
Democratic Republic of the Congo Private Health Sector Assessment



Summary

The private health sector is an important player in the Democratic Republic of the Congo's health system, but the extent of its contribution remains largely unknown. The Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project, with funding from the United States Agency for International Development, the World Bank, the International Finance Corporation, and the Bill & Melinda Gates Foundation, conducted an assessment of the role of the private sector in improving health system performance in the Democratic Republic of the Congo. The assessment focuses on key health challenges, including family planning and maternal and child health. It uses the World Health Organization's six health system pillars as a framework: leadership/governance, service delivery, access to essential medicines, financing, health workforce, and health information systems. This brief highlights the methods, findings, and recommendations from the full assessment report.

Keywords: child health, Democratic Republic of the Congo, DRC, family planning, maternal health, maternal and child health, policy, private sector assessment, private sector health, public-private dialogue, public-private partnerships, reproductive health, supply chain

Photo: USAID/Rosalie Colfs/Handicap International Project

Recommended Citation: SHOPS Plus. 2019. *Democratic Republic of the Congo Private Health Sector Assessment*. Brief. Rockville, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates.

This brief is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of Abt Associates and do not necessarily reflect the views of USAID or the United States government.



August 2019



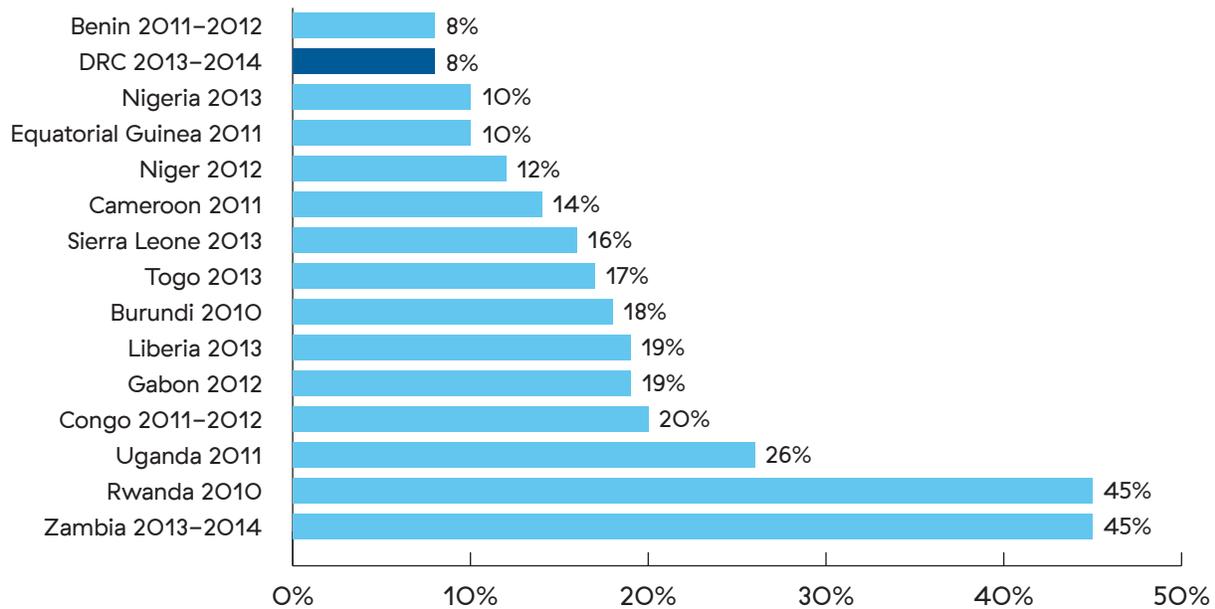
Democratic Republic of the Congo

Private Health Sector Assessment

With a population of 78.7 million, the Democratic Republic of the Congo (DRC) is Africa's fourth most populous country (World Bank 2016). The country is experiencing rapid population growth, especially among youth ages 15 to 30 years (USAID 2014), with an expected increase of 10 million people by 2050. Most of the population lives in poverty and is not active in the formal economy. Declines in the global price of minerals and petroleum have led to slower economic growth in recent years. Gross domestic product grew only slightly between 2015 and 2016, from \$37 billion to \$38.5 billion (2.4 percent, down from 6.9 percent in the previous year). During that same period, inflation increased from 1 percent to 12 percent. Ongoing political instability discourages investment, diverts attention from economic issues, and increases the cost of doing business (export.gov 2017a). In recent years, the DRC has made it easier to start a business, including in the health sector, although significant room for improvement remains (World Bank 2017a, 2017b). In a 2017 ranking of ease of doing business in a country, the DRC ranked 182 of 190 countries (World Bank 2017b).

Two decades of conflict and insecurity have led to the deterioration of the health infrastructure. Structural barriers to access (e.g., distance, lack of transport, and prohibitive fees) combined with sociocultural barriers, prevent service use, drive unhealthy behaviors, and further exacerbate poor health outcomes. These barriers contribute to some of the highest maternal and child mortality rates in the world. The DRC also has one of the lowest modern contraceptive prevalence rates (mCPR) in Africa, with only 8 percent of married women using a modern method (Figure 1) (Barroy et al. 2014). Maternal mortality in the DRC has increased from 549 deaths per 100,000 live births in 2007 to 846 in 2014 (MPSMRM, MOH, and ICF International 2014). While under-5 mortality has fallen steadily from 148 deaths per 1,000 live births in 2007 to 104 in 2013-14, 60 percent of children under 5 are not covered by basic treatment services for diarrhea, fever, and respiratory infections—contributing to the DRC's status as one of five countries that collectively account for half of all deaths globally among children under 5 (WHO 2012; Barroy et al. 2014).

Figure 1. Use of modern contraceptive methods in the DRC and nearby countries



Source: Demographic and Health Surveys, depending on national data availability (Barroy et al. 2014)

Assessment scope and methodology

In order to address these health challenges, the DRC Ministry of Health (Ministère de la Santé Publique, MOH) asked its development partners to identify how the country could improve health outcomes by increasing engagement with the private sector. With funding from USAID, the World Bank, the International Finance Corporation, and the Bill & Melinda Gates Foundation, the Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project conducted a private health sector assessment (PSA) that examined opportunities and constraints for strategic private sector engagement across the six health system pillars: leadership/governance, service delivery, access to essential medicines, financing, health workforce, and health information systems.¹

¹ Brunner, Bettina, Virginie Combet, Sean Callahan, Jeanna Holtz, Emily Mangone, Jeff Barnes, Cathy Clarence, Auguste Assi, and Stephanie Gober. 2018. *The Role of the Private Sector in Improving the Performance of the Health System in the Democratic Republic of Congo*. Bethesda, MD: Abt Associates Inc.

The assessment facilitates ongoing efforts by providing:

- An estimate of the size, scope, and scale of the DRC's private health sector, with an emphasis on key stakeholders and their roles;
- An overview of the types of health services and products offered by the private sector, with a particular focus on family planning (FP) and maternal and child health;
- Benchmarks and lessons learned from comparable low-income countries;
- A summary of key policies, market conditions, and business needs that inhibit or enable private sector participation in the health system; and
- Strategic priorities and a three-year road map for action.

The MOH and its development partners are using the report's findings and recommendations to build strategic partnerships with the private sector to improve health outcomes in the DRC.

A team of private sector experts composed of 10 international and DRC-based specialists collected data in two phases. First, the team conducted a desk review of over 200 documents to understand the current state of the private health sector in the DRC. The team shared its findings with stakeholders at a launch event in Kinshasa in October 2017. Second, in November and December 2017, the assessment team conducted a data collection trip to the DRC to interview 215 stakeholders representing the private and public health sectors, development partners, and other key stakeholders. These interviews helped the team identify opportunities for strengthening private sector engagement in health. As part of a follow-up workshop, the team collaborated with stakeholders to prioritize recommendations and develop a three-year road map for action.



In the Democratic Republic of the Congo, 60 percent of children under 5 are not covered by basic treatment services for diarrhea, fever, and respiratory infections.

Photo: EU/ECHO/Malini Morzaria

Findings

The National Health Development Plan (Plan National de Développement Sanitaire 2016-2020) identifies four sectors within the DRC health system: public medical, private medical, private pharmaceutical, and traditional medicine (Table 1). The MOH leads the public health sector at the central level. It is responsible for the health system and creates national strategies, defines policies and priorities, sets standards and guidelines for service delivery, and implements several vertical disease programs (e.g., for malaria, HIV, reproductive health, and adolescent health). The MOH directly delivers services through national-level tertiary facilities, and advises and supports provincial and district health zones to deliver health care at lower-level public facilities.

Table 1. Structure of the health system in the DRC

Public medical sector	Private medical sector		Private pharmaceutical sector	Traditional medicine*
	For-profit	Nonprofit		
Health centers, general reference hospitals, provincial and national hospitals, other state and parastatal entities involved in service delivery	Private medical and paramedical practices, clinics, polyclinics, and diagnostic centers	Health centers and hospitals managed by NGOs (including FBOs)	Pharmaceutical companies and authorized wholesale, supply, and distribution structures	Traditional healers using plants and traditional practices to diagnose diseases and conditions and provide care for patients

*This assessment focuses on the private medical sector and the private pharmaceutical sector, and their interactions with the public medical sector. Traditional medicine is not a focus of the assessment.

The private health sector is an important player in the DRC’s health system, but the extent of its contributions is largely unknown. Private providers, especially faith-based organizations (FBOs), grew in scale during the late 1990s and early 2000s to fill gaps that emerged in the public health sector as a result of political and civil destabilization. As the government sought to reestablish itself and improve health outcomes, it recognized the importance of private providers and sought to integrate them into the larger health system. As a result, the private sector is now mentioned as a key partner in several MOH strategies, policies, and plans. However, public-private engagement for health remains nascent, with the notable exception of FBOs.

The government's health system decentralization initiative has posed challenges to the MOH's efforts to engage the private health sector. Several factors have further impeded efforts to engage and regulate the private sector: overlapping areas of responsibility between the central and provincial health systems, financial and human resource challenges, and limited data about the private sector. The sector itself faces numerous constraints related to the availability of commodities, shortages of adequately trained staff, and the affordability of private health care. Meanwhile, continued political uncertainty has deterred corporate investment in the health system. Despite these challenges, there are many opportunities for the DRC government and donors to better mobilize private actors and improve health outcomes.

Key findings of the assessment are organized by World Health Organization's (WHO's) six health system pillars.

Leadership and governance

On paper, the DRC's private health sector is closely regulated by the MOH. Legislation covers the opening of health facilities, the pricing of products and services, the importation of products, and the establishment of *mutuelles*. However, enforcement of such legislation has been challenging due to the limited availability of inspectors, ongoing decentralization, and opaque regulatory processes. Stakeholders indicated a lack of familiarity with MOH regulations and a lack of understanding about which directorate or division to consult. This highlights inadequate integration of the private health sector in the decentralization process as well as the barriers the private sector faces when attempting to comply with regulations.

While the MOH is eager to further engage the private health sector, as reflected in many of its strategies and policies, this has not yet translated into widespread practice. The government has the potential to interact with the private health sector in a number of ways, as a regulator, a convener of public-private stakeholder groups, and a facilitator of public-private partnerships (PPPs). While the MOH has established the groundwork to govern public-private collaboration, the processes, institutions, and frameworks need to be clarified and strengthened.

Challenges also exist on the private sector side. Alliance du Secteur Privé de la Santé (ASPS), the private health sector alliance, is the main organization for private providers. It aims to improve the governance and performance of the private sector by strengthening its visibility and federating all private sector stakeholders (ASPS-RDC 2017). However, as of February 2019, the ASPS

was still finalizing its legal authorization to operate. As a result, public-private engagement for health—especially within the for-profit sector—has been limited, with few opportunities for dialogue. There is growing interest in multi-sectoral fora to advance collaboration (Box 1). While the ASPSP could potentially act as the intermediary for the private sector and facilitate public-private collaboration, its role and mandate to advocate for the private sector are unclear.

Box 1. Interest in expanding public–private collaboration

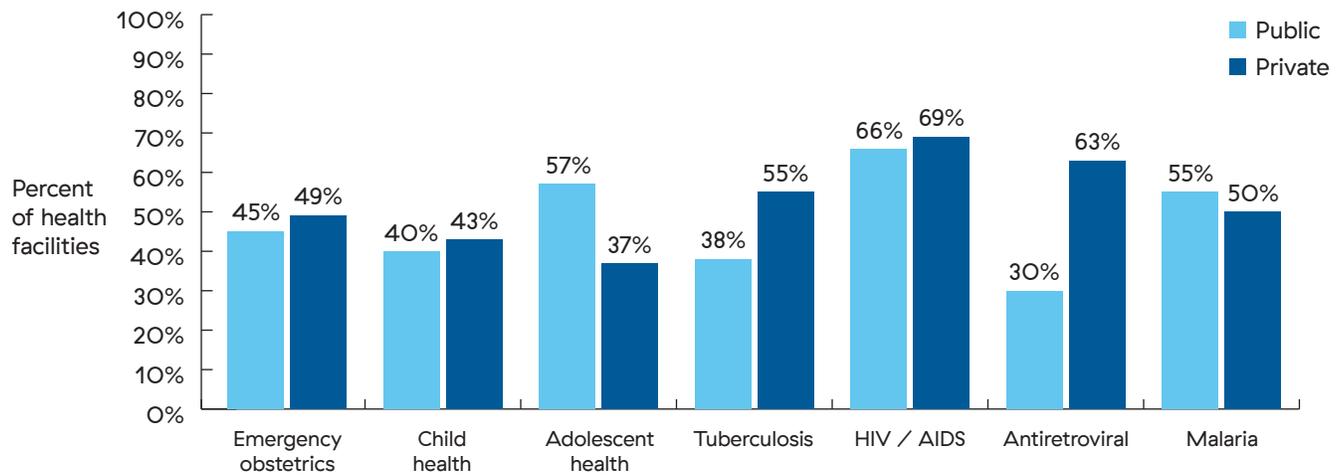
During the assessment launch event in October 2017, public and private sector participants expressed interest in improving collaboration by including the private sector’s perspective in public dialogue, having the public sector provide more support to the private sector, and improving referral systems between the two sectors. Participants identified multiple challenges: distrust on both sides, the perception that the private sector had inadequately applied MOH policies and norms, perceptions that the MOH could improve engagement with the private sector, and lack of strong private sector governance.

Beyond general engagement and dialogue, actual PPPs for health in the DRC are still nascent. The legal framework for PPPs is piecemeal—consisting of laws to regulate partnerships, approval requirements by the Ministry of Justice, ministerial decrees for access to facilities, and conventions with certain partners to formalize their relationship. MOH restructuring has created institutional barriers to the quick decision making and autonomy needed to create and manage PPPs. Additionally, the MOH lacks a clear strategy for health PPPs. Nonetheless, the MOH is keen to jump-start PPPs in health.

Service delivery

The private health sector is an important source of health services in the DRC. Private facilities account for 44 percent of outpatient care and 25 percent of inpatient care (Wang et al. 2016). Eighty percent of facilities offering basic surgery are private (MOH 2014b). Private facilities also score higher than public facilities in operational capacity, at 41 percent and 18 percent, respectively. On average, private facilities, including for-profit facilities, FBOs, and NGOs, are more likely than public facilities to have basic infrastructure—including access to electricity, clean water, sanitation, and communication equipment—and essential medicines (Figure 2). However, many facilities in both sectors still do not have access to these components.

Figure 2. Availability of medicines and products in health facilities by type of service



Source: MOH 2014a

Private facilities largely operate independently, and often lack training, qualified personnel, equipment, supplies, salaries, or incentives to provide quality services. Government efforts to better integrate private facilities within the health system have been limited. If the DRC is going to address its high maternal and child mortality rates, it will need to mobilize the private sector to increase access to FP, nutrition, and maternal and child health products and services.

The private sector's role varies across health areas. The private sector is an important source of modern FP methods, with private facilities, pharmacies, and shops serving 60 percent of modern FP method users (MPSMRM, MOH, and ICF International 2014). At the same time, service provision for FP is limited in the private sector: only 32 percent of private facilities have FP services available, including a room for FP service provision and staff trained in FP (MOH 2014a). Increasing access to FP products and services is important as the DRC seeks to address its high maternal and child mortality rates. However, private providers do not currently receive continuing training on FP, which limits their ability to deliver the full range of modern methods.

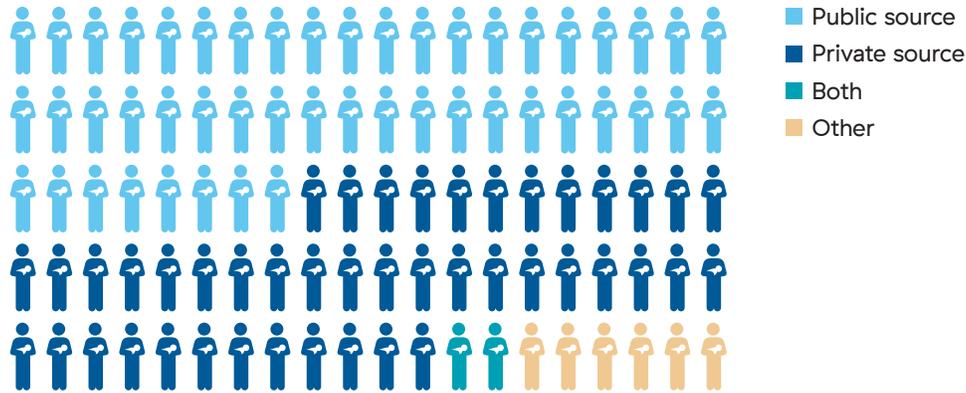
The majority of live births—almost two-thirds—occur at public facilities, compared to 16 percent at private facilities (MPSMRM, MOH, and ICF International 2014). This is true despite the fact that private facilities are more likely to offer key maternal health service inputs. The 2014 WHO Service Availability and Readiness Assessment (SARA) found that private facilities were more likely than public ones to have antenatal care guidelines; clinicians trained in antenatal care and delivery; and relevant equipment, tests, and commodities such as antibiotics and iron and folic acid tablets (MOH 2014a).

The Plan Stratégique National de Prise en Charge Intégrée des Maladies du Nouveau-né et de l'Enfant 2017–2021 highlights disparities in coverage among various child health services, components, and geographic areas. In response, the strategy calls for strengthening provider capacity; increasing the percentage of health trainings with integrated management of neonatal and childhood illnesses (IMNCI); scaling up family- and community-based IMNCI practices nationwide; improving the availability of IMNCI drugs; strengthening management of IMNCI data; and ensuring coordination of IMNCI at all levels of the health system.

Eighty-four percent of private providers offer preventive and curative child health services (MOH 2014a). While private providers are less likely to provide vaccination services than public providers (63 percent versus 83 percent), private facilities are slightly more likely to have key child health inputs, such as guidelines for IMNCI and growth monitoring; staff trained in IMNCI; and relevant medicines and products, such as oral rehydration solution and zinc tablets (MOH 2014a). Among caregivers who seek sick child care outside the home for fever, acute respiratory infection, or diarrhea, 44 percent sought treatment or advice from the private sector (Figure 3). Most go to nonclinical sources, such as pharmacies, shops, or markets (81 percent), with less than one-quarter going to a private clinical facility, such as a hospital, doctor's office, or clinic (SHOPS Plus 2017). However, private outlets have played a limited role in addressing malnutrition among young children and infants (Box 2).

Figure 3. Source of child health care in the DRC

Among caregivers who seek sick child care outside the home, **48%** seek treatment or advice from public sector sources and **44%** from private sector sources.



Source: SHOPS Plus 2018

Box 2. Opportunities to improve private sector engagement and nutritional outcomes

Chronic malnutrition is widespread in the DRC, with an estimated 6.3 million young children experiencing stunting (MPSMRM, MOH, and ICF International 2014). In 2016, the MOH and key stakeholders launched an advocacy effort to promote nutrition (MOH [n.d.]). They called for coordination and high-level engagement among stakeholders via a robust institutional framework, as well as interventions focused on the first 1,000 days of life. However, financial commitments have not been fulfilled, and most nutrition-specific interventions are donor-supported. Interviews with stakeholders revealed a lack of services and products in the private sector for malnourished children. Therapeutic products are typically offered for free as part of humanitarian interventions, making it a less profitable market for private providers.

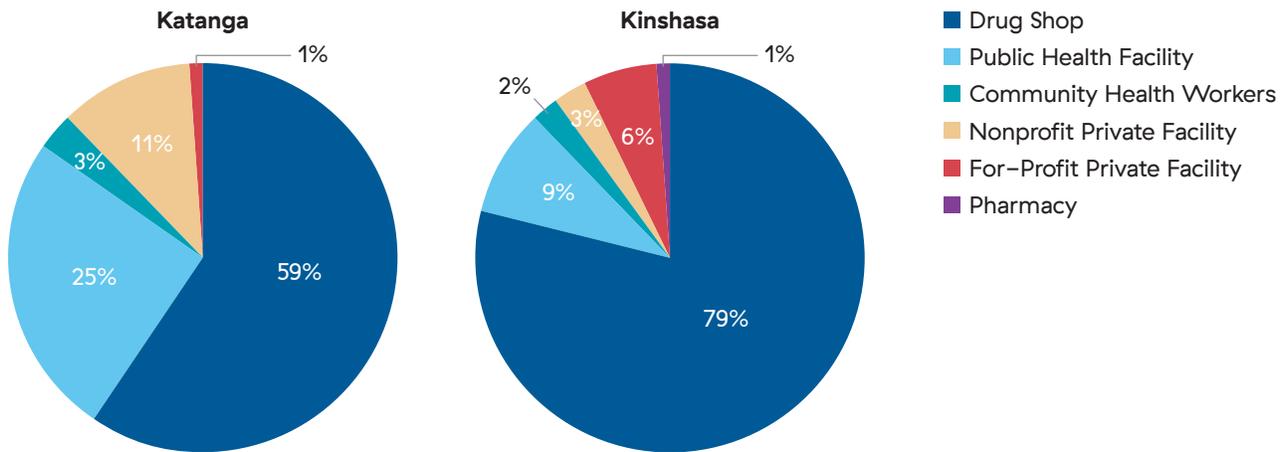
Access to essential medicines

The supply chain in the DRC is large, complex, largely unregulated, and characterized by fragmentation and duplication. This is true in both the public and private sectors. In 2009, there were 99 distribution channels for the public and nonprofit sectors, with 85 percent of partners using their own procurement agencies, warehouses, and distribution systems, causing waste and duplication (Ntembwa and van Lerberghe 2015). While the private sector plays a significant role in procuring and distributing medicines and supplies to private pharmacies, drug shops, clinics, and hospitals, its distribution system is even more fragmented than the public sector's. A shortage of reliable data on the main actors makes the situation even more challenging: because registration and regulation are ineffective, the government can only estimate the number of private importers, wholesalers and drug shops.

The manufacturing, procurement, and distribution processes contribute to the fragmentation of the supply chain. Only 10 percent of commercial sector pharmaceutical products in the DRC are manufactured locally (Office Fédéral des Migrations 2014), and most production units are in Kinshasa (MOH 2011). Local pharmaceutical manufacturing is highly dependent on imported inputs and packaging equipment, and multiple import taxes increase costs and lower price competitiveness, discouraging local production (MOH 2011). Nineteen nongovernmental nonprofit regional distribution centers (*centrales de distribution régionale des médicaments*) distribute pharmaceuticals to public and private nonprofit facilities across the country (ASRAMES 2016). While most of these centers are part of FEDECAME, a central procurement federation, several procure through other channels, which they can access more easily.

The retail pharmaceutical sector is dominated by unregistered drug shops that call themselves “pharmacies.” Estimates of their number vary from 8,000 to 10,000, compared to 109 registered pharmacies (Office Fédéral des Migrations 2014; 7sur7.cd 2015; Order of Pharmacists 2017; MOH 2017a). Most of the authorized pharmacies are in Kinshasa, and all are confined to major urban areas where consumers with more purchasing power reside (MOH 2017a). The authorized pharmacies represent 59 percent and 79 percent of contraceptive-selling outlets in Katanga and Kinshasa, respectively (Figure 4). Drug shops are typically operated by an owner or staff member without any pharmaceutical training; most dispense drugs without a prescription, encouraging the common practice of self-medication. Unregulated drug outlets compete with registered pharmacies (operated by fully qualified pharmacists), making qualified pharmacists less likely to open and operate quality pharmacies. Drug shops also receive little or no credit from wholesalers; stockouts occur frequently, and are generally due to the shops' lack of liquidity rather than to unavailability of medicines.

Figure 4. Outlets stocking modern contraceptives



Note: N = 350 for Katanga and N = 433 for Kinshasa. Numbers in the Katanga pie chart do not sum to 100 due to rounding.

Sources: Population Services International and FPwatch 2015; SHOPS Plus 2017; President's Malaria Initiative 2017

An estimated 40–45 percent of medicines sold in the DRC are counterfeit (Office Fédéral des Migrations 2014). Poor quality medicines circulate in part because the MOH lacks the resources to implement a strong quality assurance program (MOH 2011). The MOH does not have a national drug control laboratory of its own; instead, it relies on laboratories at the University of Kinshasa, the Congolese Office of Control, and two private laboratories. Many of these do not have adequate equipment and cannot perform specialized tests (MOH 2011). The Office of Control laboratory is the only one accredited to ISO 17025 standards (WHO 2015) and has primary responsibility for drug testing.

Financing

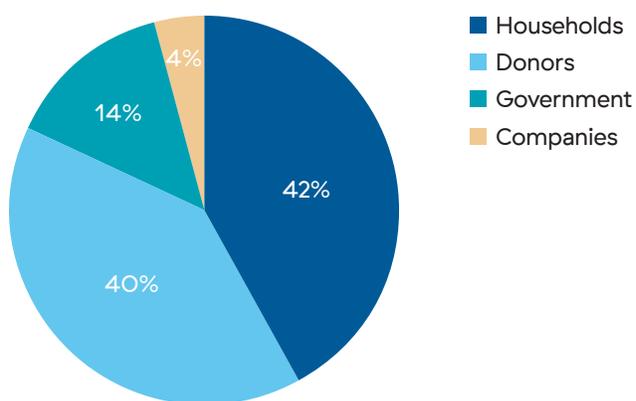
Financing is essential to improving access to health care services in the DRC. The assessment considered two aspects of financing: (1) health financing or demand-side mechanisms, such as insurance, which can reduce financial barriers to accessing care at private facilities and provide greater financial protection against catastrophic health spending, and (2) access to financing for private providers to expand operations.

Health financing

The health financing landscape in the DRC faces several challenges, including low allocation of public resources to health, insufficient risk-sharing and health financing mechanisms, and fragmentation of official development assistance.

Government financing for health has fluctuated in recent years and remains below the 15 percent Abuja Declaration threshold (WHO 2011). Households represent the largest proportion of health expenditure, followed by donors (Programme National des Comptes de la Santé 2016); together, the two account for 82 percent of total health expenditures. More than half of that spending (42 percent of total health expenditures) comes from households (Figure 5).

Figure 5. Health expenditure by source of financing, 2014



Source: Programme National des Comptes de la Santé 2016

Private health financing programs currently have a limited role in the DRC—they cover few citizens and the country is beginning to open up to private insurance companies. Current programs include health mutuelles and benefit programs sponsored by employers for employees and their families. Private health insurance and other health benefit programs are concentrated among formally employed people in wealthier income quintiles and reach no more than 3 to 4 percent of the population (MPSMRM, MOH, and ICF International 2014). Employers are required by law in the DRC to provide health benefits to employees and their families. Employers, particularly in remote work sites, may provide on-site health services. In urban areas, they typically contract with an individual or a network of providers, either directly or through a third-party administrator. The benefits vary in type and amount, with some employers excluding specific services or offering additional benefits to managers.

Mutuelles are private, community-owned insurance programs that could help extend insurance to a greater proportion of the population. While the government published a law in February 2017 that clarifies the fundamental

principles for organizing and governing mutuelles, these private insurance programs remain nascent in the DRC (Mutabunga bin Lubula et al. 2017). Although there are cases of mutuelles helping reduce out-of-pocket payments, many face persistent external constraints, including a lack of trust and understanding of insurance; inadequate provision of care, which negatively affects quality and efficiency; and chronic health system underfunding and people's inability to pay for health care.

Due to the relatively limited scope of health financing mechanisms, the private insurance industry was not regulated until recently. Legislation was passed in 2015 to privatize the insurance sector, and in 2016, a presidential decree established an insurance regulatory body, the Autorité de Régulation et de Contrôle des Assurance (ARCA). At this early stage, ARCA is still determining how it will regulate private health insurance, including mutuelles and other community-based schemes that target low-income and informal populations (ARCA 2017).

Access to finance

While the government is working to improve the DRC's business climate, limited access to capital is a significant challenge that impedes private providers' ability to expand and offer high-quality services. While the DRC's financial sector comprises 19 licensed banks and 120 microfinance institutions and cooperatives (export.gov 2017b), the country has one of the lowest bank penetration rates in the world: only 11 percent of the population has a bank account (World Bank 2017c). Family members and friends are the main source of loans, followed by informal lenders who may not be trustworthy or may impose higher interest rates.

Most private health care providers in the DRC are considered micro, small, or medium enterprises (MSMEs). To expand and improve their services, providers need access to financial resources. Banks interviewed during this assessment stated that private health providers are eligible for loans under the same conditions as any MSME; however, MSMEs in the DRC face a number of constraints to access financing. For example, loan terms are often not feasible, with loan maturities limited to six months or less, and interest rates of around 16 to 18 percent (export.gov 2017b). While microfinance institutions offer an alternative source of financing for health businesses, they pose similar challenges. Such institutions tend to offer smaller loans than bank loans, with higher interest rates and shorter loan terms. Box 3 describes how two private health practices have obtained financing.

Box 3. Examples of financing

The first loan that the **Centre Médical du Centre Ville** (Lubumbashi) obtained was for the construction of a new site. It has taken out several major loans, including a current loan for a large site expansion. The loan term is three years, at 25–26 percent interest, with the title to the property and inventory as collateral.

Health Centre Kalebuka (Lubumbashi) auto-finances some of its operational costs by selling water at the pump, which was installed by World Vision, inside the compound. The income from this side business helps the center ensure it has permanent electricity.

Many private health facilities in the DRC are self-funded, often starting with an initial investment from the owner or a loan from a family member or friend. Interviewed providers relayed the difficulty of accessing formal financing due to high interest rates, significant collateral requirements, and restrictively short loan terms. Providers also lacked understanding of the information needed to prepare a loan proposal. Health care businesses are typically run by clinicians without business and financial management skills, making it more difficult for them to assess the potential return on investment or present attractive loan requests to banks and microfinance institutions.

Health workforce

There is little publicly available data on the size and scope of the private health workforce in the DRC. However, the limited available data and anecdotal evidence suggest that the private sector trains and employs a large number of health workers. Additionally, the private sector plays a role in regulating human resources for health (HRH) through cadre-specific orders, health unions, and associations that advocate for the health workforce and develop HRH policies on issues such as remuneration and health worker safety. The public sector plays a significant role in the development, supervision, and regulation of the private health workforce.

Provider training

There are three main types of health training institutions in the DRC: secondary education institutions, higher education institutions for technical medicine, and universities with faculties of medicine and pharmacy. Under the government's decentralization reforms, medical training institutes fall under the oversight of

provincial governments, and there is no centralized data repository or process for sharing information about health workers trained in either the public or private sectors. The majority of secondary-level institutions and universities with faculties of medicine and pharmacy are private, whereas the higher education institutions are almost evenly split between the public and private sectors.

Overlapping mandates, the involvement of many stakeholders, and a rapidly growing number of private training institutions have created fragmented accreditation and compliance processes that do not adequately ensure the quality of training institutions. Stakeholders cited examples of municipalities accrediting training institutions that did not meet the necessary standards. Furthermore, if the MOH recommends closing a noncompliant training institution, it cannot enforce that recommendation.

Problems with the quality of training persist in many of the private institutions. Stakeholders reported that the content of different training levels was not differentiated, and many of the private training institutions lack infrastructure, equipment, qualified teachers, and sites suitable for practical training. Despite challenges with the quality of their programs, training institutions continue to provide certificates to their students.

Human resources for health

After medical professionals complete their training, a significant number are employed by the private sector. The 2014 WHO SARA report found that trained health staff and health protocols were slightly more available in the private sector in most health areas, except for malaria (MOH 2014a). The geographic distribution of health workers shows large disparities between Kinshasa and the rest of the country, especially for physicians (World Bank 2014). Available data from reports and stakeholders indicate that across the public and private sectors, there is a disproportionately high percentage of practicing nurses and a shortage of physicians, pharmacists, and midwives (Ntembwa and van Lerberghe 2015; Office Fédéral des Migrations 2014).

Dual practice is commonplace in the DRC due to lack of compensation for public sector staff. Wage payments in the public sector are irregular, and the pension system is not functioning. Health workers are likely to earn more money working in the private sector than in the public sector, making dual practice financially attractive (Bertone and Lurton 2015).

Health information systems

Limited telecommunications and power infrastructure have posed challenges to implementation and scale-up of the national health information system, *Système National d'Information Sanitaire* (SNIS). Adding to these challenges, only 26 percent of the population has access to mobile SIM (GSMA 2017), and the DRC's internet and broadband market has been slow to grow.

The MOH uses several health information systems that have implications for the private sector. DHIS2 is the SNIS platform for data management and analysis, health program monitoring and evaluation, facility registries, service availability mapping, and some logistics and supply chain management. The MOH rolled out DHIS2 across all 516 health zones in 2016. While more than 89 percent of the country uses the new platform (MOH 2017b), rates of private sector participation in DHIS2 vary across provinces. One of the biggest achievements of the DHIS2 transition is the creation of a registry of private sector facilities as part of the public health reporting system. Nonprofit private facilities that register in the system receive training on the new paper-based data collection tools, and receive many of the same free products as public facilities (e.g., vaccines and malaria medications). In return, registered private facilities summarize data on key health indicators monthly and participate in public health service delivery, such as the administration of vaccines on monthly vaccine days.

In 2014, IMA World Health and IntraHealth began piloting iHRIS, an electronic, open source health workforce information system in Kasai province. iHRIS helps health systems in low-resource settings collect and manage data on human resources for health numbers, skills, qualifications, locations, and other important factors for decision making. These data can help countries address shortages in human resources and other barriers within the health sector. As one example of the pilot's success, it led to the identification and removal of 2,000 ghost workers who were drawing a salary without actually working. iHRIS currently includes FBO providers but does not yet have strong engagement with for-profit and other types of nonprofit providers.

Photo (facing page): MONUSCO/Myriam Asmani

Recommendations



Recommendations

The following recommendations build on the findings of the PSA and suggest opportunities for the government and development partners to integrate the private sector in health system decision making and planning, improve regulation of the private sector, and increase private sector investment. This assessment revealed that there is political will to increase private sector engagement in health that has not been mobilized due to public sector decentralization; political instability; insufficient funding, transparency, and data that inhibits the MOH's ability to regulate the private sector; and commodity and human resource bottlenecks that threaten the quality and accessibility of health services. Going forward, these recommendations can help move the private health sector agenda forward to strengthen the DRC's health system and improve health outcomes.

Leadership and governance

Provide targeted technical assistance to strengthen national and regional public-private dialogue, including strengthening ASPS's presence, advocacy, and value to the private health sector.

As a convening entity for the private health sector, ASPS can offer a much-needed forum for industry groups and professional bodies to debate important

issues, and an avenue for government and donors to engage with the private health sector. Strengthening forums for public-private dialogue at the national and local levels will enable the private sector to advocate with a unified voice and strengthen PPPs for a stronger, more organized, and better-coordinated health sector. New forums at the national and health zone levels could be established, or existing platforms could be repurposed.

Build the MOH's capacity to better leverage PPPs, including support to develop a health PPP strategy and strengthen the capacity of the Direction de Partenariat to transition to a higher profile PPP unit and serve as focal point for private sector engagement.

A health PPP strategy should include a general PPP framework, PPP definition, delineation of institutional coordination and responsibilities, a list of potential projects and award procedures, and an agreement template. A higher profile PPP unit could also strengthen engagement with the private health sector, including pharmaceutical, medical device, and technology companies (e.g., Philips and MasterCard) to pilot, introduce, and/or scale up new products that improve access to and delivery of health services.²

² In May 2018, as a result of this assessment and its recommendations, the MOH successfully operationalized this recommendation, creating a new PPP Unit to support greater focus on PPPs in health.

Service delivery

Collect additional information on service delivery in the private sector.

Limited information is available about the demand for products and services in the private sector, the number of private providers, the role the private sector plays in the provision of products and services, and the quality of the products and services they provide. Stakeholders can improve their understanding of private providers' role in service delivery by incorporating questions about the private sector in upcoming studies, such as WHO's next SARA, and investing in complementary studies.

Make use of and strengthen existing provider networks and franchises to reinforce private provider training on FP counseling and service provision.

Although there is a general perception of higher quality services in the private sector, providers often offer a limited range of services due to a lack of clinical skills. Furthermore, donor-sponsored programs tend to exclude the private for-profit sector; as a result, private providers often do not receive regular updates about FP and other services. Donor and government stakeholders should consider strategies for reaching private providers with new and refresher trainings for FP and other services.

Explore opportunities to expand current PPP efforts for vouchers to include FP commodities.

In the DRC, cost is a barrier to the use of FP services in the private for-profit sector, especially for long-acting methods such as implants (MPSMRM, MOH, and ICF International 2014). Donors and the DRC government should consider strategies to reduce prohibitively high costs for FP commodities, such as vouchers.

Adopt an integrated approach and support strategic interventions to improve child health case management and engage the private sector in nutrition programs.

This assessment revealed political will for working with the private sector to improve child health outcomes. Donors and the DRC government should therefore increase involvement of private sector actors to implement the 2017-2021 IMNCI strategy. Doing so would include creating a conducive policy and regulatory environment; ensuring wide availability of high-quality, affordable products; generating demand and educating caregivers about appropriate care-seeking behavior; and improving private provider knowledge and skills. Additionally, donors and the MOH could better engage the private sector in nutrition programs by promoting local food fortification, using private transporters to move therapeutic products to difficult areas, and increasing private sector participation in strategy and planning.

Access to essential medicines

Encourage collaboration between donors, international NGOs, and FEDECAME to improve the national system for commodity forecasting and procurement.

International organizations can support FEDECAME by coordinating procurement and distribution with the network, and by expanding the existing practice of contracting out storage and distribution to regional distribution centers. In particular, efforts should consider how the network can be more responsive to international NGOs' needs to integrate these programs into the FEDECAME system. Additionally, existing donor programs can provide technical support to FEDECAME to include cost controls, marketing, and risk management.

Encourage the creation of pharmacy and drug shop networks.

Creating links among pharmacies and drug shops could bring order and regulation to the fragmented and unregistered pharmaceutical retail sector. The government could help pharmacies and drug shops achieve economies of scale by giving them access to a guarantee fund for loans designated for the expansion of drug outlet networks, conditioned on compliance with national siting and registration requirements and the opening of locations in underserved areas.

Strengthen the private pharmaceutical supply chain, from manufacturing to sale.

To reduce dependence on foreign imports and promote economic growth, the government could encourage local production of quality medicines by revising the customs and taxation regime to incentivize local manufacturing through policy reform, providing technical support, and increasing access to financing. Such reforms could include taxing imported drugs that are ready for sale at a higher rate than that for pharmaceutical ingredients imported for manufacturing and production. Donors and implementing partners should support local manufacturers to improve quality; build the capacity of regional distributors to handle medicines; build public sector capacity to oversee and enforce drug regulations and inspect pharmacies; raise the quality standards of drug wholesalers; and define a scope of practice for a new, formal second tier of drug shops that would be able to sell a limited range of essential medicines.

Establish a searchable online database of registered drugs and develop an anti-counterfeit strategy.

Stakeholders expressed concerns about the quality of pharmaceuticals in the private sector in the absence of a strong, easily accessible system to track commodities and supplies. Increasing access to

information about which drugs are registered would help address the serious problem of counterfeit drugs in the DRC. A user-friendly, more interactive online database of registered drugs could serve as an effective regulatory tool.

Financing

Health financing

Strengthen health financing programs by building the capacity of mutuelles and private providers.

Key areas of needed support include product design, pricing, risk management, and administrative processes through mutuelle support organizations. Donors can also help mutuelles test scale-up models, in partnership with microfinance institutions, associations, or cooperatives. This support could include supporting a third-party administrator or employer to develop and scale up an improved model to administer an employee benefit program. At the same time, private providers can improve their readiness to participate in mutuelles and other health financing initiatives by developing a scalable provider network with common quality, pricing, and treatment standards.

Support ARCA and other stakeholders to develop and implement an effective framework for regulating and strengthening the mutuelle sector.

Effective regulation of mutuelles will require a way for ARCA, schemes, and other key stakeholders to implement and monitor adherence to common performance standards. These standards can focus on clinical care, service mix, pricing and billing practices, reporting, and patient service standards. Growth and expansion of the sector will also require building a stronger culture of insurance in the country. Donors can collaborate with ARCA, nascent insurance companies, mutuelles, health providers, and other actors to educate consumers about insurance, and pilot an insurance program targeted at informal, vulnerable groups.

Collaborate with mutuelles and corporate sponsors to cover FP and preventive health services and products.

Most health financing programs (including mutuelles and those that are sponsored by employers) focus on curative care and not preventive services such as FP. Covering FP could be a cost-effective investment for sponsors of health financing programs.

Access to finance

Work with financial institutions and providers to expand lending to the health sector.

The DRC government and donors should pursue measures that mitigate supply-side barriers and educate financial institutions about the private health sector to help increase the private health sector's ability to access financing. This support could include establishing a risk-sharing mechanism with specific banks, such as a USAID Development Credit Authority portfolio guarantee, and providing technical assistance to banks to reduce the cost of lending to the health sector. On the provider side, donors can support programs to provide business and financial management training and counseling for private health providers to help them understand what is needed and meet the terms to access financing.

Assess the landscape for health enterprises, and determine the most promising activities to jump-start health companies.

There are not many organizations in the DRC positioned to help health enterprises become attractive to investors, and current incubator efforts do not focus on health. Activities such as creating a seed fund for promising entrepreneurs and identifying potential investors and priority health areas could increase opportunities for health enterprise and innovation. Additionally, a health enterprise conference in Kinshasa could build on the innovation activities in other sectors.

Health workforce

Increase coordination among stakeholders involved in HRH management to improve training and accreditation systems, as well as resource planning.

The MOH's new Directorate of Human Resources could collaborate with other ministries to establish a coordinating body that would facilitate and enforce the accreditation, regulation, and standardization of high-quality training programs. This entity could also help define regulations, roles, responsibilities, and authorities at the national, provincial, and local levels. Donors can also support the MOH to work with partners, including professional orders and provider associations, to improve training programs across public and private training institutions, including programs for trainers, scholarships, and e-learning opportunities. Finally, donors and implementing partners can help the MOH collaborate with public and private sector stakeholders to better map the human resources available in the private sector across key health areas to identify and address gaps, and incorporate the private for-profit sector in the MOH's staffing plan.

Health information systems

Review and improve FP and child health indicators in DHIS2 to improve services, reduce stockouts, and track contraceptive prevalence and demand.

At the time of the assessment, DHIS2 FP indicators included the number of specific contraceptive products delivered, some program-related data, and the number of new and renewing users. However, these indicators do not paint a complete picture of FP commodity supply or demand. Stakeholders could conduct a review of DHIS2 to identify opportunities to add and improve variables and collect systematic and actionable data.

Support further scale-up of DHIS2 and other health information systems with an emphasis on increasing interoperability and private sector engagement.

The percentage of private facilities in the DRC registered in DHIS2 is unclear. Of the facilities that are registered, nearly 3,000 are not categorized as public, private, or faith-based, making it difficult to assess differences in reporting by sector or health indicator. Conducting a private sector survey to map private health facilities in the DRC, including pharmacies and drug shops, could improve participation in DHIS2. To increase the usefulness of the platform to private providers, stakeholders should also look at how DHIS2 can be used to develop and distribute actionable data dashboards for decision making in the private sector. Finally, as the iHRIS scales up to address the significant health workforce challenges in the DRC, stakeholders should more strongly engage with for-profit and nonprofit providers to help balance and distribute human capital.

Three-year road map for action

The PSA team summarized opportunities to strengthen private sector engagement in health in a three-year road map. In a consultative workshop, stakeholders from the public and private sectors provided additional guidance and validated the road map. The road map prioritizes recommendations, provides a timeline, and outlines key stakeholder responsibilities. Table 2 summarizes the recommendations and stakeholder leadership responsibilities; see the full PSA report for additional information.

Conclusion

The goal of this brief is to inform health policy and planning that increases the role of the private sector and improves health outcomes. It should be used by the government of the DRC and stakeholders to inform future investments in the private sector. The DRC has established many of the policies and institutions required to facilitate private sector engagement in health; this brief will help stakeholders operationalize these policies by recommending measures that foster collaboration and transparency across the private and public health sectors. Stakeholders can strengthen nascent policies, regulations, and institutions to mobilize the public and private sectors to deliver high-quality, accessible, and effective care throughout the DRC.

Table 2. Key road map recommendations and stakeholder responsibilities

Recommendation	Public	Private	International development partners
Strengthen public–private dialogue	X	X	
Build the MOH’s capacity to better leverage PPPs	X		
Collect additional information on service delivery in the private sector	X	X	X
Reinforce private provider training on FP counseling and service provision	X	X	X
Expand current PPP efforts for vaccines to include FP commodities	X		X
Improve child health case management and engage the private sector in nutrition programs	X	X	X
Encourage stakeholder collaboration to improve commodity forecasting and procurement	X	X	X
Create pharmacy and drug shop networks	X	X	
Strengthen the private pharmaceutical supply chain	X		X
Establish online database of registered drugs and develop anti–counterfeit strategy	X		
Build capacity of mutuelles and private providers	X		X
Support ARCA and other stakeholders to regulate and strengthen the mutuelle sector	X		X
Collaborate with mutuelles and corporate sponsors to cover FP and preventive services/products	X	X	
Expand lending to the health sector	X		X
Determine the most promising activities to jump–start health enterprises	X	X	
Improve training and accreditation systems for the health workforce, as well as HRH planning	X	X	X
Improve FP and child health indicators in DHIS2	X		
Scale up DHIS2 and other health information systems, with emphasis on interoperability and private sector engagement	X		X

Note: Public sector actors include all government agencies; the private sector includes private for–profit and nonprofit organizations and federations that represent the private sector; international development partners include donors and implementing partners that are based outside of the DRC.

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Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a five-year cooperative agreement (AID-OAA-A-15-00067) funded by the United States Agency for International Development (USAID). The project strategically engages the private sector to improve health outcomes in family planning, HIV, maternal and child health, and other health areas. Abt Associates implements SHOPS Plus in collaboration with the American College of Nurse-Midwives, Avenir Health, Broad Branch Associates, Banyan Global, Insight Health Advisors, Iris Group, Population Services International, and William Davidson Institute at the University of Michigan.



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