would make the national policy dialogue between government structures, civil society organizations and international partners more relevant, and their agreed actions more effective.

Recapitulating efforts over the last 10 to 15 years shows that the inefficiencies created by the collapse of the health system in the DRC were interlinked and complex. It also shows how diverse the responses had to be. It is easy to become swamped by the details of specific measures, and tempting to imagine a single, magic solution might exist. Fortunately, the complexity of the situation and its solutions was accepted, as was the need to maintain a sense of direction and a comprehensive approach throughout. With hindsight, two factors seem to have been critical in maintaining coherent responses and achieving results that, though modest, were difficult to imagine in the plight of the country in 2005.

First, the health authorities, within and beyond the MOH, had a comprehensive vision and strategy for the sector – not just in technical terms, but also in terms of how to collaborate with international development partners. It is with reference to this strategy that specific measures, institutions and mechanisms could be tested, improved, redesigned and adapted as circumstances changed and new constraints were confronted.

Second, stable leadership and growing domestic consensus on the direction the reform should take have been crucial. This continuity built the level of trust required for partners of the DRC to agree to align with the national health sector. Without ownership of its own strategy and continuity in its implementation, the Government would not have been able to lead an effective policy dialogue on alignment of international development assistance. Other countries that have undergone a collapse of state may be able to identify with and emulate the health financing experiences of the DRC.

# 7 REFERENCES


1. Institute for Health Metrics and Evaluation. Global burden of disease database (http://www.healthmetricsandevaluation.org/gbd/visualizations/country).
2. Ministère de la Santé Publique. Comptes nationaux de la Santé 2010 et 2011 RDC. Programme National des Comptes de la Santé. Kinshasa; 2013 (http://www.minisanterdc.cd/new/images/Documents/CCM/CNS_RD_Congo_Rapport_final_2010_2011.pdf, accessed 12 May 2015).
3. Abuja declaration on HIV/AIDS, tuberculosis and other related infectious diseases. Abuja: Organisation of African Unity; 2001 (http://www.un.org/ga/aids/pdf/abuja_declaration.pdf).
4. Stratégie de renforcement du système de santé. Kinshasa: Ministère de la Sante Publique; 2006 (http://planificationfamiliale-rdc.net/docs/2_StrategieDeRenforcementDuSystemeDeSante_SRSS_Juin2006.pdf, accessed 15 May 2015).
5. Jean Bosco Kahindo, Hyppolite Kalambay. Documentations des résultats de la mise en œuvre des principes de l'efficacité de l'aide dans le secteur de la santé. Rapport analytique consolidé de l'étude de cas de la République Démocratique du Congo, 2012.
6. Cartographie des interventions de la lutte contre le VIH/SIDA en République Démocratique du Congo. Kinshasa: Ministère de la Santé Publique; 2008.
7. Etat des lieux du secteur de la santé: Rapport d'étude réalisée par l'Ecole de Santé Publique, Université de Kinshasa; 2009.
8. Ministère de la Santé Publique. Cartographie des systèmes d'approvisionnement et de distribution des médicaments et autres produits de santé en RDC. Kinshasa: Programme National d'Approvisionnement en Médicaments Essentiels ; 2010.
9. République Démocratique du Congo. Stratégie de Croissance et de Réduction de la Pauvreté. Kinshasa: Ministère du Plan; 2010.
10. Muvudi M et al. Analysis of the implementation of the Paris Declaration in the health sector in the Democratic Republic of Congo. Med Trop (Mars). 2011;71(3):229–31 (http://www.ncbi.nlm.nih.gov/pubmed/21870544, accessed 15 May 2015).
11. Plan national de développement sanitaire 2011–2015. Kinshasa: Ministère de la Santé Publique; 2010.
12. Rapport du forum de haut niveau sur l'efficacité de l'aide en République Démocratique du Congo. Kinshasa: Ministère du Plan; 2009.
13. Manuel de procédures de gestion applicables aux financements du secteur de la santé (PGFSS) 2ème édition. Kinshasa: Ministère de la Santé Publique; 2011.
14. Integrated Healthcare Technology Package [web costing tool]. Geneva : World Health Organization; c2007 (www.ihtp.info, accessed 1 November 2014).
15. Rajan D, Kalambay H, Mossoko M, Kwete D, Bulakali J, Lokonga JP et al. Health service planning contributes to policy dialogue around strengthening district health systems: an example from DR Congo 2008–2013. BMC Health Serv Res. 2014;14(1):522.
16. The world health report. Primary health care – now more than ever. Geneva: World Health Organization; 2008 (http://www.who.int/whr/2008/en/, accessed 15 May 2015).
17. The world health report. Health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010 (http://apps.who.int/iris/handle/10665/44371, accessed 15 May 2015).

18. Ministère de la Santé Publique. Rapport du processus de rationalisation des ressources humaines pour la santé dans les HGR de Boma, Kabondo, Lukula et Makiso-Kisangani. Kinshasa: Direction d'Etudes et Planification; 2010.

19. Rapport de la réunion du Comité de Coordination technique du Comité National de Pilotage du Secteur de la Santé sur l'utilisation de l'aide internationale. Kinshasa: Ministère de la Santé Publique; January 2013.

20. Direction de la Préparation et de Suivi Budgétaire. Rapport de l'état de suivi budgétaire au 31 décembre 2013. Kinshasa: Ministère du Budget; January 2014.

# 8 ANNEX: REDUCING INEFFICIENCIES BY ALIGNING INTERNATIONAL HEALTH SECTOR SUPPORT

| Inefficiency | Nature of the problem | Cause of the problem | Consequences of the problem | Description of the reform | Effects of the reform | Policy implications and lessons learnt |
|---|---|---|---|---|---|---|
| **Disproportionate management costs** | The large number of projects and programmes generated high management costs. For example, the management cost and international technical assistance of the health programme under the 9th European Development Fund 2006–2009 amounted to €30.5 million, 38% of the total programme budget of €80 million. | The main cause is the collapse of the state due to armed conflicts and weak governance. Also, leadership was lacking to engage with donors in order to reduce project managements costs. | A significant proportion of international aid in the health sector was not used to establish sustainable health services. Very few resources reached communities targeted by the project. Improvement in health status was minimal. | 1) Establish a national management unit;<br>2) Establish a national steering committee;<br>3) Develop consensual fiduciary arrangements. | Management costs reduced from an average 25% to 9%; more money invested in service delivery through projects and programmes. | **Policy implications**<br>Increased trend towards institutional support, replacing project aid as primary modality for international assistance in health.<br>**Lessons learnt**<br>1) Strong leadership can align international aid and implement the Paris Declaration at the country level;<br>2) Countries need to invest their own resources in health services to build a sustainable health system. |
| **Fragmentation and duplication of field interventions** | Instead of small polyvalent district health teams, many had up to 18 staff, each representing a different programme with its own resources and operations. These teams had to support the same health centres and communities. | 1) The DRC was almost totally dependent on international aid (global health initiatives, etc.) to finance health services. In 2005, most of these funds were earmarked for specific programmes and not basic health services.<br>2) In the context of lack of governance, partners had little confidence in the health system. Establishing their own services or those that depended on them was seen as the only way to get rapid results. | 1) Duplication and waste in allocation and use of resources;<br>2) Large burden on staff time at district and health facility level to attend training seminars, respond to supervision visits and write reports;<br>3) Frustration among health workers who did not have enough time to provide health services;<br>4) Declining quality of district health services which created conditions for unregulated private health services to expand;<br>5) Loss of confidence in public health services. | 1) Establish integrated health district teams and common use of available resources;<br>2) Replace multiple steering committees of development partner projects with one national steering committee. | 1) Coordinated resource allocation at all levels of the health system;<br>2) Progressive improvement in quality of services at peripheral level and less use of unregulated private health services in areas where the reform was implemented. | **Policy implications**<br>To make this reform effective, it was extended to the intermediate (provincial) level which was also very fragmented. These intermediate teams have been replaced by integrated teams. Development partners have agreed to align with the integrated intermediate plan using a single contract. |

| Inefficiency | Nature of the problem | Cause of the problem | Consequences of the problem | Description of the reform | Effects of the reform | Policy implications and lessons learnt |
|---|---|---|---|---|---|---|
| **Disruption of service delivery in the health districts** | Cost estimates to run a health district and a health centre are US$ 1 200 000 and US$ 100 000 per year respectively. Instead of offering hospitalization and reference services (their roles), district hospitals were offering first contact services which are the remit of the health centres. | In the context of the collapse of the State, district hospitals received no funds other than user fees. To improve their fiscal base, they started to offer selected primary health services that were funded by international partners. | 1) Declining quality of health services delivered at all levels of the health district;<br>2) Deteriorating ability of district hospitals to deliver quality second-line health services or technical support to health centres;<br>3) Unregulated expansion of private health services in the health district (up to 118 primary health facilities instead of the standard 15– 20 health facilities per district) and decline in the quality of their services. | 1) Establish leadership at the district level;<br>2) Rationalize the role of the district hospital and health centre;<br>3) Rationalize the health district road map;<br>4) Establish financing by diagnosis-related groups. | 1) Re-establish roles at each level of service in the health district;<br>2) Improve quality of health service at the district hospital;<br>3) Re-establish referral and counter-referral systems. | **Policy implications**<br>The content of the reform was used as a basis to develop the GAVI health system strengthening proposal 2015–2019. |
| **Overstaffing of public health services in urban areas** | National health standards for staffing a health centre (ca. 10 000 inhabitants) are 3 nurses and 2 non- professional staff; and a district hospital (ca. 150 000 inhabitants) are 5 –10 medical doctors and 30 nurses. In urban areas, many health centres have more than 30 nurses. Mont Ngafula II District Hospital (22 beds) has 15 medical doctors. | 1) Explosive development of unregulated private training institutions;<br>2) Freeze on retirement benefits for health staff in the public sector due to collapse of state;<br>3) Centralized human resource management that does reflect the real needs of health facilities. | 1) Waste of financial resources because staff no longer show up for work but continue to draw salaries and other incentives;<br>2) Poor functioning of health facilities;<br>3) Declining quality of health services. | 1) Decentralize human resource management;<br>2) Retire eligible staff (required an inter-sector initiative involving the ministries of health, civil service, and finance). | 1) Better alignment between workload and staffing in health centres and district hospitals;<br>2) Improved salaries and other incentives for health workers;<br>3) Improved quality of health services. | **Lessons learnt**<br>1) The human resource reform was complex and one of the most difficult to conduct because of the resistance it generates. HRH reforms require strong coordination and inter-sector interventions that include other ministries.<br>2) Performance and counter performance of the health sector depend on national governance and leadership. |

| Inefficiency | Nature of the problem | Cause of the problem | Consequences of the problem | Description of the reform | Effects of the reform | Policy implications and lessons learnt |
|---|---|---|---|---|---|---|
| **Multiplication of supply chains for medicines and health products** | In 2009, there were 99 distribution channels of medicines and other health products; 85% of partners in the health system used their own procurement agencies, warehouses and distribution systems. | The main cause was the collapse of the State due to armed conflicts and weak governance and leadership. There was not enough leadership to engage with donors in order to achieve an alignment with the national procurement and supply management system. | 1) Duplicated and thus wasted resources.<br>2) Some health units received more health products than needed, while others experienced stock-outs due to the lack of a coordinated procurement system;<br>3) Medicines and other health products expired in the health facilities;<br>4) The national procurement system suffocated and the volume and turnover of stock reduced;<br>5) Parallel distribution systems for medicines and other health products multiplied. | 1) Align donors with the national procurement and supply system to store and distribute health products and reinforce coordination;<br>2) Inject domestic resources into the national procurement and supply system from resources recovered through the public sector reform;<br>3) Pool resources for the transport of supplies. | Reduced transport costs of drugs by aligning with pooling policy. | **Lessons learnt**<br>By scaling up the pooling of resources for drug transportation, established by CAMENE (Regional Centre of Drugs Distribution of Equateur Province), the SNAME will save more than US$ 3.5 million each year. This amount can increase the turnover of the entire procurement system. |
| **Inappropriate allocation of medical equipment** | In 2006, although the Government financed the replacement of equipment in health centres and hospitals to the tune of US$ 100 million, most of it never reached the health facilities due to political influence. | Lack of governance: most of the equipment bought was used for election campaigning. | Financial investment had no impact on improving health service delivery. | Use UNICEF procurement services to purchase, distribute and install equipment in health facilities. | Improved health service delivery and quality of services. US$ 160 million allowed the replacement of equipment in 1000 health centres and 200 district hospitals. | **Policy implications**<br>The Government and partners such as GAVI and the Global Fund now use the UNICEF procurement services to invest in health sector equipment. |

**Health System Governance, Policy and Aid Effectiveness** (HGS)

**Health Financing Policy** (HFP)

**Cost Effectiveness, Expenditure and Priority Setting** (CEP)

**WE ARE ALSO PROUD TO HOST THE SECRETARIATS FOR:**

ihp+ P4H Social Health Protection Network

In an increasingly interconnected world, we know that we achieve more when we work with others.

Recent collaborations include: Abt Associates Inc.; Australian Agency For International Development (AusAID); Bill & Melinda Gates Foundation; European Commission – Europeaid Cooperation Office (AIDCO); France, Ministry Of Foreign And European Affairs; Global Alliance for Vaccines and Immunisation (GAVI); Germany, Deutsche Gesellschaft Für Internationale Zusammenarbeit (GIZ) Gmbh; Global Fund To Fight Aids, Tuberculosis And Malaria (GFATM); Luxembourg Development Cooperation; Netherlands, Ministry of Health, Welfare and Sport; Norwegian Agency For Development Cooperation (NORAD); Republic of Korea, Ministry of Health and Welfare; Republic of Korea, National Health Insurance Service (NHIS); Rockefeller Foundation; Susan G. Komen Breast Cancer Foundation Inc.; Spanish Agency for International Cooperation and Development (AECID); Swedish International Development Cooperation Agency (SIDA); United Kingdom-Department For International Development (DFID); United Nations Development Programme (UNDP); United States Agency For International Development (USAID).

And we are proud to be part of the Providing for Health Initiative (P4H) and to co-host the secretariat for International Health Partnerships (IHP+).

**Work with us so we can support countries to reach our shared objective:**
**country health governance and financing systems that ensure universal and sustainable coverage.**

For additional information, please contact:

Department of Health Systems Governance and Financing
Health Systems and Innovation
World Health Organization

Email
hgfdepartment@who.int

Website
www.who.int/topics/health_systems/en/