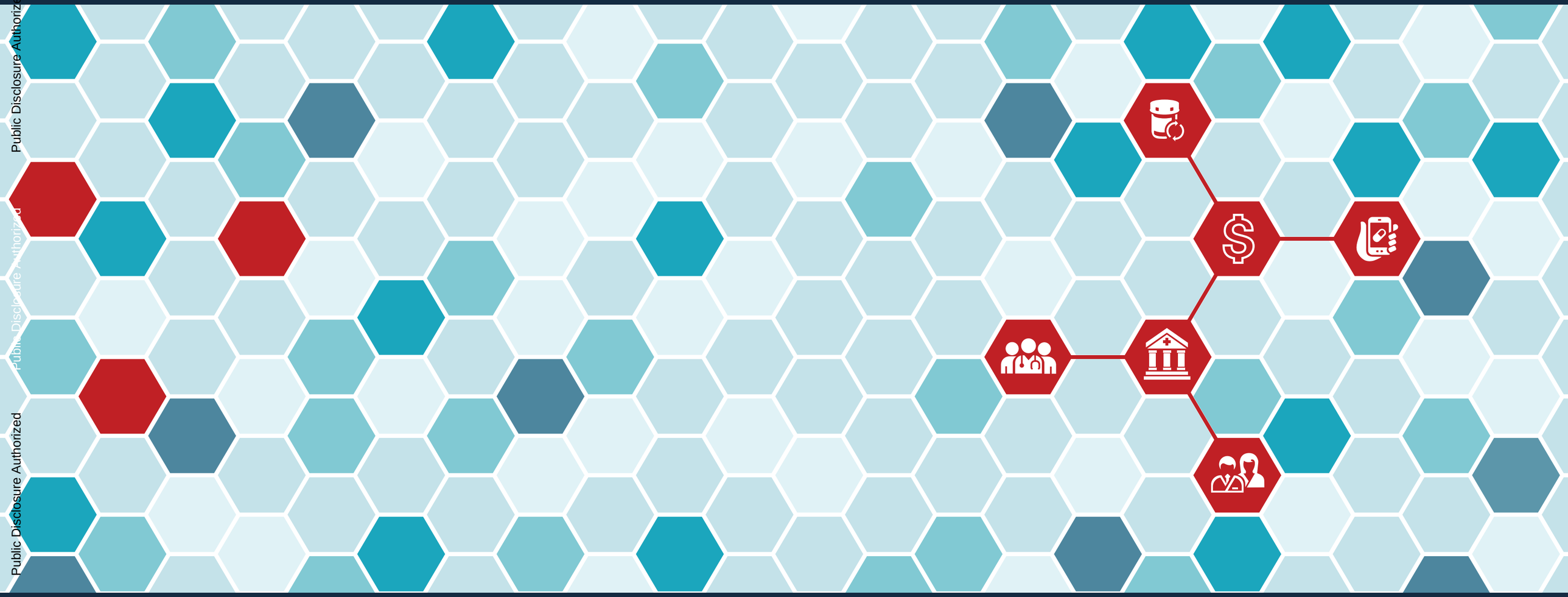

The Role of the Private Sector in Improving the Performance of the Health System in the Democratic Republic of Congo

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Table of Contents

TABLE OF TABLES

TABLE OF FIGURES

Acronyms

ABEF	Association pour le Bien-Être Familial
Abt	Abt Associates
ACT	Artemisinin-based combination therapy
ARCA	Autorité de Régulation et de Contrôle des Assurances
ASF	Association de Santé Familiale
ASPS	Alliance du Secteur Privé de la Santé
ASRAMES	Association Régionale d'Approvisionnement en Médicaments Essentiels
B&MGF	Bill & Melinda Gates Foundation
BDOM	Bureau Diocésain des åuvres Médicales/catholiques
CDR	Centrale de Distribution Régionale des Médicaments
CLC	Community life center
CNMN	Comité National Multisectoriel de Nutrition
CNP-SS	Comité National de Pilotage du Secteur de la Santé
CODESA	Comité de Développement de l'Aire de Santé
CPN	Commission Pharmaceutique Nationale
CPR	Contraceptive prevalence rate
CTMP	Comité Technique Multisectoriel Permanent pour le repositionnement de la planification familiale en RDC
DCA	Development credit authority
DHIS2	District Health Information System 2
DHS	Demographic and Health Survey
DPM	Direction de la Pharmacie et du Médicament
DPS	Division Provinciale de la Santé
DRC	Democratic Republic of Congo
FBO	Faith-based organization
FDI	Foreign direct investment
FEDECAME	Fédération des Centrales de Distribution des Médicaments Essentiels
FINCA	Foundation for International Community Assistance
FP	Family planning

GAHN	Global Access Health Network
GDP	Gross domestic product
GSK	GlaxoSmithKline
HRH	Human resources for health
iHRIS	Human Resource Information Solution
IFC	International Finance Corporation
IHP	Integrated Health Project (USAID)
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
LMIS	Logistics Management Information System
MCH	Maternal and child health
mCPR	Modern contraceptive prevalence rate
MESP	Mutuelle de Santé de l'Enseignement Primaire, Secondaire et Professional
MFI	Microfinance institutions
MOCC	Mouvement Ouvrier Chrétien du Congo
MSME	Micro, Small, and Medium Enterprises
MSP	Ministère de la Santé Publique
NCIFP	National composite index to rate the enabling environment for family planning
NGO	Nongovernmental organizations
OCC	Office Congolais de Contrôle
ORS	Oral rehydration solution
PBF	Performance-based financing
PEPFAR	President's Emergency Plan for AIDS Relief
PMA2020	Performance Monitoring and Accountability 2020
PMI	President's Malaria Initiative
PMTI	Private medical training institute
PNAME	Programme National d'Approvisionnement en Médicaments Essentiels
PNDS	Plan National De Développement Sanitaire
PNLP	Programme National de Lutte contre le Paludisme
PNPMS	Programme National de Promotion des Mutuelles de Santé
PNSR	Programme National de Santé de la Reproduction
POMUCO	Plateforme des Organisations Promotrices des Mutuelles de Santé du Congo
PPP	Public–private partnership
PRONANUT	Programme National de Nutrition
PSI	Population Services International

SARA	Service Availability and Readiness Assessment
SBC	Social and behavior change
SNIS	Système National d'Information Sanitaire
TB	Tuberculosis
TPA	Third-party administrator
U5M	Under-five mortality
UHC	Universal health coverage
UMUSAC	Union des Mutuelles de Santé du Congo
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
UHC	Universal Health Coverage
WB	World Bank
WHO	World Health Organization

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Executive Summary

The World Bank, in partnership with the International Finance Corporation (IFC), the Bill and Melinda Gates Foundation (B&MGF), and the United States Agency for International Development (USAID), engaged Abt Associates (Abt) to conduct an assessment of the role of the private sector in improving health system performance in the Democratic Republic of Congo (DRC). The assessment uses the World Health Organization's (WHO's) six health system pillars as a framework: leadership/governance, service delivery, access to essential medicines, financing, health workforce, and health information systems. The assessment included eight focus regions to reflect the geographic diversity in size and composition of the private health sector: Kinshasa, Matadi, Lubumbashi, Kolwezi, Bukavu, Goma, Mbuji-Mayi, and to a limited extent, Kisangani.

The assessment provides:

- An estimate of the size, scope, and scale of the 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 particular focus on family planning (FP) and maternal and child health (MCH);
- Benchmarks and lessons from comparable low-income countries;
- An overview of policies, market conditions, and business needs that inhibit or enable private sector participation in the health system; and
- Strategic priorities with a three-year road map for action.

Abt finalized the scope of work with the World Bank, the IFC, the B&MGF, USAID, and the Ministry of Health (Ministère de la Santé Publique, MSP) and conducted a launch event in October 2017. Following the launch, a team of private sector experts completed an extensive desk review of over 200 documents, followed by a data collection trip to the DRC to interview 215 stakeholders in the seven priority geographic areas (excluding Kisangani). The findings, recommendations, and opportunities presented in this report are complemented by a prioritized three-year road map, a plan developed as part of a validation and prioritization effort in April 2018.

KEY FINDINGS AND RECOMMENDATIONS

The private health sector is an important player in the DRC's health system, but the extent of its contribution remains 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—the private sector is now mentioned as a key partner in several MSP

strategies, policies, and plans. However, public–private engagement for health remains nascent, with the notable exception of FBOs. Efforts by the central level to improve engagement have been slow as the government simultaneously seeks to decentralize the health system to provincial and lower levels of government. Overlapping areas of responsibility between these levels, combined with financial and human resource deficits, as well as limited data about who and where the private sector is, have all further decelerated efforts to engage and regulate the private sector. The private health sector itself faces numerous constraints related to the availability of commodities, shortages of adequately trained staff, and financial affordability of private health care. Furthermore, continued political uncertainty has deterred increased corporate investment in the health system. Despite these obstacles, there are numerous opportunities for the DRC's government and donors to better leverage private actors and improve health outcomes. Table 1 summarizes key findings and recommendations identified as part of the assessment process.

Table 1. Key assessment findings and recommendations

Findings	Recommendations
Integration of private sector in decision making and implementation of health sector strategy	
Leadership and Governance • Alliance du Secteur Privé de la Santé (ASPS) is unclear of its role and mandate to advocate for private sector. • There are insufficient forums for the private for-profit sector to meet regularly with the public sector and resolve challenges or collaborate. In addition, there is no uniform process for engaging FBOs already partnering with the government. • MSP restructuring has created institutional barriers to quick decision making and autonomy needed for public–private partnerships (PPPs). MSP also lacks a strategy for health PPPs. *Service Delivery* • The DRC government has developed an integrated infant, neonatal, maternal and child health strategy but has not fully implemented it to improve health outcomes. • Private providers do not receive regular updates about FP and do not routinely counsel on FP. *Private Sector Supply Chain and Systems* • Donor procurements (for example, for President's Emergency Plan for AIDS Relief [PEPFAR], Global Fund, and the President's Malaria Initiative) occur outside (FEDECAME) systems.	*Leadership and Governance* • Provide targeted technical assistance to strengthen national and regional ASPS presence and advocacy. • Strengthen ASPS's ability to organize provider trainings, work with financial institutions to identify facilities in need of financing, and build connections between providers and financial institutions. • Increase public–private dialogue at the national and health zone levels through forums and implementation of the FBO convention currently under review. • Build the MSP'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. *Service Delivery* • Leverage an integrated approach to improve child health case management that includes securing 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.

Table 1. Key assessment findings and recommendations (*Continued*)

Findings	Recommendations
Integration of private sector in decision making and implementation of health sector strategy	
Health Financing • The DRC has recently passed legislation (Loi Organique no.17/002 du 8 février 2017) that will enable scale-up of coverage in community-based mutuelles, as well as other financing mechanisms, such as mandatory health insurance for civil servants. • Health financing programs vary, with ad hoc management structures, payment arrangements, and administrative processes. Programs usually purchase services through fee-for-service models and struggle to manage risks of moral hazard and fraud. • The DRC has piloted performance-based financing (PBF) schemes to help improve health system performance. To date, schemes have largely excluded private providers. *Health Workforce in the Private Sector* • Human resources for health (HRH) data in the private sector are limited because not all stakeholders report to the MSP. • Private providers say that FBOs and NGOs are favored by the MSP above for-profit health facilities for contracting. • Initiatives to increase HRH motivation are limited by the MSP's inability to pay the salaries of its staff in public facilities and private facilities they are contracting with. • Training plans exist for all levels of HRH, but the quality and accessibility of training varies because of inadequate resources and trainers, as well as geographic/financial constraints. *Information Systems and Digital Health Initiatives* • Limited information is available about what drugs and commodities are registered. • Private sector data are routinely collected and include high levels of private sector reporting for those registered, an achievement that needs to be continuously reinforced and incentivized. • District Health Information System 2 (DHIS2) FP and child health data are limited and do not provide a complete picture of commodity supply or demand. • The logistics management information system (LMIS) is insufficient to monitor and strengthen the supply chain.	• Leverage and strengthen existing provider networks and franchises to reinforce private provider training on FP counseling and service provision. *Private Sector Supply Chain and Systems* • Encourage collaboration among donors, international nongovernmental organizations (NGOs), and FEDECAME to improve the national system for commodity forecasting and procurement. *Health Financing* • Establish an advocacy forum for mutuelles to engage government and other key stakeholders to implement and monitor adherence to common performance standards focused on clinical care, service mix, pricing and billing practices, reporting, and patient service standards. • Support expansion of strategic purchasing for health financing programs, including contracting, which includes new models for quality assurance of contracted private providers. • Validate successes and challenges of PBF and the extent to which they have engaged private providers. Test whether and how PBF can promote quality and efficiency in the private sector. *Health Workforce in the Private Sector* • Support MSP to collaborate with public and private sector stakeholders to better map the HRH available in the private sector across key health areas to identify and address HRH gaps. • Develop and implement with the MSP's Directorate of Human Resources a systematic approach to improve HRH motivation in both the public and private sector in collaboration with partners. • Support MSP to work with partners, including orders and provider associations, to improve training programs across public and private training institutions, including programs for trainers. *Information Systems and Digital Health Initiatives* • Establish a comprehensive web-based database of registered drugs and approved lots for frequently used medicines.

(*continues on page xviii*)

Table 1. Key assessment findings and recommendations (*Continued*)

Findings	Recommendations
Integration of private sector in decision making and implementation of health sector strategy	
• 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 participation by sector or health indicators. • No internal reports are generated recurrently to provide decision makers with insight into differences in public and private service delivery or to offer feedback to private providers. • Steady progress has been made toward implementing a human resource information solution (iHRIS) to collect and manage data on HRH numbers, skills, qualifications, locations, and other important data for decision making. These data can enable policy makers to identify critical resource gaps and priorities. • The Integrated Health Project (IHP) is initiating a data dashboard for health program decision making at the health zone level.	• Continue to build a culture of data reporting and use by acknowledging private sector priorities, challenges, and incentives. • Review and improve FP and child health indicators in DHIS2. • Support development of a LMIS platform, such as OpenLMIS, that is separate from and interoperable with DHIS2, for stock management. Although the public sector would manage the LMIS, private sector engagement would be critical to its success and utility. • Conduct a private sector survey to map private health facilities in the DRC, including pharmacies and drug shops, to improve participation in DHIS2 and the LMIS. • Develop and distribute actionable data dashboards for decision making in the private sector. • Continued technical support is needed to scale the iHRIS nationally to address significant health workforce challenges. Stronger engagement with for-profit and nonprofit providers could help balance and distribute human capital. • Explore increasing private sector integration in the new IHP data dashboard
Regulation of the private sector	
Leadership and Governance • There is no Order of Midwives in the DRC to help regulate this cadre. *Private Sector Supply Chain and Systems* • The customs and taxation regime is not differentiated for the import of primary inputs and final products, which increases costs for local manufacturers. *Health Workforce in the Private Sector* • There are significant variations in the quality of private sector HRH, arising from a lack of clarity in the accreditation process for training institutions, inadequate availability of resources, and inadequate training quality. • The accreditation process for training institutions is unclear because of the influence of multiple actors. • Some students are entering post-graduation clinical care without sufficient practical training, which negatively affects the quality of care	*Leadership and Governance* • Support the establishment of an Order of Midwives. *Private Sector Supply Chain and Systems* • Assess the feasibility of revising the customs and taxation regime to incentivize local manufacturing. *Health Workforce in the Private Sector* • Work with the MSP's new Directorate of Human Resources in collaboration with the Ministry of Primary, Secondary and Professional Education and the Ministry of Higher Education to institute a coordinating body that can facilitate the regulation and standardization of training programs and improve the quality and standardization of training. • Establish and enforce a uniform accreditation system for training institutions. • Clarify and codify standard operating procedures related to the placement of private students (all cadres and disciplines) in public facilities.

Table 1. Key assessment findings and recommendations (*Continued*)

Findings	Recommendations
Improved environment for private sector investment	
Leadership and Governance • Generally, legislation currently inhibits access to private health services and products. • The current customs and taxation regimes raise the costs of local production of medicines and the costs that consumers pay for imported commodities. *Service Delivery* • Cost is a major barrier to the use of FP services in the private sector. Private Sector Supply Chain and Systems • The decentralized regional supply chain network, FEDECAME, has limited capacity and requires new financing strategies to manage bad debt risk. • Regional distribution centers need to improve debt management to grow operations. • The private sector supply chain is heavily fragmented and in need of a major overhaul, as well as capacity strengthening to deliver and handle medicines according to pharmaceutical norms. • The major barrier for local manufacturers is their failure to achieve the quality standards that would allow them to participate in FEDECAME and international organization tenders. *Health Financing* • The DRC lacks a culture of insurance among citizens, limiting demand for insurance. • The majority of health financing programs focus on therapeutic care rather than preventive services, such as FP. • Private providers have limited experience with or know-how to work with health financing programs, and their clinical and service standards vary widely. Access to Finance • The ASPS could be a valuable partner to expand financing for the private health sector. • Health providers often have weak business and financial management capacity and are unable to provide financial statements or accounts history to prove their repayment capacity to financial institutions.	*Leadership and Governance* • Conduct a legal and regulatory review to identify regulatory articles related to the private health sector needing reform. • Encourage local drug manufacturing through policy reform, technical support, access to financing, and revising customs and taxation regimes. *Service Delivery* • Explore opportunities to expand current PPP efforts for vaccines to include FP commodities. *Private Sector Supply Chain and Systems* • Through existing programs from the World Bank and other partners, provide technical support to FEDECAME beyond procurement, storage, and logistical issues to include cost controls, marketing, and risk management. • Assist the entire FEDECAME network (including regional centers) to access new financing opportunities and manage bad debt. • Strengthen the private supply chain by building capacity of regional distributors to handle medicines; building public-sector capacity to supervise and enforce drug regulations and inspect pharmacies; raising the quality standards of drug wholesalers; and defining a new scope of practice for second-tier drug shops that can sell a limited range of essential medicines. • Provide technical support through the WHO to manufacturers to improve quality. *Health Financing* • Collaborate with the Autorité de Régulation et de Contrôle des Assurances (ARCA; new insurance regulator), 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. • Strengthen readiness of private providers to participate in mutuelles and other health financing initiatives by developing a scalable provider network with common quality, pricing, and treatment standards.

(*continues on page xx*)

Table 1. Key assessment findings and recommendations (*Continued*)

Findings	Recommendations
Improved environment for private sector investment	
• Many private health providers are unable to access financing from banks and microfinance institutions, and those who are able to borrow face significant collateral requirements, restrictively short loan terms, and very high interest rates.	• Strengthen health financing programs by building the capacity of mutuelles in product design, pricing, risk management, and administrative processes through mutuelle support organizations. Test models to scale mutuelles in partnership with microfinance institutions, associations, or cooperatives. • Explore ways to use technology to improve the efficiency of health financing programs. Access to Finance • Strengthen the capacity of ASPS to support the private health sector, including by organizing business training sessions for providers; maintaining a members' database to advise financial institutions on potential clients; and providing general information about the private health sector that could be used in training for financial institutions. • Provide business and financial management training and counseling for private health providers. • Evaluate the potential to develop partnerships and market links within the health ecosystem that would generate benefits to all parties.
Opportunities for private sector investment	
Leadership and Governance • International pharmaceutical and medical device manufacturers support market research and various social programs in the DRC, even without a local presence. *Service Delivery* • Private sector engagement in nutrition programs remains relatively limited. *Private Sector Supply Chain and Systems* • Congolese law permits nonpharmacists to own a pharmacy, provided the owner employs a pharmacist to oversee operations and follow professional standards. This regulation creates an opportunity for owners to develop networks of pharmacies and achieve economies of scale.	*Leadership and Governance* • Work with pharmaceutical, medical device, and technology companies (for example, Phillips and MasterCard) to bring and/or scale up new products that improve access to and delivery of health services. *Service Delivery* • Support strategic interventions to engage the private sector in nutrition programs, including promoting local food fortification, leveraging private transporters to move therapeutic products to difficult areas, and increasing private participation in strategy and planning. *Private Sector Supply Chain and Systems* • Encourage the creation of pharmacy and drug shop networks.

Table 1. Key assessment findings and recommendations (*Continued*)

Findings	Recommendations
Improved environment for private sector investment	
Health Financing • Health financing programs run by third party administrators or private sector employers often face challenges related to provider payments, costs, or fraud, among others. *Access to Finance* • It is difficult for private providers to obtain financing to build or expand their practice. • There are few organizations in the DRC positioned to provide technical assistance to health enterprises that would enable them to be investor ready. *Information Systems and Digital Health Initiatives* • Although many implementing partners are raising awareness about key health areas, there is no coordinated approach to partnering with telecommunications agencies, such as Orange, Vodacom, Airtel, and Africell, which have large physical, virtual, and human networks across the DRC and can be leveraged to improve national communication infrastructure.	*Health Financing* • Support a third-party administrator (TPA) or employer to develop and scale up an improved model to administer an employee benefit program. *Access to Finance* • Partnerships between equipment suppliers and banks can develop (for the bank) a pipeline of clients needing loans to purchase equipment and (for the supplier) a source of financing. Work with financial institutions to expand lending to the health sector, potentially through a risk-sharing mechanism (such as a USAID Development Credit Authority portfolio guarantee), identify medium or longer-term funding, and provide technical assistance to banks to reduce the cost of lending to the health sector. • Assess the landscape for health enterprises and determine the most promising activities to jump-start health companies. *Information Systems and Digital Health Initiatives* • Assess, harmonize, and aggregate demand for digital health services in the health sector. • Convene implementing partners, telecommunications agencies, and the MSP to establish a digital health network coordinating body that harmonizes approaches to digital communication and outreach strategies for key health priorities. This includes exploring PPP opportunities for communication and data collection and transmission.

1. Background and Methodology

1.1 BACKGROUND

With a population of 78.7 million, the 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 by 2050. Most of the population lives in poverty and is not active in the formal economy. The National Institute of Statistics found that the DRC's informal sector represented 89 percent of total economic activity in 2012 (export.gov 2017b).

Despite natural resource wealth and significant donor investment, the DRC has experienced limited improvements in its economic and development outcomes. Declines in the global price of minerals and petroleum have led to slower economic growth in recent years. Gross domestic product (GDP) 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). Inflation increased from 1 percent to 12 percent between 2015 and 2016. Ongoing political instability discourages investment, diverts attention from economic issues, and increases the cost of doing business (export.gov 2017b). Foreign direct investment (FDI) statistical data are unavailable (Box 1). The United Nations has an ongoing, large-scale peacekeeping operation in the east of the DRC, where violence persists because of the presence of several militias and foreign armed groups (U.S. Department of State 2016).

Box 1. Foreign Direct Investment in the DRC

Obtaining reliable statistical data on FDI in the DRC remains a challenge. The largest foreign investors in the DRC are Chevron Oil, with its Congo Gulf Oil subsidiary, Citibank, Telecel, Mobil, Group Damseaux conglomerate, Bralima brewery, UNIBRA brewery, Tabacongo/Rothman Corp., Hasson Group, and BAT Congo.

Source: Mia n.d.

Ease of doing business

In recent years, the DRC has made it easier to start a business, including in health, by combining multiple registration procedures, reducing the time required to obtain a building permit, and eliminating the requirement for a woman to obtain her husband's permission to start a business (World Bank 2017a; 2017d). The DRC has also established a one-stop shop for opening a business and accessing credit information by establishing a credit registry known as the "centrale des risques" in the Banque Centrale. In addition, the government has created the National Agency for Investment Promotion, which uses provisions of the new Investment Code to simplify investments and make the procedures more transparent. Probusiness incentives range from tax breaks to duty exemptions granted for three to five years, and are dependent upon the location and type of enterprise, the number of jobs created, the extent of training and promotion of local staff, and the export-producing potential of the operation.

Table 2 lists the DRC's "Doing Business" rankings by topic. The DRC ranked 182 of 190 countries in 2017—although reforms have made it easier to start a business, there remains significant room for improvement (World Bank 2017d). On a scale of 0 to 100, the Millennium Challenge Corporation (MCC) gave the DRC high marks for fiscal policy (94) and business start-up (76) but low marks in regulatory quality (18), access to credit (24), control of corruption (18), and government effectiveness (20) (MCC 2017).

Health outcomes

Despite gradual improvements in some key health indicators, two decades of conflict and ongoing insecurity have

Table 2. Ease of doing business in the DRC

Topics	Doing Business 2018 Rank
Overall	182
Starting a business	62
Dealing with construction permits	121
Getting electricity	175
Registering property	158
Getting credit	142
Paying taxes	181
Enforcing contracts	172

Source: World Bank 2017d rankings of 190 countries.

led to a significant deterioration in health infrastructure. Low financing for health and weak government oversight exacerbate service inadequacies, with poor deployment of the limited resources that are available. Structural barriers to service access (for example, distance, lack of transport, and prohibitive fees), combined with inequitable gender norms (Box 2) and harmful cultural beliefs, prevent service use, drive unhealthy behaviors, and further exacerbate poor health outcomes.

Limited access to health services has resulted in some of the worst maternal and child mortality rates in the world. The latest Demographic and Health Survey (DHS) from 2013–14 indicated that maternal mortality is 846 deaths per 100,000 births. Despite relatively satisfactory antenatal care coverage, there is a lack of emergency obstetric care. 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 (Barroy et al. 2014).

Under-five mortality (U5M) has fallen steadily from 148 deaths per 1,000 live births in 2007 to 104 in 2013–14 (Barroy et al. 2014). However, the DRC is one of five countries that collectively accounts for half of all deaths globally among children younger than five (WHO 2012). Sixty percent of children younger than five nationwide are not covered by basic treatment services for diarrhea, fever, and respiratory infections (Barroy et al. 2014). Use of oral rehydration solution (ORS) and zinc remains low, even in provinces with large urban areas, such as Katanga, where use of ORS and zinc is at 38.3 percent and 0.9 percent, respectively (MPSMRM, MSP, and ICF International. 2014). The DRC also has high rates of malnutrition, which has significant economic consequences amounting to 4.5 percent of GDP lost annually (World Food Programme 2017).

Box 2. Congolese women: a vulnerable group

Ninety-seven percent of Congolese women face at least one constraint (that is, domestic violence or limited economic opportunity) that limits their ability to access health care and negatively affects their health outcomes.

Source: World Bank 2017a.

1.2 REGIONAL CONTEXT

The DRC is a vast country with significant regional variation in culture, economy, language, and health indicators. Many locations can be accessed only by plane or boat, adding to regional differences. Kinshasa province, home to the capital city, generally outperforms the rest of the country for most health indicators. North and South Kivu, where instability has been concentrated in recent years, have the highest rate of infant mortality. The former Katanga province has the highest fertility rate at 7.8 children per woman and the lowest use of contraceptives at 3.9 percent. Table 3 summarizes general health characteristics for the key regions of this report.

1.3 ASSESSMENT PURPOSE, SCOPE, AND GEOGRAPHIC FOCUS

1.3.1 Purpose and scope

To guide the MSP and development partners in their strategies and health investments, the World Bank and IFC, in partnership with the B&MGF and USAID, are implementing a private health sector assessment. This assessment supports ongoing and future government and donor efforts by providing:

- An estimate of the size, scope, and scale of the 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 particular focus on FP and MCH;

Table 3. General and health characteristics for focus provinces

Province	City	General characteristics	Health indicators*
Kinshasa 	Kinshasa	Capital with estimated 11 million inhabitants; third largest urban area in Africa by population; best roads; economic, diplomatic, and MSP hub	Total fertility rate: 4.2 mCPR: 19% MCH: 98% U5M: 83 Malaria: 18%
Kongo Central 	Matadi	Port city with high level of movement of contraband products	Total fertility rate: 6.0 mCPR: 17% MCH: 94% U5M: 124 Malaria: 24%
Kasaï Oriental 	Mbuji-Mayi	Mainly rural and sparsely populated, with large areas inaccessible by road; site of significant conflict	Total fertility rate: 7.3 mCPR: 4% MCH: 72% U5M: 122 Malaria: 29%
Haute Katanga 	Lubumbashi	Provincial capital and hub for industrial mining companies	Total fertility rate: 7.8 mCPR: 4% MCH: 63% U5M: 121 Malaria: 32%
Lualaba 	Kolwezi	Large mines dominate, with small city center	Total fertility rate: 7.8 mCPR: 4% MCH: 63% U5M: 121 Malaria: 32%
South Kivu 	Bukavu	City with extensive donor and humanitarian presence; significant unrest and number of internally displaced persons	Total fertility rate: 7.7 mCPR: 8% MCH: 93% U5M: 139 Malaria: 10%
North Kivu 	Goma	City with extensive donor and humanitarian presence; significant unrest and sporadic violence	Total fertility rate: 6.5 mCPR: 12% MCH: 92% U5M: 65 Malaria: 5%
Tshopo 	Kisangani	One of the three "command centers" for the Congolese economy along with Kinshasa and Lubumbashi; important center of commerce, finance, and industry	Total fertility rate: 5.9 mCPR: 5% MCH: 83% U5M: 112 Malaria: 38%

Sources: DHS 2013–14 data based on the previous administrative division with 11 provinces; Discoverworld.com 2017.
Total fertility rate: number of live births per woman; mCPR: using any modern method (%); MCH: births delivered in a health facility (%); U5M: deaths per 1,000 live births; Malaria: children ages 6 to 59 months who tested positive for malaria according to microscopy (%).

- Benchmarks and lessons learned from comparable low-income countries;
- An overview of 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 assessment uses the WHO's six health system pillars: leadership/governance, service delivery, access to essential medicines, financing, health workforce, and health information systems (Figure 1).

The assessment also examines regional variations, focusing on Kinshasa, Matadi, Lubumbashi, Kolwezi, Bukavu, Goma, Mbuji-Mayi, and to a limited extent, Kisangani (Figure 2). The assessment focused on urban areas generally as they have the highest density of private health facilities in the country. These cities were chosen for their geographic diversity to better identify widespread general challenges the private sector faces in the DRC, as well as specific regional variations.

1.3.2 Definitions

The following definitions are used throughout the report:

- **Private health sector**: Composed of for-profit commercial entities and nonprofit organizations, such as NGOs and FBOs, that provide health services, products, and information. Supporting these are private laboratories, diagnostic services, and pharmaceutical supply chain actors.
- **PPPs:** Any formal collaboration between the public sector at any level and the nonpublic sector (for-profit, nonprofit, traditional healers, midwives, or herbalists) to jointly regulate, finance, or deliver services, products, equipment, research, communication, or education (Barnes 2011).
- **Key health stakeholders:** An individual or group who can affect or is affected by an organization, strategy, or policy in health.

1.3.3 Assessment methodology

The Abt Associates approach to private sector assessments is based on the collective experience of conducting more than 30 assessments in sub-Saharan Africa, Latin America and the Caribbean, Europe and Central Asia, the Middle East, and Asia. The DRC assessment consisted of five steps:

- **Plan:** Abt worked with the World Bank, the IFC, the B&MGF, USAID, and the MSP to finalize the assessment scope, key questions, and schedule.
- **Learn:** In preparation for fieldwork, the assessment team (composed of 10 international and DRC-based specialists) conducted a comprehensive desk review to understand the current state of the private health sector in the DRC using WHO's health pillars as a

Figure 1. Health system pillars

Figure 2. Assessment's geographic scope

framework. The team shared high-level findings with stakeholders at a launch event in Kinshasa on October 24, 2017, attended by public and private sector stakeholders, and presided over by the Minister of Health, Dr. Oly Ilunga Kalenga. In November and December 2017, the assessment team conducted key informant interviews with representatives from the private and public health sectors, development partners, and other key stakeholders in the seven focal cities. Kisangani, which was added later to the list of cities, was included in the desk research but not in the field visits because of security concerns. This report is a summary of the desk research and stakeholder interviews, and presents key findings and recommendations.

- **Analyze:** Analysis began during the stakeholder interviews and continued as the team wrote the assessment. The team compiled meeting notes and other quantitative and qualitative data and reviewed them, following up on outstanding questions by telephone and e-mail. The team prepared a draft report and a road map for action based on the analysis.
- **Share and act:** The assessment team validated and prioritized findings and recommendations during a stakeholder workshop in April 2018. Approximately 46 public and private sector stakeholders convened to discuss the findings, prioritize recommendations, and validate a three-year strategic road map. Following the workshop, both public and private stakeholders had the opportunity to provide additional feedback in writing. The team then produced the final report, which includes the Current State and Opportunity Assessment, as well as the Three-Year Road Map for Action. The MSP and its development

partners will be able to use the report's findings and recommendations to build strategic partnerships with the private sector to improve health outcomes.

1.3.4 Limitations

In general, the DRC has limited high-quality data available about the private health sector. The country lacks a robust system for collecting routine data about the number of private providers, their role in delivering health products and services, and the quality of those services. These data gaps mean that the assessment team relied on data generated by periodic donor-funded studies, such as the Demographic and Health Surveys and Service Availability and Readiness Assessments. This reliance means that some of this analysis may be incomplete or out of date with more recent developments given the time lag in data collection for these studies.

1.4 OVERVIEW OF THE REPORT

This report provides a comprehensive overview of private sector participation in the DRC's health system based on existing literature and data sources and using WHO's six pillars of health as a framework. The assessment provides a brief overview of the health system and key actors, including the size, scope, and scale of private sector providers; assesses the enabling environment for the private sector; and provides benchmarks and lessons learned from comparable low-income countries.

2. Introduction to the Private Health Sector in the DRC

2.1 KEY REGIONAL THEMES

Although each province has its own identity, there are a few key similarities across regions identified by the assessment that affect the private health sector, as described here.

Ongoing decentralization is impeding integration of the private health sector. As could be expected, the move from 11 to 26 provinces and reorganization of the MSP from 13 to seven directions has been disruptive. During the transition period, national, provincial, and health zone staff are unsure of their new roles, procedures, and reporting requirements, especially with regard to the private health sector. Inspectors are still following old geographic boundaries, whereas new inspectors are needed in new provinces. The rollout of professional orders from 11 to 26 provinces is incomplete, and new roles within each province are not yet defined. This lack of clarity exacerbates marginalization of the private sector at the national, provincial, and health zone levels.

MSP's desire to increase engagement of the private health sector is not yet operational. The MSP, particularly under the new minister, is keen to increase engagement of the private health sector, which is cited in many strategies and policies as an important stakeholder. However, although FBOs and NGOs are included to varying degrees in the strategic planning process, private for-profit groups are not routinely included in any planning or policy discussions. At the provincial and district levels, there is no forum for the private sector to discuss challenges or partnerships with the public sector.

Political uncertainty deters corporate investment, resulting in a "wait and see" attitude. There are opportunities in the DRC for multinational corporations to expand their social investment and address health-related concerns. However, companies and investors seek a stable environment as a prerequisite to launch operations or invest in a country. Because of ongoing conflict and political uncertainty, the environment in the DRC is not conducive to corporate investment. However, opportunities may exist to expand current social investments by multinational corporations to address health-related concerns.

Lack of funding and transparency inhibits MSP's ability to regulate the private health sector. The persistent budget deficit means there is insufficient funding for supervision of health enterprises or enforcement of health standards. Lack of compensation for public-sector staff leads to increased dual practice by health professionals. At all levels of government, inadequate compensation can also contribute to misappropriation of resources or informal facilitation fees.

Critical system bottlenecks impede the functionality of the private health sector. The private health sector faces challenges with accessing quality commodities because brands on the market change quickly depending on available imports. With insufficient oversight of health training facilities, medical graduates have varying levels of skills. Given the high poverty rate in the country, the private health sector in all provinces faces difficulties with growing health businesses.

2.2 HEALTH SYSTEM STRUCTURE

The 2016–20 National Health Development Plan (Plan National de Développement Sanitaire 2016-2020, PNDS) identifies four main health sectors: public medical, private medical, private pharmaceutical, and traditional (see Table 4).

The PNDS builds on health sector decentralization that began in 2006 with the National Health System Strengthening Strategy (Stratégie de Renforcement du Système de Santé), mandating division of the country's existing 11 provinces into 26 (Wright 2015). The MSP is devolving authority to the 26 new provincial health divisions (Division Provinciales de la Santé, DPS), but the process is incomplete.

Table 4. 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 parastate structures 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

2.2.1 The public health sector

The MSP is responsible for the health system and creates national strategies, defines policies and priorities, and sets standards and guidelines for service delivery. Within the MSP, the existing 13 departments are being restructured into seven central directorates to oversee HRH, strategic planning, service delivery, pharmacy and medicines, disease control, health education, and family health. In addition, the government is launching two new cross-cutting directorates focused on financial affairs and technology. The MSP also implements several health area-specific national programs.[1] The MSP directly delivers services through national-level tertiary hospitals, and advises and supports provincial and operational organizations (health zone and health area) to deliver health care at lower-level public facilities.

Provincial health divisions (DPS) organize and manage primary health care through provincial hospitals and lower-level clinics. Provincial health inspectorates (Inspections Provinciales de Santé) monitor and oversee these clinics in partnership with provincial governors and ministers of health. The DPS also facilitates implementation of directives and policies established at the central level. In this role, they regularly interact with private providers in their regions.

[1] These include programs to fight malaria (Programme National de Lutte contre le Paludisme), acute respiratory infections (Programme National Infection Respiratoire Aigu), diarrhea (Programme National de Lutte contre les Maladies Diarrhéiques), and HIV (Programme Nationale Multisectoriel de Lutte contre le SIDA, and Programme National de lutte contre le VIH/SIDA), as well as those to promote reproductive (Programme National de Santé de la Reproduction) and adolescent health (Programme Nationale de Santé Adolescents).

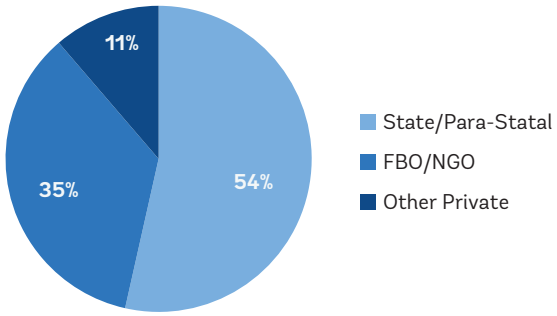
Health zones (Zones de Santé) are the lowest constituent of the public health sector. There are 516 zones across the country, led by a management team under the direction of a zonal medical officer and covering 100,000 to 150,000 inhabitants with a general referral hospital. Three hundred ninety-three health zones have government-run general reference hospitals, and the remaining 123 have either a faith-based hospital or a private health facility that serves as the reference hospital for the zone (President's Malaria Initiative [PMI] 2017). Health zones are further broken down into 8,504 health areas, each of which operates a health center covering 5,000 to 10,000 people. Health areas are managed by a local committee (Comité de Développement de l'Aire de Santé, CODESA) that brings together 10 local leaders—including the zonal medical officer—to identify health needs, manage health centers, and organize community activities (MSP 2016; Barroy et al. 2014; Secrétariat General du MSP 2006).

2.2.2 The private service delivery health sector

The PNDS highlights the important role of the private health sector in service delivery. Available data indicate that the private sector accounted for 46 percent of the DRC's 469 hospital structures in 2017 (Figure 3). FBOs manage or comanage with the MSP approximately 40 percent of health zones and 50 percent of all facilities in the country. These figures are estimates given the difficulty of collecting accurate information about the private sector (Barroy et al. 2014).

The importance of the private sector varies by province. In most provinces covered by this assessment, the public sector has the largest number of hospital structures, with the exception of Bas-Congo and South Kivu, where NGOs, including FBOs, and other private

Figure 3. Distribution of hospital structures by type, 2017



Source: MSP 2017a.

hospitals combined outnumber public hospital structures (Figure 4).

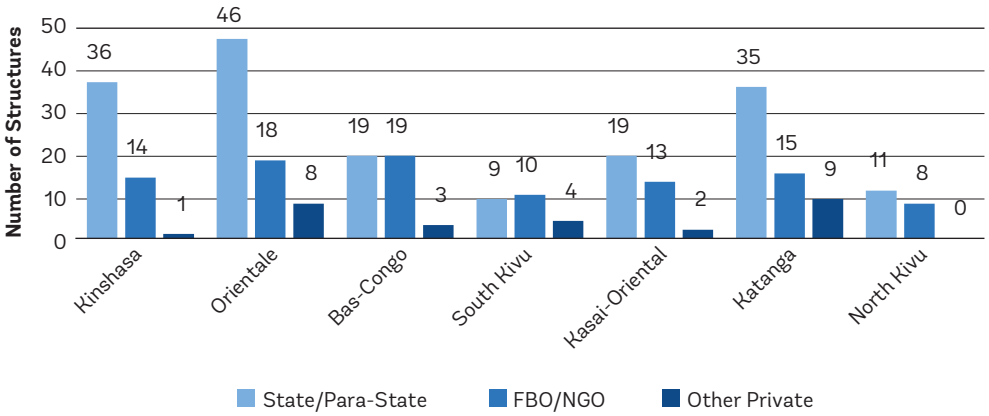
In addition to the hospital level, there are 1,288 authorized (licensed) private lower-level health facilities across the country. These facilities are concentrated in urban provinces, with almost 60 percent in Kinshasa (Figure 5). (Provinces in dark blue in Figure 5 are those covered by the current report.)

Private provider associations and private sector organizations

The ASPS, the private health sector alliance, is the main organization for private providers, aiming to improve the governance and performance of the private sector by strengthening its visibility and federating all private sector stakeholders (ASPS-RDC 2017). The ASPS obtained legal authorization to operate in 2017. It currently has 30 members, meets monthly, and is transitioning its leadership. The ASPS has much to learn from other private sector federations, such as the Kenya Healthcare Federation (Box 3).The ASPS is discussed more in the recommendations for Leadership and Governance (section 3.3).

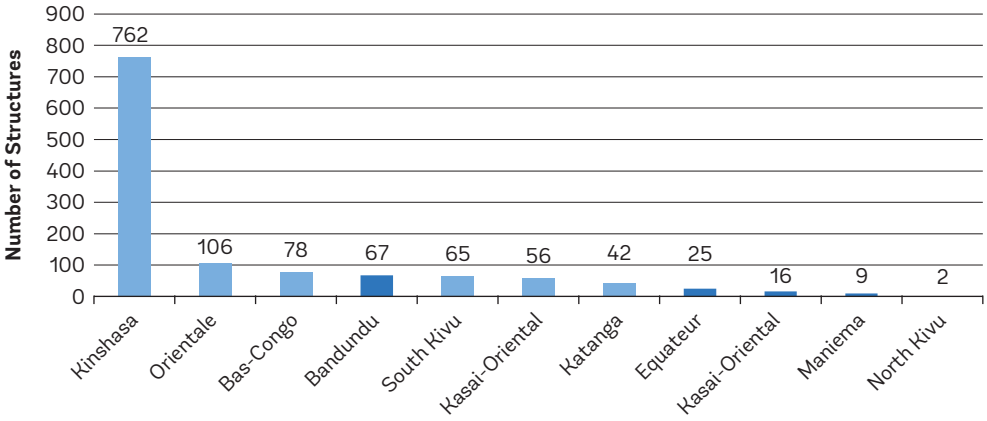
Private providers also participate in the Order of Doctors (Ordre des Médecins), Order of Pharmacists (Ordre des Pharmaciens), and Order of Dental Surgeons (Ordre des Chirurgiens-Dentistes), which are cadre-specific, founded and regulated by law, and open to both public and private providers. They are responsible for ensuring members respect ethics rules and advocating for the medical profession. Providers must be members of their respective Orders to practice. There is not yet an Order of Midwives (Ordre des Sages-Femmes), although the Société Congolaise de la Practice de Sages-Femmes has been advocating for one for several years. The Projet de Loi to create the Order is at the MSP but has not been brought before Parliament. The Orders are complemented by associations, federations, and unions (for example, the National Association of Nurses of Congo, Association National des Infirmiers du Congo), whose main role is to advocate for and protect member interests.

Figure 4. Distribution of hospital structures by type and by province,* 2017



Source: MSP 2017a.
*Data available based on the previous administrative division with 11 provinces.

Figure 5. Distribution of the 1,288 authorized private health care structures by province,* 2017



Source: MSP 2017g.
*Data available based on the previous administrative division with 11 provinces.

2.2.3 The private pharmaceutical sector

Exact numbers in the private pharmaceutical sector are unknown because of the prevalence of unlicensed and unregistered facilities. The MSP identified 30 manufacturing laboratories, 91 authorized and 171 unauthorized wholesalers, and 109 authorized pharmacies in 2017 (MSP 2017b, 2017c, 2017d, 2017e, 2017f). Most of the 109 authorized pharmacies are in Kinshasa, and all are limited to the major urban areas where consumers with more purchasing power reside. The number of unregistered drug shops is not known, but nationally these are likely to be in the tens of thousands. In Kinshasa province alone, the Order of Pharmacists estimates there are around 5,000.

Distributors are complemented by 19 private regional distribution centers (Centrale de Distribution Régionale des Médicaments, CDRs) across the DRC, organized into a federation (FEDECAME). The CDRs supply public and private nonprofit facilities with pharmaceutical products as part of the National Supply System of Essential Drugs (Système National d'Approvisionnement en Médicaments Essentiels) (ASRAMES 2016). Section 5.1provides additional information on the size and scope of the private pharmaceutical sector.

2.2.4 Traditional practitioners

Information on traditional practitioners in the DRC is limited. In 2013, the MSP's National Program for Promotion of Traditional Medicine and Medical Plants (Programme National de Promotion de la Médecine Traditionnelle et de Plantes Médicinales) undertook a census of traditional practitioners, but the results are not publicly available (Le Phare 2013). The use of traditional medicine is likely

Box 3. Kenya Healthcare Federation

The Kenya Healthcare Federation is an example of a more advanced private sector alliance. Founded in 2004, the Kenya Healthcare Federation works with private providers, hospitals, pharmaceutical manufacturers, and insurers to promote strategic public–private partnerships by maximizing the contribution of the private sector. The organization conducts advocacy, PPP, networking, and regional integration activities for members. Achievements include reversing taxation on imported pharmaceutical products, participating in ministerial and presidential forums, and collaborating with donors, including USAID, United Nations Population Fund (UNFPA), and the World Bank on health projects.

Source: Kenya Healthcare Federation, 2016

to be high because it often is a first recourse due to the absence of modern health facilities and the cost of services (MSP 2016). In Lubumbashi, the number of traditional practitioners is estimated to have doubled in the past five years, whereas in Kolwezi, more than 400 traditional practitioners use radio, television, and signage to advertise cures for sterility, headaches, stomachaches, and impotence, among others (Mayanga 2013). In 2015, traditional practitioners and healers formed the Union of Traditional Practitioners of Congo (Union des Tradipraticiens du Congo) to encourage conformance to the MSP and WHO's health norms (Radio Okapi 2015).

3. Leadership and Governance

3.1 INTRODUCTION

The MSP is eager to further engage the private health sector, which is reflected in many of MSP's strategies and policies (Box 4). Current policy emphasis on better private sector integration into the health system has not yet translated into widespread practice, particularly with regard to the for-profit sector. Key challenges related to the private health sector mentioned in MSP strategies include:

- The private for-profit sector remains poorly known and insufficiently regulated (PNDS 2016–2020).
- Collaboration within the health sector and with other sectors, both private and community-based, is not optimized to support supply and demand for services or care quality (PNDS 2016–2020).
- In the absence of effective quality assurance mechanisms, the uncontrolled growth of the private sector is a danger to the health of the population (PNDS 2016–2020).
- Private structures are weakly integrated into health information systems because of insufficient contracting (PNDS 2016–2020).
- Tensions exist between the public and private health sectors (Katanga 2015–2016 Provincial Health Human Resources Development Plan).
- Negotiation is needed with the private sector to improve resource allocation and avoid dual employment (Plan Stratégique de la Réforme Hospitalière 2010).
- PPP expansion requires stronger regulatory measures to award contracts to private structures licensed or certified by the government (Cadre de Planification en faveur des Populations Autochtones).

Box 5 illustrates the progress on FP policy in the DRC.

Box 4. Key health strategies

- Plan National de Développement Sanitaire (PNDS) 2016–2020
- Plan Stratégique National Multisectoriel en Nutrition, 2017–2021
- Plan Stratégique National Prise en Charge Intégrée des Maladies du Nouveau-né et de l'Enfant (PCIMNE), 2017–2021
- Plan Stratégique National de Lutte Contre le VIH et le Sida 2014–2017
- Plan Stratégique National de la Santé et du Bien-être des Adolescents et des Jeunes 2016–2020
- Plan Stratégique de la Réforme Hospitalière 2010
- Plan Pluriannuel Complet du PEV de la République Démocratique du Congo, 2015 2019
- Plan National de Développement de l'Informatique de la Sante 2014
- Planification Familiale—Plan Stratégique National à Vision Multisectorielle 2014–2020
- Cadre de Planification en faveur des Populations Autochtones
- Plan National de Développement des Ressources Humaines Pour la Santé 2011–2015
- Plan Provincial de Développement des Ressources Humaines de la Santé 2014–2016 Kasaï Occidental
- Plan Provincial de Développement des Ressources Humaines de la Santé 2015–2016 Katanga

3.1.1 Private health sector regulation

On paper, the DRC's health sector is closely regulated. Relevant legislation covers the opening of health facilities, pricing of products and services, importing products, and establishing mutuelles. However, some regulations

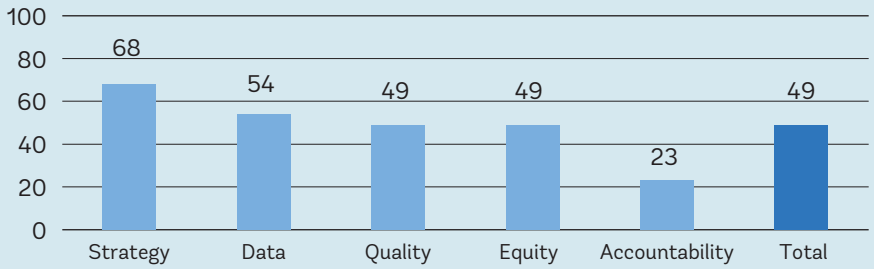
Box 5. Spotlight on FP policy in the DRC

The DRC's Penal Code (dating to 1933) stipulates that any act likely to prevent conception should be penalized, including selling, distributing, exhibiting, and disseminating contraceptives. This law, which is still in force albeit largely ignored, is problematic for FP service provision.

The government established the National Program of Reproductive Health (Programme National de Santé de la Reproduction, or PNSR) in 2001 to address maternal mortality, FP, and related issues. Until the early 2000s, it focused more on maternal mortality than FP. With increased political pressure, the policy environment for FP has become more favorable, and in 2013, the DRC's government presented the Declaration of Commitment to FP at the Third International Conference on FP in Addis Ababa. In 2014, the government adopted the Plan Strategique Nationale de Planification Familiale 2014–2020, the result of a year-long collaborative process among the government, local and international NGOs, religious institutions, international donors, and the private sector.

Track20, the global effort to measure progress toward FP2020 goals, has developed a national composite index to rate the enabling environment for FP (NCIFP). Figure 6 shows the most recent ratings for the DRC highlight areas of progress, including the country's FP strategy and the need for significant improvement in accountability.

Figure 6. NCIFP scores by dimension



Sources: Family planning in the DRC; Track20 2017

have not been updated in many years and may not be followed. In addition, stakeholders indicated as part of the assessment a lack of familiarity with MSP regulations and understanding about which directorate or division to consult, highlighting inadequate integration of the private health sector in the decentralization process.

The private health sector in the DRC interfaces with several of the MSP existing directions at central and peripheral levels, depending on the type of facility and location. The new structure outlined in the Cadre et Structures Organiques from April 2017 highlights the MSP divisions with a role in governing the private sector, including

- Services rattachés auprès du Secrétaire Général: Among other services, helps formalize terms of collaboration between the Ministry and civil society organizations, NGOs, and the private sector.
- Direction des Soins de Santé Primaires: Oversees primary health care in terms of information systems and dissemination of policies, directives, tools, and norms.
- Direction des Établissements de Soins et des Partenariats: Promotes participation of private health facilities in public health, develops policies and regulations governing all health establishments (public or private), reviews and approves contracting efforts with private actors, and inspects and authorizes all health facilities. Several key stakeholders interviewed for this report indicated that private facilities outside Kinshasa deal directly with provincial and health zone level officials and may have no interface with the central level of the MSP.
- Direction de la Pharmacie et des Médicaments (DPM): Oversees the quality and availability of modern and

traditional medicines affecting both private pharmacies and drug shops; many informal pharmaceutical products bypass the direction.

- Direction de l'Enseignement des Sciences de la Santé: Oversees training of all public and private training institutions.
- Direction Laboratoire de Santé: Oversees the opening and quality control of laboratories and develops protocols and policies.
- Direction Ressources Humaines: Responsible for the continuing education of all health professionals but focuses mainly on public-sector providers; also manages the National Human Resources for Health Observatory.

3.2 PRIVATE ENGAGEMENT AND PARTNERSHIPS

This section discusses forums for public–private dialogue, PPPs, and corporate engagement.

3.2.1 Forums for public–private dialogue in the health sector

There is growing interest in multisectoral forums to better engage the private sector in planning (Box 6) and to create opportunities for public–private dialogue, as highlighted here:

- The MSP began organizing the Comité National de Pilotage du Secteur de la Santé (CNP-SS) meetings in 2017 to inform implementation of the PNDS and decentralization efforts. Participants include representatives from the MSP and other related ministries at the national and regional level, technical and financial partners in the health sector, as well as representatives from civil society. The private for-profit sector is not currently included. This platform has the potential for becoming a platform for cross-sector collaboration and is discussed in the Recommendations section.
- In many provinces, the Comité Provincial de Pilotage includes donors, implementing partners, NGOs, and FBOs, but not private for-profit providers.
- The National Pharmaceutical Commission (Commission Pharmaceutique Nationale, CPN), created by the MSP in 2000, studies the problems facing the pharmaceutical and parapharmaceutical sector. The CPN includes members from the MSP, the DPM, the National Orders of Physicians and Pharmacists, the National Union of Pharmacists, universities, and professional associations (WHO 2015). Although the CPN has not met regularly, it could be reactivated.
- Sustainable Investment in Katanga (L'Investissement durable au Katanga) is a dialogue platform established in 2011 to bring together mining companies, civil society, donors, and international NGOs to discuss sustainable development and Katanga's mining industry.
- The National Multisector Nutrition Committee (Comité National Multisectoriel de Nutrition, CNMN) was established in 2015 and includes an interdepartmental platform and technical committee of experts. Although the CNMN is not yet functional at the national level, South Kivu and Kasai have established provincial multisector nutrition committees (SUN 2016).
- There are several dialogue platforms for universal health coverage (UHC), cooperatives, and mutuelles, including La Plateforme des Organisations Promotrices des Mutuelles de Santé du Congo (POMUCO) and L'Union des Mutuelles de Santé du Congo.

Although the ASPS can serve as the interlocutor for the private sector, there is not yet a strong national-level platform for public–private dialogue. Collaboration between the public and private health sectors at the central level remains weak, leading to silos and duplicative activities and structures. Although intersectoral collaboration is improving, the monitoring and implementation of

Box 6. Interest in expanding public–private collaboration

During the assessment launch event in October 2017, public and private sector participants highlighted their interest in improving collaboration by integrating the private sector's perspective into public dialogue, having the public sector provide more support to the private sector, and improving referral systems between sectors. Challenges mentioned included the lack of trust on both sides, the perceived poor application of the MSP's policies and norms by the private sector, perceptions that the MSP could improve engagement with the private sector, and lack of strong private sector governance.

contracts remain insufficient (MSP 2016). Public–private dialogue at the district level is also inadequate.

3.2.2 PPPs for health

PPPs can be a tool to accelerate development progress by sharing risks and responsibilities among sectors. PPPs in the DRC are nascent, although mining companies have had concessions with the government for decades. 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. The pending Loi sur Le Partenariat Public–Privé defines the legal framework for PPP contracts in the DRC (JuriAfrique 2016). On January 9, 2018, the Ministre du Plan presented the PPP Law, previously adopted by the Assemblée Nationale, to the senate, and the senate will conduct a thorough review of the 110 articles before voting. Priority PPP sectors include agriculture, manufacturing, telecommunications, and energy but not health.

The concept of PPPs for health is not new in the DRC (Box 7). In the early 2000s, the Italian and Belgian aid agencies and the World Bank provided financing to explore development of PPPs and define a legal framework. This led to development of the Vadé Mécum du Partenariat in 2002, which provided a framework and defined the principles of contracting in health. Although the Vadé Mécum has not been implemented, it outlines the following partnership objectives (MSP 2002):

- Integrating privately owned care institutions into the National Health Strategy;
- Integrating primary health care activities into private care facilities;
- Transferring management from public medical institutions to private ones;
- Supporting public structures through financing of specific activities and/or sponsorship or partial or global support;
- Supporting schools and institutes that teach health sciences; and
- Integrating private pharmacies, support to CDR, and partnerships with wholesalers.

The MSP is currently looking to operationalize the Vadé Mécum to jump-start PPPs in health. As the decentralization process continues, PPPs, mainly in the form of service agreements, would also devolve to the provincial and health zone levels, as has been done in Tanzania. Although the Mbanza-Ngungu Charter, a document developed in 1984 as the basis for intrasectoral and intersectoral partnerships, it has not served a large role to date at the peripheral level and needs updating in the context of PPPs (MSP [n.d.]b]). The Comité Technique Multisectoriel Permanent pour le Repositionnement de la Planification Familiale en RDC (CTMP) is a promising forum at both the central and provincial levels (Box 8).

Box 7. Jason Sendwe Hospital—a PPP example in Lubumbashi

In 2004, with the help of the Belgian Aid agency, management of Jason Sendwe Hospital in Lubumbashi (managed by Gecamines since 1974) was transferred to the University of Lubumbashi. A hospital management convention was signed between the MSP and the University, whereby the government retains control of the facility, and the University manages the 1,200-bed hospital in conjunction with the Congolese government and the province. In 2015, the facility received operating room equipment from the Gertler Family Foundation.

Source: Gertler Foundation 2014; Dikembe Mutombo Foundation 2017.

Box 8. Comité Technique Multisectoriel Permanent pour le Repositionnement de la Planification Familiale en RDC

The CTMP is a government-led initiative operating at the central and provincial levels. In March 2015, the prime minister endorsed the CTMP, raising its visibility. The CTMP currently operates in 12 of the 26 provinces, with plans to scale up to all provinces. The CTMP has successfully engaged the private sector, raising funds from private companies for FP services and partnering with Vodacom and Orange to provide health messages that can include FP. Callers receive 10 free health messages and then pay a fee to the telecom provider.

Current organizational structure for health PPPs

The Direction des Partenariats was established in 2003 to ensure proper management of partnership-related data at all health system levels and technical support and coordination with internal and external partners (see Box 9 for an example of an existing PPP) (MSP 2013). A reorganization of the MSP is under way, in which the Direction des Etablissements des Soins et Partenariats will manage partnership activities.

The Direction currently manages donor projects and contracts for health zone and facility management with each major religious group—Catholics, Protestants, Kimbanguists, and Muslims (see Figure 7 for the status of health zone with FBO reference hospitals) (U.S. Department of State 2011). The Direction manages the contract review and implementation period, usually lasting three to five years (and up to 25 years). The MSP retains control of structures, whereas FBOs manage staff and pay for equipment and facility investments.

The following challenges regarding PPPs were identified in a workshop supported by the Italian Aid Agency in 2011 and still persist:

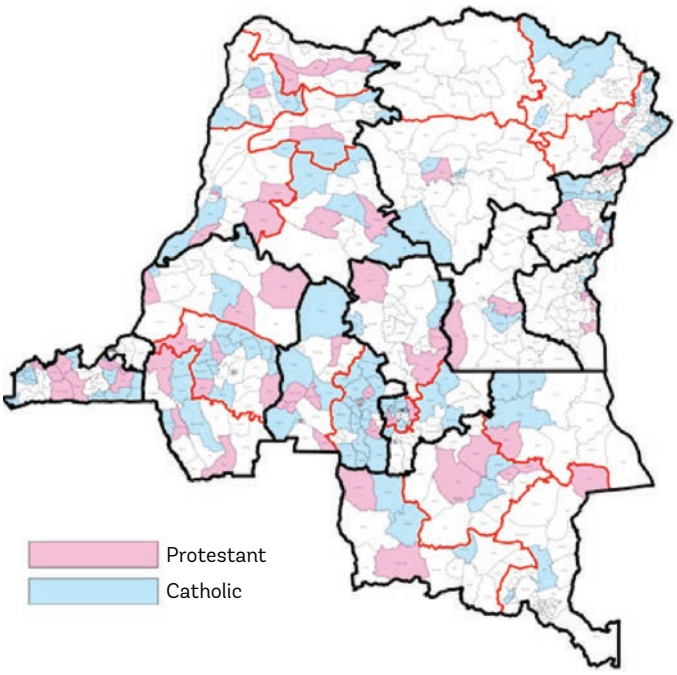
- Insufficient monitoring, evaluation, and coordination of externally funded projects;
- Information and communication deficits within the MSP, especially at the central level;
- Inadequate alignment between donor projects and government priorities, with projects implemented without informing provincial and central level MSP leaders;
- Poor government control over the financial flow or management of external aid;
- Confusion about partnership management and promotion, leading to overlapping responsibilities rather than intrasectoral and intersectoral collaboration; and
- Insufficient development of public–private approaches with the potential to contribute toward increased coverage of services (Direction de Gestion du Partenariat pour la Santé n.d.).

Box 9. PPPs in action in South Kivu

The Catholic Church created the Bureau Diocésain des œuvres Médicales (BDOM) in South Kivu to facilitate collaboration with the MSP and manage the Church's health structures and pharmaceutical depot. By 2012, the Ministry had contracted BDOM Bukavu to manage 12 health districts. BDOM was responsible for improving administrative management of the facilities, increasing access to and quality of services, reinforcing the capacity of the District Executive Team (Equipe Cadre de District), and mobilizing resources to support districts. The partnership led to improved health outcomes and public–private collaboration while also strengthening the state's credibility and reach. Weaknesses included the lack of government compliance regarding commitments made for exemptions and personnel salaries.

Source: Mushagalusa 2014.

Figure 7. Health zones with FBO reference hospitals, 2016



Source: Baer and Sambu 2016.

3.2.3 Corporate engagement

Corporate engagement, in which resources and expertise from the corporate sector help advance social goals, can be mutually beneficial to companies and governments. The corporate sector, donors, and governments benefit through access to complementary technical expertise in areas such as supply chain, access to new technologies, and the ability

to take solutions to scale. For corporates, it is critical that partnerships not only promote the public good but also benefit business and align with corporate brands.

Current regulations in the DRC require companies to make social investments related to their business (Jansson 2010). Additionally, companies are increasingly motivated by consumer demand, whereas international companies face increased pressure to demonstrate social responsibility (Cone Communications 2017). For example, recent trends demonstrate heightened consumer demand for supply chain transparency, especially for minerals sourced from DRC. Although companies such as Microsoft and Apple may not have a business presence in the DRC, they purchase Congolese cobalt for the production of electronics, and public pressure has influenced their implementation of programs with social goals. Likewise, companies such as GlaxoSmithKline (GSK) are under increased consumer pressure to ensure their products contribute to advancing positive health outcomes and access to services.

The mining sector

Mining contributes almost one-third of the DRC's GDP and includes mining companies, logistics and security companies, as well as companies that purchase mined commodities (for example, copper, cobalt, and lithium) (CIA n.d.). Companies such as Microsoft and Apple mainly fund programs for environmental protection or the prevention of human trafficking and child labor, such as the Mines to Markets Program supported by Microsoft, General Electric, and Boeing through Pact (Box 10). Some companies also support community health efforts. For example, Qualcomm purchases many Congolese commodities for their electronic products and supports the development and delivery of educational materials for miners about health risks and the signs of respiratory diseases, including tuberculosis. Mining companies with a local presence also support health programs for their staff and local communities. For example, the mining company Banro supports health care facilities for its workers and the surrounding community and upgrades to infrastructure, such as roads and water (Box 11).

Box 10. Mines to Markets Program

Microsoft, General Electric, and Boeing support programs to prevent child labor by addressing factors that attract children through the Pact Mines to Markets program. Together, they support programs to raise awareness of children's rights, improve the capacity of local orphanages, and support home-based day care for younger children. While these programs do not currently include a health focus, there are opportunities to include information for caregivers about malaria, nutrition, pneumonia, and diarrhea, thereby leveraging corporate investment to improve child health.

Source: Pact n.d.

Box 11. Banro's contributions to DRC

Banro invested US$492 million in South Kivu and Maniema provinces and employs over 1,000 people in technical, professional, management or supervisory roles, with another 3,000 employed through contractors, generating another 20,000 jobs indirectly, and ultimately supporting over 200,000 Congolese. The Banro Foundation upgrades and constructs new roads, housing, health facilities, and potable water systems. The Foundation has built 10 new schools, rehabilitated two existing schools, and provided vocational training and skills development to its employees.

Source: ResolutionPossible 2013.

Health care companies

International pharmaceutical and device manufacturers support market research and social programs in the DRC, even without a local presence. Their motivation is to support a positive brand association with social good on a global scale, as well as product development and new market growth. For example, GSK is currently conducting its own assessment of the pharmaceuticals market related to respiratory infections (both pneumococcal vaccines and antibiotics), which is critical for product expansion by GSK in the DRC. These efforts are critical to improving the accessibility of quality care in low-resource environments and also to understanding how programs can be implemented effectively with private sector partners.

Medical device manufacturers also invest in product design for low-resource environments to both create new markets and advance health goals. For example, as part of their vision for "health care without bounds," Phillips has developed a new product designed to improve

Box 12. Philips Community Life Centers in Kenya

Results from Kenya are tremendous. Within the first 18 months of the CLC opening, the total number of outpatient visits per month increased from 900 to 4,080. For children, this number quadrupled from 533 to 2,370. For antenatal care, the number grew 15-fold, from 13 to 188 patients per month, with the number of fourth visit antenatal care patients each month growing 16-fold, from six to 94.

Source: Philips n.d.

health access in rural areas of DRC. The product is called Community Life Centers (CLCs) and has just launched in Tadu in northeastern DRC. The CLC offers vital primary health care services using Phillips products, including a fetal Doppler that can be used to detect infant heartbeats during routine antenatal visits and delivery. The CLCs are designed to be a community hub where technologies are bundled to provide access to health and social services (Box 12). The availability of products designed specifically for contexts such as the DRC may present new opportunities for PPPs.

3.3 RECOMMENDATIONS

This section highlights recommendations for the MSP and donors on regulating the private sector, private engagement, and partnerships and corporate engagement.

3.3.1 Regulation

Conduct a legal and regulatory review to identify regulatory articles needing reform related to the private health sector

Finding: There is confusion about how current legislation affects access to private health services and pharmaceuticals. The World Bank in Senegal and USAID in Côte d'Ivoire have helped identify legislative and regulatory bottlenecks related to private health service and product delivery to pave the way for more efficient private health delivery.

Recommendation: Undertake a legal and regulatory review to help identify legislative and regulatory bottlenecks related to private health service and product delivery using a participatory process to ensure buy-in and prioritization of the most urgent changes needed.

3.3.2 Public–Private Dialogue

Support the ASPS to assume a stronger leadership role within the private sector and with the government

Finding: ASPS is a fledgling private sector umbrella organization, which is unclear of its role and does not have a formal platform to interact with the public sector. Potential roles include overseeing compliance of quality norms for member organizations, connecting private providers to UHC initiatives, serving as a clearinghouse on financing strategies for private providers, and helping increase contracting opportunities with the MSP. An important component of the ASPS's ability to represent the private health sector is that its constituency represents a cross-section of private sector stakeholders. As a convening entity for the private health sector, it can offer a much-needed venue for industry groups and professional bodies to debate important issues and an avenue for government and donors to engage with the private health sector. At the provincial and district levels, the ASPS can advocate for private sector interests and collaborate on health initiatives.

Recommendations:

- Strengthen the ASPS's capacity to fulfill its role as an effective interlocutor for the private health sector by conducting an institutional analysis and benchmarking to assess its financial, programmatic, and organizational performance and needs and using the results to develop a tailored capacity-building plan.
- Develop a dynamic advocacy plan and agenda for the ASPS consistent with its core mission and backed by member consultation and a consensus-building process.
- Undertake a review of ASPS membership to identify constituencies lacking representation, such as companies with worksite clinics, and establish a growth plan to ensure the ASPS's membership represents the entire private health sector, not just private health providers.
- Develop a resource mobilization plan to increase ASPS's long-term financial sustainability, identifying

potential public and private sources of financing from financial institutions, the government, donors, professional bodies, and industry groups, as well as through membership fees, in-kind contributions, fund-raising, training and services revenue, and conference fees.

- Establish regional ASPS branches to address health priorities in each region.
- Ensure the ASPS aligns with the West Africa Healthcare Federation and the Africa Healthcare Federation to accelerate learning and participates in the planned Central Africa Federation to build on private sector initiatives in the region.

Leverage and build the capacity of ASPS to add value to the private health sector

Finding: The ASPS could be a valuable partner in expanding financing for the private health sector.

Recommendation: Work with and build ASPS's capacity to conduct the following activities:

- Manage the logistics for provider business training sessions;
- Carry out training of trainers to increase training availability and sustainability;
- Develop guidelines and checklists for providers to understand regulatory requirements to maintain their professional accreditation and ensure that their health care businesses are properly registered, facilitating health providers' access to formal financing;
- Maintain a member database that financial institutions could consult to verify licensing/certification status of health providers wishing to borrow from the financial institution;
- Provide general information about the private health sector and facilitate training for financial institutions;
- Offer a forum for financial institutions and private providers to discuss concerns;
- Organize trade fairs to connect health providers to financial institutions and other business input suppliers;
- Support sectoral studies on topics such as how to improve the supply and maintenance of medical equipment in the DRC or identifying specific financing needs of female providers or FBOs; and
- Evaluate the potential to structure a risk mitigation instrument, such as a mutual guarantee fund, that would be available to members of the ASPS who meet minimum requirements.

Launch national- and district-level public–private dialogue forums

Finding: As remarked by the minister of health at the assessment launch in October 2017, there is a need for a cadre de concertation for the private for-profit health sector to meet regularly with the public sector to resolve challenges and collaborate. Based on lessons from Abt's work in Côte d'Ivoire, Benin, and Senegal, the private sector is motivated by the prospect of a greater role in decision making and partnerships. A strong forum for public–private dialogue enables the private sector to advocate with a unified voice, strengthens PPPs, and leads to a stronger, more organized, and better-coordinated health sector.

Recommendations:

- Establish or repurpose a small technical committee at the national level to meet monthly or quarterly (depending on stakeholder interest), with the ASPS representing the private for-profit sector, and including other representatives, such as FBOs. Potential topics for the national forum include streamlining the current registration process, private sector reporting, quality standards, and collaborative opportunities for training in service delivery, business, and financial management. Two existing platforms that could be repurposed are the CTMP and the CNP-SS. The CTMP, which brings together public-sector staff and private companies to focus on funding FP activities, could expand beyond FP to other health areas and include private providers. The CNP-SS, which currently focuses on decentralization of the public sector, could add a private sector voice and potentially serve as the public–private platform at the national and provincial level. Additional review is needed to determine whether the CTMP or CNP-SS could serve as a public–private dialogue vehicle.
- Establish or repurpose public–private dialogue forums at the health zone level to strengthen private sector representation and reporting, resolve issues, and share resources, learning from efforts in other countries.

In Yamoussoukro, Côte d'Ivoire, the health district leadership created a public–private forum to better integrate private providers in the health information system and engage the private sector in achieving public health goals. The USAID-funded Strengthening Health Outcomes through the Private Sector (SHOPS) project documented the experience in a case study and trained all regional- and district-level health officers in the country on the Yamoussoukro model. With SHOPS's assistance, districts launched public–private dialogue platforms with road maps for activities to guide future public–private collaboration (SHOPS Project, 2016).

Support the establishment of an Order of Midwives

Finding: Currently there is no Order of Midwives in the DRC, which means there is no coordinating body to ensure midwives are trained, can access continuous education, or are meeting quality standards. The Société Congolaise de la Practice de Sages-Femmes has been advocating for several years for a Midwife Order, similar to other cadres. By the end of 2017, the arrêté (decree) to make the Association into an Order was pending signature at the MSP.

Recommendation: Identify a champion within MSP to support establishment of an Order of Midwives. Specifically for FP, the Order could increase sensitization and promote FP, distribute short- and long-term contraceptive methods in partnership with UNFPA, and disseminate good practices.

3.3.3 Partnership Strategy

Develop a health PPP strategy to guide MSP's partnership activities

Finding: Currently there is no health PPP strategy, although there is the pending Vadé Mécum du Partenariat, which focuses on financing modalities for PPPs.

Recommendations:

- Develop a PPP strategy for health aligned with the Vadé Mécum du Partenariat and with the following elements: general PPP framework, PPP definition, institutional coordination and responsibilities, identification of potential projects and award procedures, and agreement template. The PPP strategy will also need to describe the planned decentralization of PPPs to the health zone level and the roles/responsibilities and capacities needed at the central and peripheral levels.
- Develop a preliminary list of PPPs to consider—potential PPP opportunities include the Clinique Kinoise in Gombe, Kinshasa; mining and railroad hospitals in Katanga region; the Katana Hospital in South Kivu and Bas Congo; health facilities affiliated with Perenco; the Société Congolaise des Industries de Raffinage; and cement production. MSP could work with partners such as the IFC, which has extensive experience providing technical assistance to governments to support the formation of health PPPs. For example, in Lesotho, IFC helped the government develop an 18-year PPP agreement with Tsepong, a local health care company operating a private hospital and clinics, to develop a network of PPP clinics with more-advanced medical technologies, supporting better health outcomes for a larger number of public-sector clients.

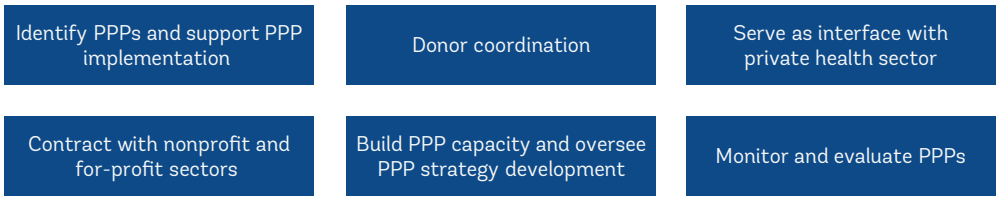
Build the MSP's capacity to better leverage PPPs and private sector investment

Finding: During the ongoing MSP restructuring, the role of the Direction des Établissements de Soins et des Partenariats is unclear, particularly the role of the Division de Partenariat et Contractualisation. Given the growing importance of PPPs, there is a need to create a high-level private sector cellule (unit) at the Secrétaire Général level and also clarify the responsibilities of the Division de Partenariat et Contractualisation.

Recommendations:

- Create a private sector cellule as the first contact within the MSP to accompany the development and integration of the private sector and promote the Congolese health sector to attract new investors. This cellule could report directly to the Secrétaire Général with a line to the minister of health and a dotted line to the Cabinet to have access to decision makers and the requisite autonomy.
- The new Division de Partenariat et Contractualisation could oversee contracting with the private health sector, donor coordination, and PPPs (Figure 8). It should liaise with the National Agency for Investment Promotion for larger PPP projects and with regions and health zones for smaller PPPs and serve as a focal point within the MSP for updated and accurate information on the private health sector.

Figure 8. Role of the PPP Unit within the MSP



Move forward with finalizing the FBO convention

Finding: FBO conventions are piecemeal, with each faith community negotiating contracts separately and for different time periods. This can lead to favoritism, lack of transparency, and unfairness. There has been much discussion about the need for a uniform convention so all FBOs receive the same treatment and have the same terms with the MSP.

Recommendation: Facilitate dialogue to bring the negotiations to a close and obtain approval for a standardized convention for all FBOs that contract with the MSP.

Collaborate with pharmaceutical and medical device companies to improve access to and delivery of health services

Finding: International pharmaceutical and medical device manufacturers support market research and various social programs in the DRC, even without a local presence. Government and donors could consider working with companies to ensure their products become available in the DRC. By working with such companies, DRC is more likely to become a country where these companies elect to design and/or user test new products.

Recommendation: Work with pharmaceutical and medical device companies to bring and/or scale up new products that improve access to and delivery of health services.

Partner with companies piloting and developing technologies with potential application in the health system

Finding: Companies are increasingly developing products using new technologies, such as block chain, that can strengthen programs across the health system. For example, MasterCard works in many countries, including those with poor infrastructure such as Yemen or rural Nigeria, to improve the delivery of social services. Its products, such as MasterCard Aid Network, use block chain to mobilize financial resources for refugees more efficiently while also reducing risk and empowering refugees to make their own decisions. Technology companies can help determine the latest application and use of products to capture efficiencies, reduce risk, and improve access.

Recommendation: Consult with technology companies when considering the implementation of new programs and/or reforms across the health system, especially when designing solutions to improve product tracking, pharmacovigilance, and/or vouchers.

4. Service Delivery

4.1 INTRODUCTION

The private health sector is an important source of health care across the DRC. For-profit providers are concentrated in urban areas, but FBOs and NGOs, often supported by donors, typically operate in underserved areas. Together these facilities operate at all levels of the health system and offer a broad range of services. The private sector accounts for 44 percent of outpatient care and 25 percent of inpatient care in the DRC (Wang et al. 2016). Eighty percent of facilities offering basic surgery are private (MSP 2014b). Private facilities score higher than public in operational capacity at 41 percent and 18 percent, respectively (MSP 2014a). On average, private facilities, including for-profit, FBOs, and NGOs, are more likely to have basic infrastructure (for example, access to electricity, clean water, and sanitation services, communication equipment) and essential medicines (Figure 9) than are public facilities. However, most facilities in both sectors are still likely to lack access to these inputs.

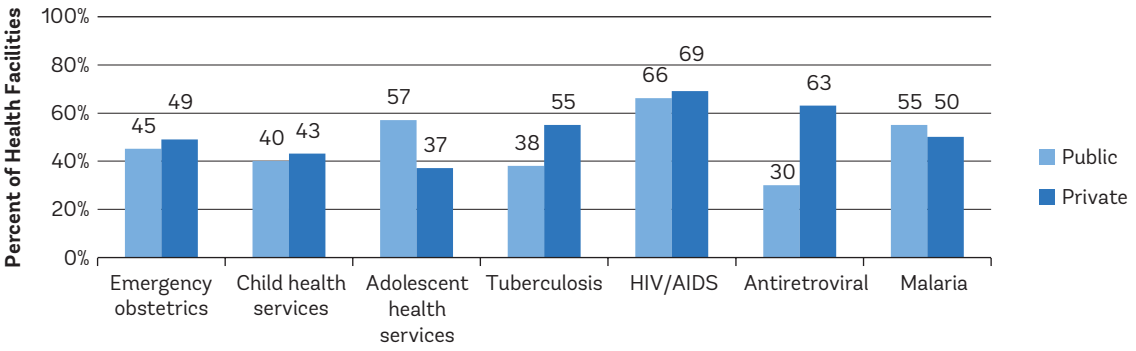
Private facilities largely operate on an independent basis, and often lack training, qualified personnel, equipment, supplies, salaries, or incentives to provide high quality services. Government efforts to better integrate private facilities with the larger health system have been limited. The increasing verticalization of health programs, exacerbated by donor funding streams, makes it challenging to develop and implement multi-pronged activities

Box 13. The role of social marketing franchises in DRC

The Association de Sante Famiale (ASF)'s Confiance franchise network, developed to deliver FP services, was the first of its kind in the DRC. Its service offering has since expanded to include the prevention and proper management of diarrhea in children younger than 5 years as well as malaria interventions where the necessary commodities are available. ASF's network comprises 116 clinics and health centers. In 2015, these facilities received 74,821 visits, averted 31,724 disability-adjusted life years, and provided 17,619 couple years protection. Most of the franchise's clients come from the richest quintiles.

Source: Viswanathan et al. 2016; Chakraborty 2013.

Figure 9. Availability of medicines and products in health facilities by type of service and sector



Source: MSP 2014a.

involving the private sector. Donors currently partner with some private actors—mainly in the FBO and NGO sector—to distribute free or low-cost FP products and trainings. However, these programs are not coordinated with larger efforts; a recent assessment of the FP market found that though there are several international donors and partners distributing free or low-cost FP products and providing training, supplies are inadequate and sporadic and there is no organization or coordinating body for these efforts (UNFPA 2017a). This lack of integration often crowds out private for-profit actors who do not participate in these efforts. Some private for-profit stakeholders interviewed stated that they do not offer certain products and services because they are not willing to compete with free options offered by donors and their partners.

4.2 FAMILY PLANNING

4.2.1 Context

The DRC's Family Planning National Multi-sectoral Strategic Plan 2014–2020 formalized the objective of increasing mCPR for all women of reproductive age to 19 percent by 2020 (MSP 2014b. Increasing access to FP products and services is important as the DRC seeks to address its high maternal and child mortality rates, but current mCPR in the DRC is among the lowest in the region (Figure 10).

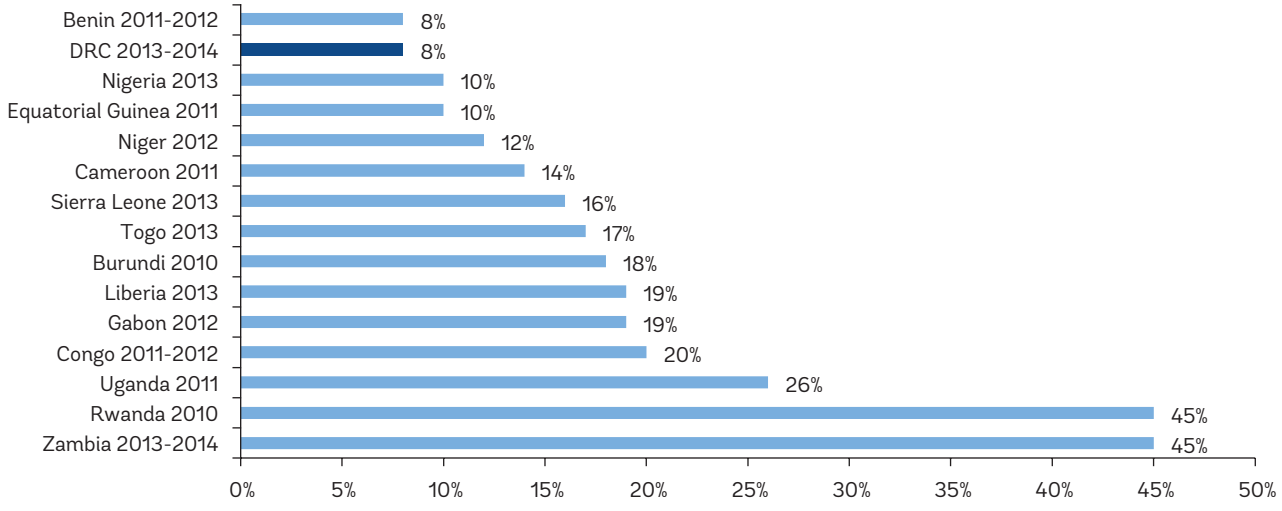
The overall contraceptive prevalence rate (CPR) is stagnant, remaining at about 20 percent of married women between the 2007 and 2013–14 DHS. Among modern method users, short-term methods—primarily condoms—dominate. The method mix shifts with age, as older users tend to use long-acting and permanent methods, especially sterilization (Figure 11).

4.2.2 Service delivery dynamics

Availability

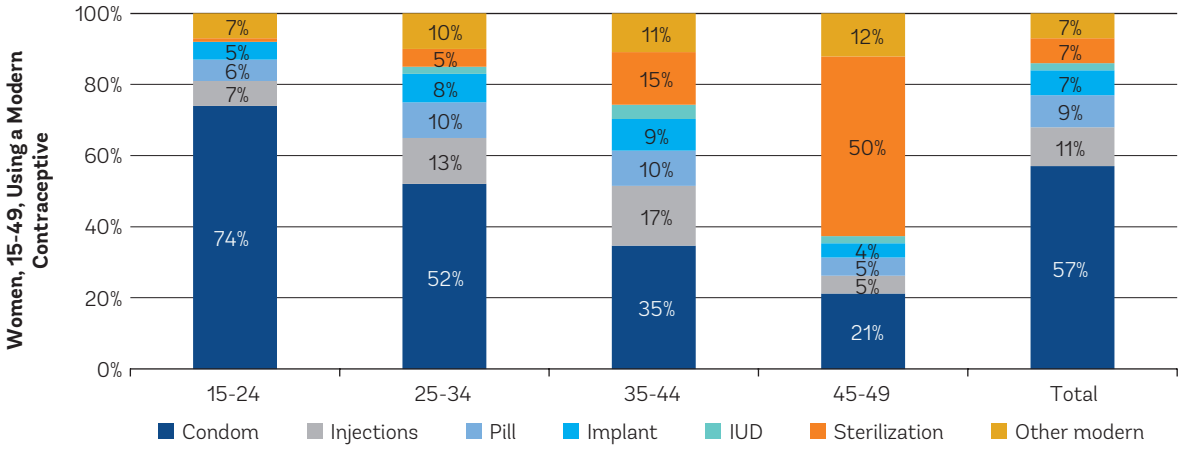
Only 32 percent of private facilities have FP services available, including a room for FP service provision and staff trained in FP (MSP 2014a). Although service availability is low, quality is rated highly relative to the public sector, with clients citing shorter waiting times and less frequent stockouts (Mpunga et al. 2017). Private clinics associated with implementing partners, such as the Association pour le Bien-Être Familial (ABEF, an International Planned Parenthood Federation affiliate) or Population Services International (PSI), are more likely to offer the full range of FP services and products. Although ABEF operates only five clinics, it has 146 partner clinics (public and private) to which it provides free FP products and training. Association de Santé Familiale (ASF), a PSI affiliate, runs a social franchise called Confiance that primarily provides FP services through its 133 clinics. In addition,

Figure 10. Use of modern contraceptive methods in the DRC and other countries



Source: DHSs, date depending on national data availability (Barroy et al. 2014).

Figure 11. Modern contraceptive method mix by age



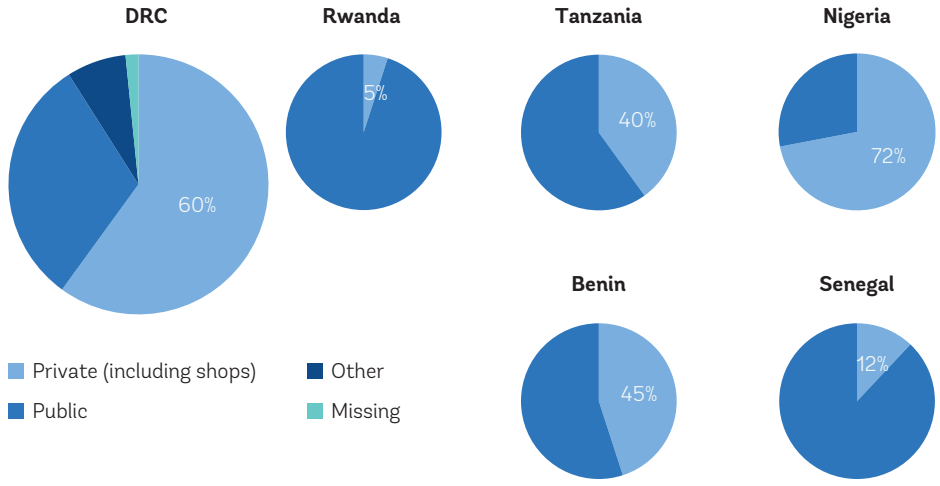
Source: DHS 2013–14; Avenir Health 2017.

ASF socially markets a variety of contraceptives under the Confiance brand (Family Planning in the DRC 2017). Private facilities that are not affiliated with a donor or implementing partner are less likely to offer FP products and services, in part because they view FP as not commercially viable. Some FBOs, particularly Catholic facilities, do not officially offer FP services, but clinicians who work there may bring and sell FP products and services or refer clients to nearby facilities with FP services.

Source of methods

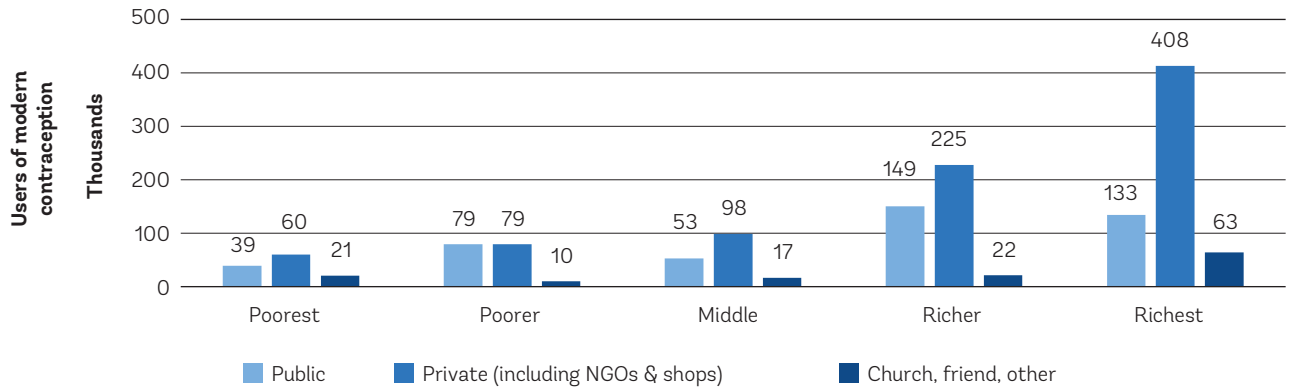
In line with perceptions about FP service quality, private outlets are the main source of modern FP methods. Private facilities, pharmacies, and shops serve 60 percent of modern method users (DHS 2013–14). Compared with other countries in the region, such as Rwanda or Senegal, in the DRC the role of the private sector is particularly important (Figure 12).

Figure 12. Regional comparison of source of FP methods



Source: DHS 2013–14; SHOPS Plus 2017.

Figure 13. Family planning source by wealth quintile



Source: DHS 2013–14; Avenir Health 2017.

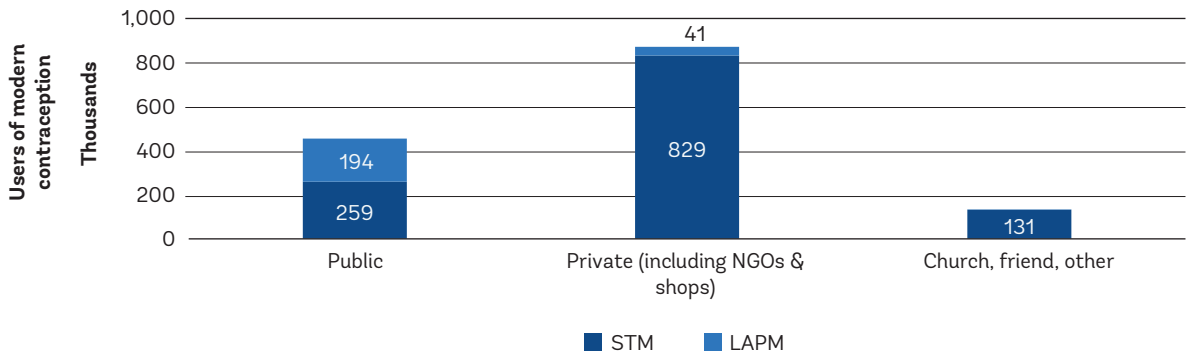
The private sector is an important source of contraceptives across all wealth quintiles, although the public–private split is less pronounced among poorer populations (Figure 13).

Pharmacies and drug shops account for over 70 percent of all privately sourced modern contraceptives. All health facilities combined (hospitals, clinics, and health centers) account for approximately 15 percent of the private sector's market share. The remainder is a mix of NGOs, mobile outreach, and shops (DHS 2013–14). In line with the reliance on pharmacies and drug shops, users of private sector services are more likely to access short-term methods that do not require a clinical service (for example, condoms, oral contraceptive pills), whereas public-sector users are more evenly split between short-term and long-acting or permanent methods (Figure 14).

Youth

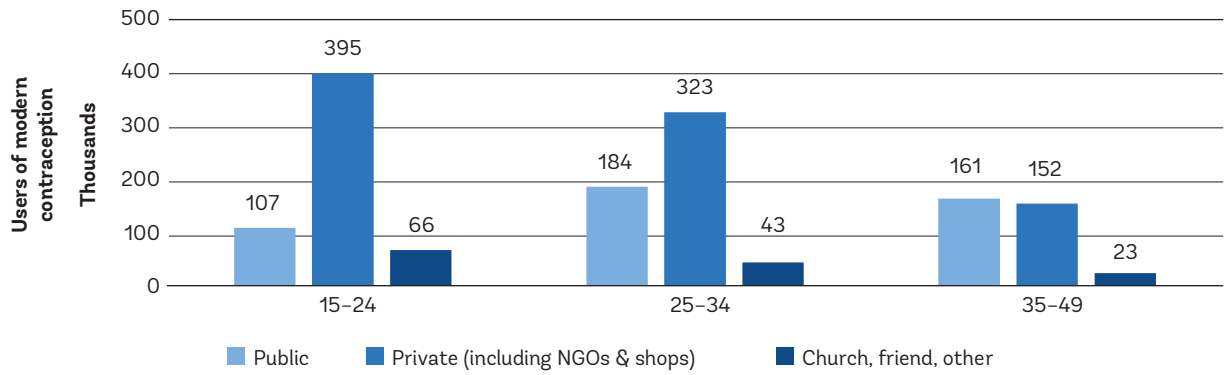
Youth and adolescents (15–24 years) are more likely to obtain FP from a private source, whereas older age groups (35–49 years) are more evenly split between public and private sectors (Figure 15). This trend reflects the types of methods used—younger people are more likely to use short-acting methods, which they can procure from a shop (for example, condoms), whereas older women are more likely to use an FP service that includes a clinical component and must be delivered at a health facility.

Figure 14. Contraceptive methods by source



Source: DHS 2013–14; Avenir Health 2017.

Figure 15. FP source by age



Source: DHS 2013–14; Avenir Health 2017.

About half of private providers surveyed in Kinshasa and Kongo Central (Matadi) (52 percent and 51 percent, respectively) offered FP counseling to adolescents (Performance Monitoring and Accountability 2020 [PMA2020] 2017; 2017a).

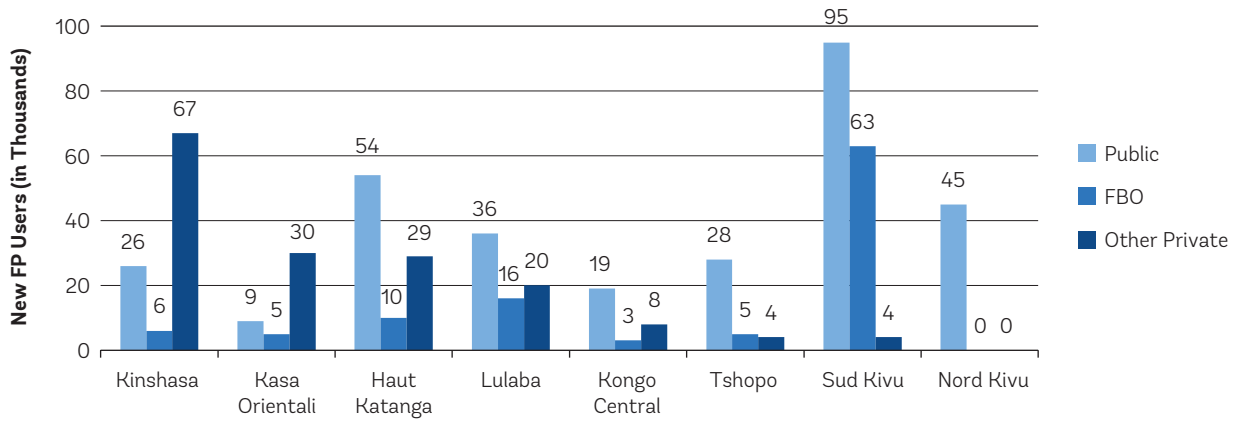
Regional FP dynamics

According to DHIS2 data, private hospitals, health centers, and health posts in 2016 served three-quarters of new FP users in Kinshasa and Kasai Oriental provinces, half of new FP users in Lualaba, and less than 50 percent of new users in the other provinces reviewed in this assessment (Figure 16). FBOs are significant contributors in South Kivu. Overall, the private sector serves just less than half (46 percent) of new FP users across these eight provinces. Service provision for renewing FP users follows a similar pattern, with the private sector serving just over half (52 percent) of renewing users.

Spotlight on private FP service provision in Kinshasa and Kongo Central (Matadi)

Contraceptive use in Kinshasa was low in 2017—only 22 percent of women reported using a modern contraceptive method (PMA2020 2017). Contraceptive use in

Figure 16. New FP users in 2016



Source: MSP 2018.

Kongo Central is even lower and falling; modern method use decreased from 20 percent in 2015 to 17 percent in 2017 (PMA2020 2017).

According to a mapping of all FP service delivery sites conducted by Tulane University in 2013, few facilities in Kinshasa were adequately prepared to deliver FP services. As shown in Figure 17, FP products are more commonly available in pharmacies (small dot with bullseye) than formations sanitaires (large dot). The abundance of red compared with green dots reflects that most facilities that are supposed to offer FP services do not have trained staff or methods (other than condoms) available.

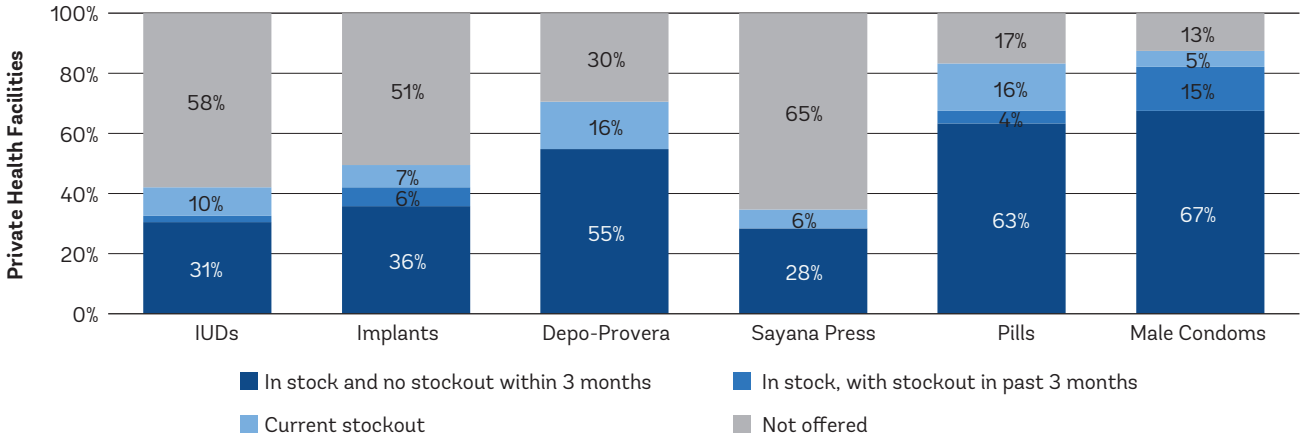
According to 2017 data, 68 percent of private facilities in Kinshasa and 62 percent of private facilities in Kongo Central offered FP services. Both cities are comparable in the number of days facilities are open (5.7 in Kinshasa; 5.4 in Kongo Central) and in some of the services they offer. User fees are charged by more private facilities in Kongo Central (31.7 percent) than in Kinshasa (11.6 percent) (PMA2020 2017). Data for 2017 are not available for other cities in this report.

Although private facilities in Kinshasa reported challenges with frequent stockouts, they were more acute for short-acting methods, such as male condoms, pills,

Figure 17. Pharmacies and facilities offering FP in Kinshasa, 2013

Source: Bertrand 2014; Family Planning in the DRC.

Figure 18. Percent of private facilities in Kinshasa offering FP with methods in stock on day of interview



Source: PMA2020 2017.

and Depo-Provera injectables. Fewer facilities reported commodity stockouts for long-acting methods, possibly because they were less likely to offer these services (Figure 18).

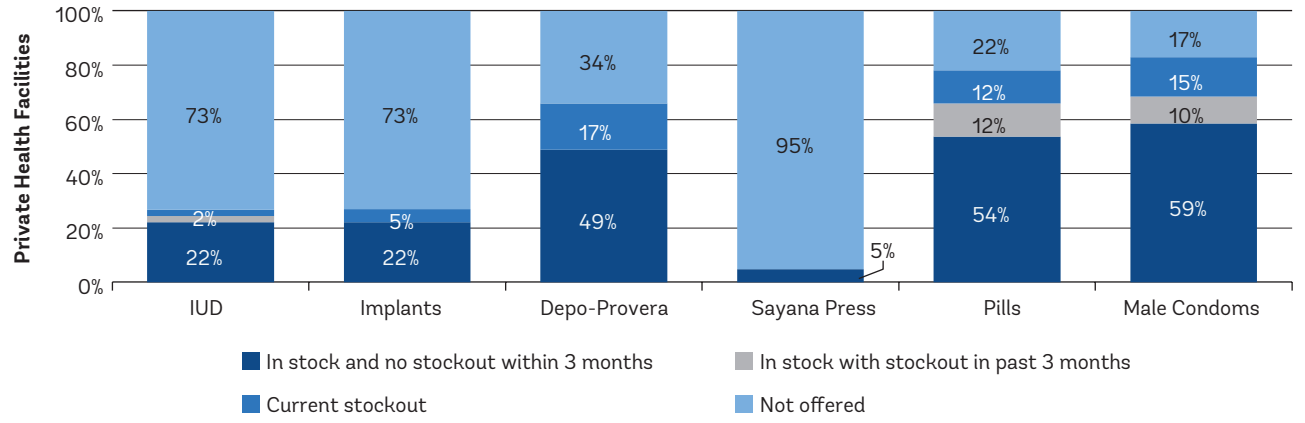
The percentage of private facilities with Sayana Press (5 percent), intrauterine devices (22 percent), implants (22 percent), and Depo-Provera (49 percent) was low (see Figure 19) (see Box 14 for information on pilot task-sharing program for Sayana Press). Private facilities were more likely to stock short-acting methods, such as pills and male condoms (54 percent and 59 percent, respectively).

4.3 MATERNAL HEALTH

4.3.1 Context

Maternal mortality has increased in the DRC from 549 deaths per 100,000 live births in 2007 to 846 in 2014 (MPSMRM, MSP, and ICF International. 2014). In addition, 35 percent of all female deaths were attributed to maternal causes (up from 19 percent in 2007). These statistics reflect the impact of war and ongoing violence, which have slowed post-conflict rebuilding of the health system and exacerbated gender-based inequities. In response,

Figure 19. Percent of private facilities in Kongo Central offering FP with methods in stock on day of interview



Source: PMA2020 2017a.

Box 14. Leveraging task sharing to improve access to Sayana® Press

A 2015 pilot in Kinshasa assessed acceptors' attitudes toward both Sayana® Press as a contraceptive method and community-based distribution by medical and nursing students, known locally as "DBCs." Sayana® Press acceptors expressed high levels of satisfaction with the method. Although most were satisfied with the counseling and services received, less than one-third realized that the community-based distributors were students. The distributors expressed satisfaction in their role, with over 95 percent stating they would recommend it to others. Their primary complaints were lack of remuneration, stock-outs, and need for greater supervision. The pilot validated the use of students in community-based distribution, paving the way for additional task-shifting pilots in Kinshasa.

Source: Bertrand, et al. 2017

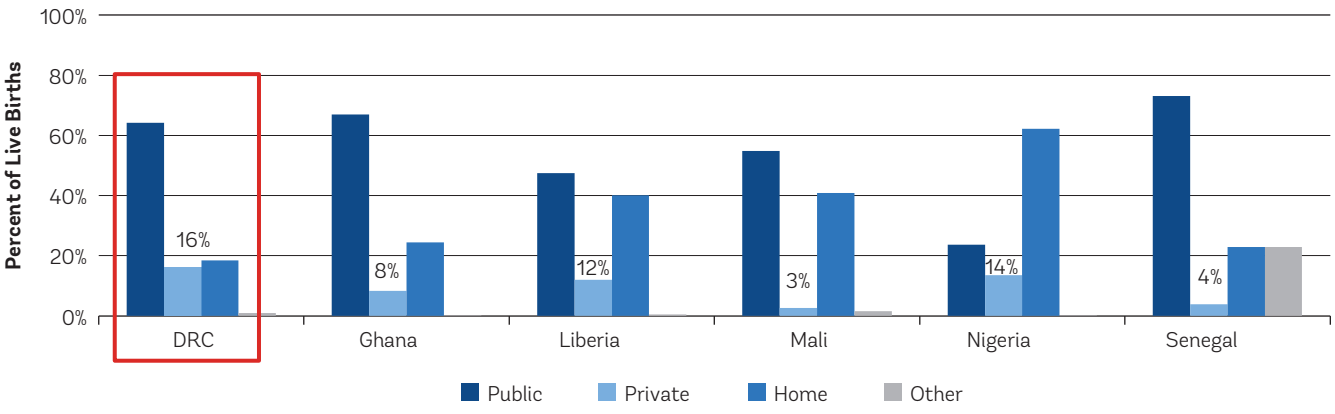
the MSP highlights maternal health as an important component of the PNDS and in the new Stratégie Intégrée pour la Santé de la Femme, de l'Enfant et des Adolescents 2017–2020, which is still under development.

4.3.2 Service delivery dynamics

Most live births occur at a public facility, whereas 16 percent occur in a private facility (DHS 2013–14). Despite this variation, the DRC's use of the private sector for births is higher than that of other countries in Central and West Africa (Figure 20).

The private sector could contribute more to maternal care, especially prenatal care and emergency obstetric services to reduce maternal mortality (Ntambue et al. 2016). The 2014 WHO Service Availability and Readiness Assessment (SARA) found that—compared with public

Figure 20. Place of live births



Source: DHS Program. n.d.

facilities—private facilities were more likely to have key inputs for maternal health services, such as 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.

4.4 CHILD HEALTH

4.4.1 Context

The DRC adopted the integrated management of neonatal and childhood illnesses (IMNCI) strategy in 1990. This approach focuses on the total well-being of the child to accelerate reductions in under-five mortality. IMNCI incorporates prevention and management of the leading causes of death, including pneumonia, malaria, diarrhea, malnutrition, anemia, HIV/AIDS, and neonatal disorders. A review of IMNCI implementation in 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, strategy objectives include strengthening provider capacity; increasing the percentage of health trainings with IMNCI; scaling up family- and community-based IMNCI practices in all 26 provinces; improving the availability of IMNCI drugs; strengthening management of IMNCI data; and ensuring coordination of IMNCI at all levels of the health system.

4.4.2 Service delivery dynamics

The private sector is an important source of care for sick children (see Box 15). 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 21). Most go to

Box 15. Private sector capacity building for child health

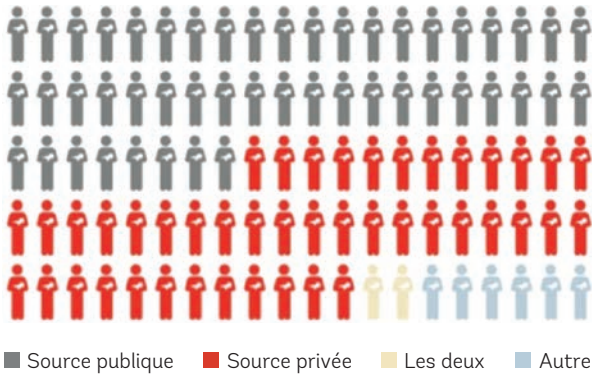
Most caregivers seeking treatment for childhood illnesses access private sector drug shops. However, knowledge of child illness case management among drug shop staff is extremely limited. A two-year pilot program (2009–11) in Kinshasa evaluated the knowledge and practices of counter agents in private pharmacies regarding the management of childhood diseases (respiratory illness, malaria, and diarrhea). Private pharmacy employees were trained and received supportive supervision in line with national policies and guidelines in counseling, dispensing, and referrals. As part of this effort, implementers examined drug dispensing practices and behaviors related to IMNCI, as well as the systemic factors supporting these practices (for example, supply chain capacity, availability of essential medicines for childhood illnesses, and ability of key actors to identify challenges and success factors in health systems strengthening processes). Pilot results reflected improved knowledge of danger signs across the board. Between 2009 and 2011, surveyed agents saw the following improvements:

- Did not know any signs of severe respiratory illness or knew only one reduced from 36 percent to 16 percent and from 49 percent to 33 percent, respectively;
- Knowledge that honey can be used for colds/coughs increased from 0 percent to 72 percent;
- Could recommend the correct treatment for pneumonia increased from 27 percent to 61 percent;
- Advised ORS + ZINC to manage diarrhea increased from 4 percent to 75 percent;
- Identified fever as a sign of malaria rose from 83 percent to 97 percent; and
- Knowledge of artesunate-amodiaquine increased from 22 percent to 72 percent.

Lessons learned reflect that private pharmacy staff are capable of dispensing medicines for the treatment of respiratory illnesses, malaria, and diarrhea by drawing on their knowledge and referring to national policies. Over the course of the pilot, almost 5,000 cases (children ages 0–5) were treated in 1.5 years, suggesting that the intervention could be useful in addressing infant mortality and behavior change in parents. Gaps in knowledge persist. The assessment team found that when asked how to take a zinc and ORS copack, drug shop staff frequently provided incorrect instructions, even when they had a concise instruction leaflet accompanying the copack product.

Source: SPS 2011.

Figure 21. Source of child health care in the DRC



Source: Bradley et al. 2017.

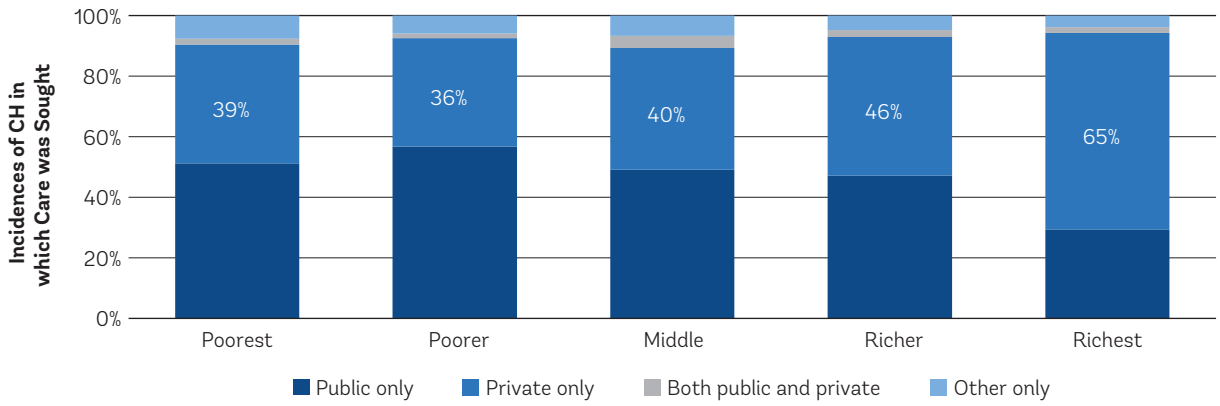
nonclinical sources, such as pharmacies, shops, or markets (81 percent), whereas fewer than one-quarter go to a private clinical facility, such as a hospital, doctor's office, or clinic (Bradley et al. 2017).

The private sector's role in the provision of child health services is significant across all wealth quintiles, from 40 percent in the lowest wealth quintile to over 60 percent in the richest (Figure 22).

This importance for lower-income households is more pronounced in the DRC compared with other countries in the region, second only to Nigeria (Figure 23).

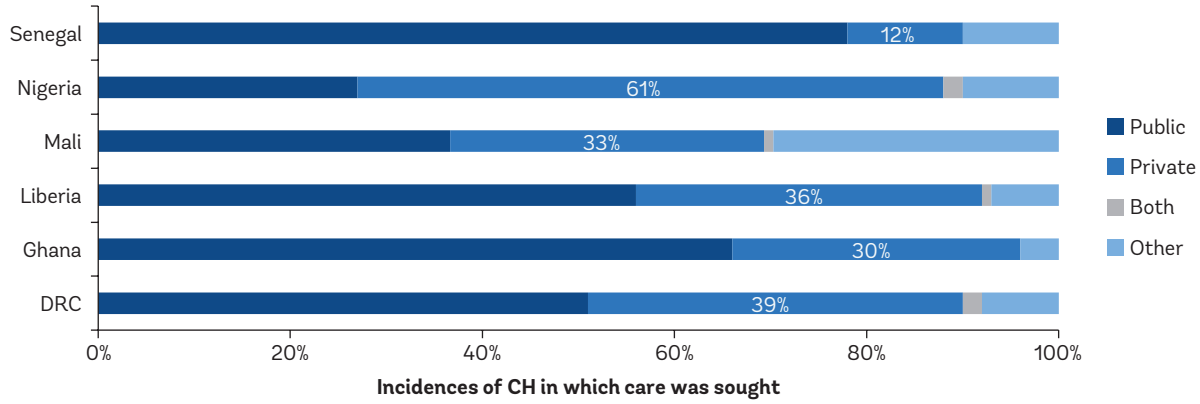
Most private providers (84 percent) offer preventative and curative child health services (MSP 2014a). While

Figure 22. Source of child health care by wealth quintile



Source: Bradley et al. 2017.

Figure 23. Source of child health care for the lowest wealth quintile in select sub-Saharan African countries



Source: Bradley et al. 2017.

private providers are less likely to provide vaccination services than are 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 in the last two years; key equipment and tools such as scales, thermometers, and general microscopy to examine parasites in the stool; and relevant medicines and products (for example, ORS, zinc tablets, vitamin A capsules, amoxicillin syrup/suspension, and paracetamol syrup/suspension) (MSP 2014a).

4.5 NUTRITION

4.5.1 Context

Chronic malnutrition affects households equally in the DRC, except the richest 20 percent of the population. The 2013 DHS estimated that 6.3 million young children experience stunting. Infant and young child feeding practices remain suboptimal—only 48 percent of children younger than 6 months are exclusively breastfed, and 52 percent of newborns are breastfed in the hour following delivery (DHS 2013–14). Although up to 79 percent of children receive timely complementary foods, only around 8 percent benefit from complementary feeding that meets criteria for a minimum acceptable diet. Women and children also have micronutrient deficiencies, with 47 percent of children younger than five years and 38 percent of women of child-bearing age experiencing anemia. The childhood stunting rate is 43 percent (DHS 2013–14).

4.5.2 Strategic collaboration and advocacy

The DRC joined the Scaling Up Nutrition Movement in 2013 and worked with key stakeholders to draft the National Multi-sectoral Nutrition Policy, along with its costed operational plan (SUN 2017). The National Nutrition Program (Programme National de Nutrition) develops protocols and guidelines, including the national protocol for management of acute malnutrition, guidelines on the nutrition community approach, and guidelines of growth monitoring through preschool consultations in health facilities. The National Multi-sectoral Nutrition Plan 2017–2021 (Plan Stratégique National Multisectoriel de Nutrition, 2017–2021) is a response to the need for a multisectoral approach. Priority is given to interventions targeting the first 1,000 days of a child's life.

As mentioned in Section 3.2, the DRC's government established the CNMN in 2015. It includes an interdepartmental platform and technical committee of experts. Although CNMN is not yet functional at the national level, multisector nutrition committees are established in South Kivu and Kasai, and the national nutrition program's technical platform, led by the MSP, met eight times between 2016 and 2017 despite not having a dedicated budget. This multistakeholder platform comprises members of various nutrition and food security "clusters," development stakeholders, nutrition-related ministries, technical and financial partners, and UN agencies.

In 2016, the MSP launched a common narrative with key stakeholders that led to strong advocacy efforts in the area of nutrition (MSP [n.d.]a). The narrative called for coordination and high-level engagement among stakeholders via a robust institutional framework, as well as interventions focusing on the first 1,000 days of life, to be complemented by access to care for women and children and nutrition-sensitive interventions. However, financial commitments have not been fulfilled, HRH remains underfunded, and most nutrition-specific interventions are supported by external partners and donors.

4.5.3 Service delivery dynamics in nutrition

In 2015, the World Bank published a policy brief comparing the cost-effectiveness of implementing and scaling up key nutrition interventions in the DRC. The goal was to help the government prioritize by identifying the most cost-effective packages and leverage additional resources from domestic budgets and development partners. Ten interventions were identified: community nutrition programs for growth promotion, Vitamin A supplementation, therapeutic zinc supplement with ORS, micronutrient powders, deworming pills, iron and folic acid supplementation for pregnant women, iron fortification of staple foods, salt iodization, public provision of complementary food for the prevention of moderate acute malnutrition, and community-based management of severe acute malnutrition in children (Shekar et al. 2015). Stakeholder interviews and visits to private clinics revealed limited services and products available for children with malnutrition. These visits found no nutrition-related commodities in private clinics, pharmacies, or drug shops. Therapeutic products are typically offered for free as part of humanitarian interventions, making it a less-profitable market for private providers.

Box 16. Ready to use therapeutic foods in the DRC

To date, there have been no successful local production initiatives for therapeutic foods. Nutriset, the French creator and supplier of Plumpy'Nut®, was granted a license for local production in the DRC. The PlumpyField network tried to support local production twice, first by providing assistance to the food company Jongea in Lubumbashi, and second by creating Amwili, a company specializing in the production of specific nutritional products for humanitarian agencies, such as the UN, Doctors without Borders, and World Vision. Amwili's factory in the DRC closed in 2012. Amwili's managing director, Nataly K. Besnier, explained that despite their efforts and the goodwill of the Congolese state, the company could not continue to operate because the economic environment and logistical costs related to production and distribution were prohibitive. Currently UNICEF provides most of the ready-to-use therapeutic foods in the DRC, whereas the World Food Program provides supplementary food. Rather than go through FEDECAME, these resources are distributed directly at the provincial level (Programme National de Nutrition [PRONANUT] or DPS), and in some cases directly to health zones.

Sources: UNICEF 2017; Nutriset n.d.

4.6 OTHER HEALTH AREAS

4.6.1 Malaria

Malaria is among the leading causes of morbidity and mortality in the DRC, accounting for 39 percent of outpatient visits and 39 percent of deaths in 2014 (PMI 2017). Malaria is also the principal cause of mortality among children under five. Diagnostic and treatment services are available in almost all facilities, and the public and private sectors have similar operational scores for diagnostic and treatment services (54 percent and 53 percent, respectively) (MSPa 2014). One of the goals of the Programme National de Lutte contre le Paludisme (PNLP) is to improve collaboration with the private sector. The PNLP's Strategic Plan 2016–20 highlights the importance of engaging the private sector in planning, with representatives from the private sector included in the malaria technical working group, and in implementing activities, such as for the sale of full-cost or subsidized insecticide-treated mosquito nets and malaria treatment (PMI 2017).

Many seeking care and treatment use the private sector, with 47 percent of children with fever being taken to private providers (DHS 2013–14). The private sector accounts for over 80 percent of the sales of antimalarial agents in Kinshasa and over 70 percent in Katanga (ACTWatch 2017). Most private sector outlets with antimalarial agents are drug stores. Private for-profit health facilities and pharmacies also stock antimalarials. Among outlets with at least one antimalarial in stock, over 80 percent of private sector outlets in Kinshasa and 50 percent in Katanga stocked nonquality-assured artemisinin-based combination therapy (ACT), whereas approximately 20 percent in Kinshasa and 50 percent in Katanga stocked quality-assured ACT (ACTWatch 2017). Quality control in the private sector is discussed in greater detail in the Access to Essential Medicines section.

Multiple projects aim to improve the quality of malaria services in the private sector. The Global Fund and the U.K. Department for International Development are cofinancing a pilot project in Kinshasa to introduce subsidized ACT in the private sector (PMI 2017). The Defeat Malaria project is working to improve malaria treatment, as well as the availability of quality rapid diagnostic test kits and antimalarial drugs at an affordable price in the private sector by subsidizing import inputs. In 2016, the project helped import 921,360 green leaf ACTs, trained 1,771 providers, and supported 4,025 private organizations to distribute green leaf ACTs and distribute 498,075 rapid diagnostic test kits (MSP 2017k).

4.6.2 Sexually transmitted infections and HIV/AIDS

The Plan Stratégique National de Lutte Contre le VIH et le Sida 2014–2017 highlights the need to engage the private sector about HIV/AIDS and other sexually transmitted infections, including planning for sector-specific plans in coordination with public and private sector stakeholders.

HIV testing and treatment are available in 72 percent of private facilities. Operational capacity for HIV counseling and testing, as well as treatment and support, is high in private facilities (84 percent and 74 percent, respectively) (MSPa 2014).

HIV prevalence among registered tuberculosis (TB) patients in the DRC is over 11 times the prevalence in the general population, at approximately 12 percent

(WHO 2016), making TB an extremely important entry point for finding new HIV patients.

4.6.3 Tuberculosis

TB incidence (including TB/HIV coinfection) is high in the DRC, at 324 per 100,000 persons. Unfortunately, the number of people developing TB has not decreased in the past few years (Figure 24).

Despite how widespread TB is, only 30 percent of health facilities provide TB services. These are offered more widely in the public (38 percent) than in the private sector (17 percent) (MSP 2014a). Only 51 percent of people with TB were reached in 2016 (Stop TB 2017). Other countries have developed multisector initiatives, in collaboration with mining companies, to combat TB that the DRC could learn from (Box 17).

Box 17. The Southern Africa TB in the Mining Sector Initiative

The Southern Africa TB in the Mining Sector Initiative, led by the World Bank, has facilitated collaboration among governments, civil society, development, and private sector partners working to combat TB in the mining sector in the Southern Africa region. This initiative has successfully reached multiple milestones, including the development of a regional harmonized framework for the management of TB supported by the rollout of training modules for service providers and health workers or the geospatial mapping of all mine workers, former mine workers, their families, and health services in South Africa.

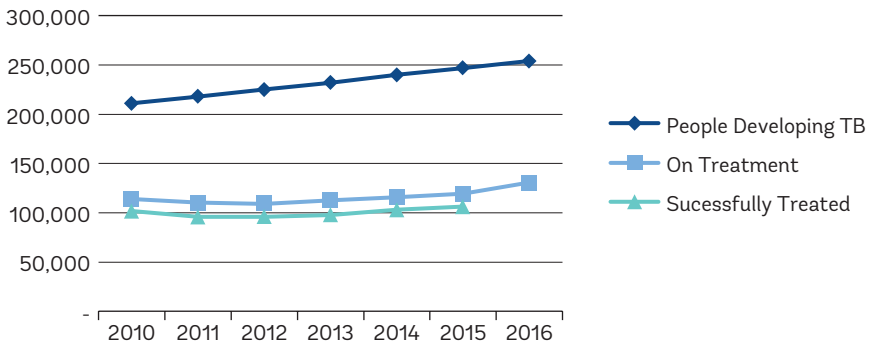
Source: World Bank 2018.

4.7 SERVICE DEMAND

Demand for health services is limited by several factors. Entrenched social and cultural norms inhibit the use of health services in the DRC—for example, misconceptions about FP and the desire for large families prevent FP uptake. Mobilization activities are often implemented independently by stakeholders with limited coordination among donors (for example, child health immunization campaigns) (see Box 18). For some health areas, such as nutrition, donor funding prioritizes supply-side interventions, such as supplements, while efforts to increase demand targeting head-of-household decision making are limited. Willingness and ability to pay also are significant barriers to service use. Over one-third of the population chooses not to use health services because of cost (Figure 25).

Examining demand for health services, including factors that drive demand, can inform social and behavior change (SBC) campaigns that aim to increase the use of priority health products and services. DHSs provide a great deal of information specific to demand for family planning. Although there may be some differences across health areas, this information can highlight populations that could potentially access health services through the private sector and interventions that could facilitate this access. For example, the assessment team's analysis of

Figure 24. Number of people developing TB, on treatment, and successfully treated, 2010–16



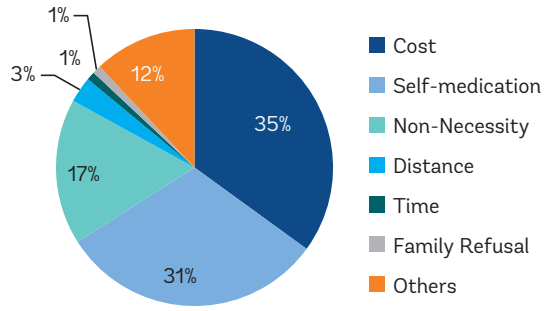
Source: Stop TB 2017.

Box 18. Changing behaviors through SBC campaigns

Social and behavior change (SBC) campaigns can contribute to changes in both knowledge levels and behaviors in the population, but they require a certain level of coordination and investment. An RCT study conducted by DMI in Burkina Faso found that partners need to broadcast for around 10 weeks (10 times per day, every day, spread across a larger number of weeks) to change a particular behavior by around 9%.

Source: DMI 2016.

Figure 25. Main reasons for nonuse of health care in the DRC, 2013

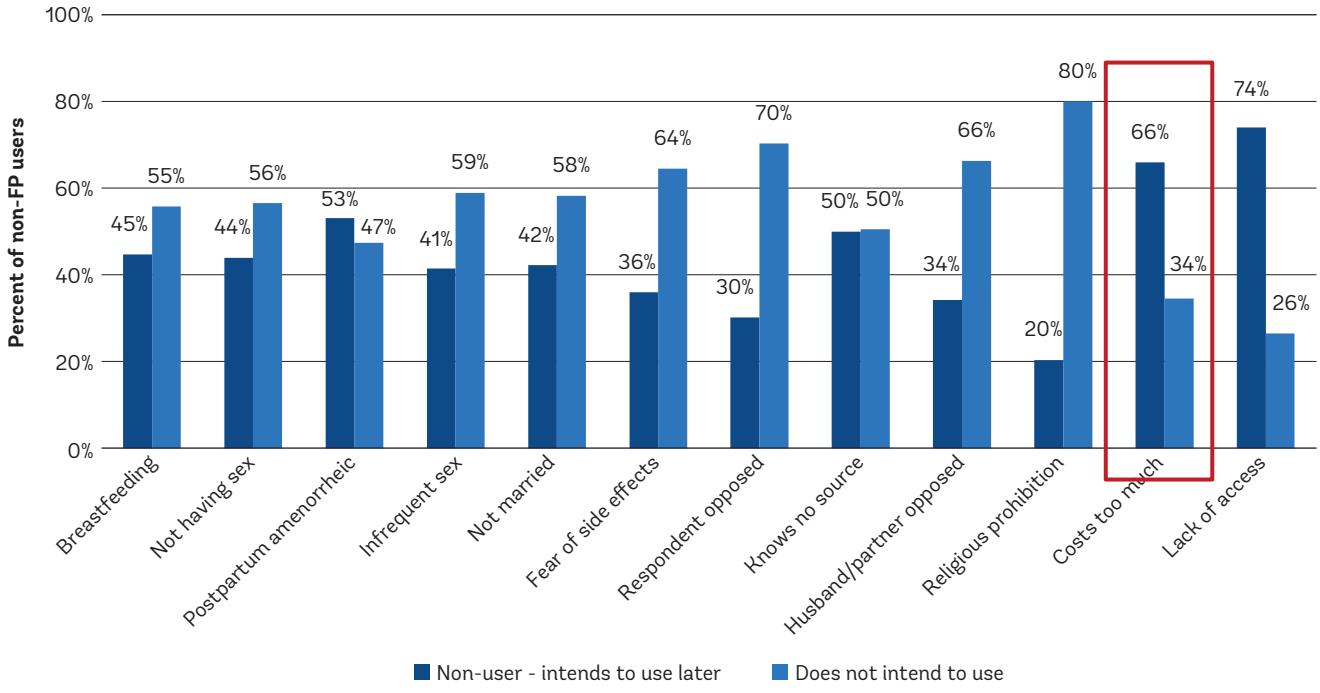


Source: Barroy et al. 2014.

the most recent DHS data reveals that there are close to 15 million women in the DRC who either want to delay or limit their pregnancies but are not using a modern contraceptive method. Among women who do not currently use a modern FP method but intend to, cost and lack of access are cited as the main barriers (Figure 26).

Although available data limits this type of analysis to FP for now, donors and the government of DRC could support similar research efforts to better understand why nonusers of child health and HIV, malaria, and other health products are not accessing care. This information can inform better-targeted interventions to build demand. It

Figure 26. Percentage of nonusers of FP by type reporting reason for nonuse



Source: DHS 2013–14.

can also inform interventions to make private providers more capable of fulfilling existing unmet demand, including clinical trainings to expand private provider service offerings, supply chain interventions to improve private provider and retail outlet access to pharmaceutical products, and health financing strategies to address high costs at private facilities.

4.8 RECOMMENDATIONS

This section provides recommendations for private sector service delivery, particularly in FP and MCH.

Collect additional information on service delivery in the private sector

Finding: There is limited information 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, as well as the quality of products and services they provide.

Recommendation: Stakeholders should integrate questions regarding the private sector in upcoming studies, such as WHO's next SARA, and invest in complementary studies to better understand the role private providers play in service delivery. Better integrating the private sector in the national health information systems will also provide key data to inform decision making, as highlighted below in the Health Information Systems section.

Madame Lusandu Chantale, FP Specialist at the Centre Hospitalier de Reference de Libikisi of the Église du Christ au Congo, Kinshasa

Strengthen private provider access to clinical trainings, especially for FP

Finding: Although there is a general perception of better quality services in the private sector, providers often offer a limited range of services because of lack of clinical skills. Donor-sponsored programs also tend to focus on public sector, FBO, and NGO providers, omitting the private for-profit sector. As a result, private providers often do not receive regular updates about FP and other services.

Recommendation: Donors and governments should consider new strategies for reaching private providers with new and refresher trainings for FP and other services. These efforts should leverage existing efforts by networks such as ABEF or PSI that currently deliver trainings on FP counseling and service provision to their members and partner providers. Expanding these training programs to cover new health areas (for example, TB or HIV) and reach more providers can help increase the availability of a greater range of services in the private sector. By working through an existing network or provider association, donors and governments can also build more links among these groups and larger numbers of independent private providers, thereby helping to address some of the fragmentation that currently characterizes the private health sector.

Invest in programs that address cost barriers to FP services in the private sector

Finding: Cost is a barrier to the use of family planning services—especially long-acting methods such as implants—in the private for-profit sector.

Recommendation: Although efforts to use vouchers have been limited in the DRC (mainly focused on humanitarian efforts and child health), donors and the DRC government may want to consider supporting such an effort. In other countries in the region, these programs have helped reduce financial barriers and increase access to priority health services (Box 19).

Leverage an integrated four-pronged approach to improve child health case management

Findings: The DRC's IMNCI strategy objectives include building capacity, improving availability of IMNCI drugs,

Box 19. Using vouchers to increase use of priority health services in Uganda

To address Uganda's high maternal mortality rate, USAID invested in a maternal health voucher program in four districts from 2012 to 2014 as part of the Saving Mothers, Giving Life Initiative. As implemented by Marie Stopes Uganda, women could purchase a low-cost voucher from a community-based distributor that covered a suite of maternal health-related services, including antenatal visits, delivery, and testing and care for pregnancy-related complications. These vouchers were redeemable at participating Marie Stopes clinics that had received proper clinical training. Once vouchers were redeemed, providers submitted claims for payments to Marie Stopes Uganda. These payments were higher than what the women originally paid for the voucher, allowing low-income clients to access high-quality care in the private sector and private providers to recoup the costs of their service provision. Over the course of this two-year program, over 36,000 women purchased a voucher. Ninety-four percent redeemed them for antenatal care and 74% for delivery.

Source: SHOPS Project 2015.

scaling up family- and community-based IMNCI practices, and improving coordination among all stakeholders. This assessment revealed political will for using the private sector to improve child health outcomes and reflected a consistent supply of zinc and ORS in drug shops in Lubumbashi.

Recommendation: To take advantage of this political will, donors and the DRC government should support an integrated multichannel SBC campaign focusing on child health and using lessons from past campaigns in the DRC to inform design. Through expanded use of the private sector in other countries, donor programs have addressed preventable child deaths in several field programs using a four-pronged approach (Figure 27): 1) securing a conducive policy and regulatory environment for treatment; 2) ensuring wide availability of high-quality, affordable

Figure 27. Four-pronged approach to improve ORS and zinc use

child health products in the public and private sectors; 3) generating demand for products and teaching caregivers when and where to seek treatment and how to correctly use products; and 4) improving knowledge and skills of providers in both the private and public sectors to promote and deliver appropriate treatment. They should also build the capacity of drug shop counter agents to prevent and treat childhood illnesses, using training and supportive supervision to improve prescription practices.

Increase private sector engagement in nutrition programs

Finding: Private sector engagement in nutrition programs remains relatively limited.

Recommendation: Specific opportunities to engage the private sector include:

- Assessing the feasibility of working with local private companies to package nutritious food (for example, fortified oil for cooking) in small quantities that can be sold at a more accessible price;
- Promoting local food fortification (that is, wheat flour, salt iodization);
- Engaging the private sector to transport therapeutic products to difficult-to-access areas; and
- Organizing a private sector network to contribute to the national nutrition plan and ensure that private sector stakeholders are aware and engaged in nutrition efforts.

5. Access to Essential Medicines

5.1 OVERVIEW OF THE SUPPLY CHAIN

The current state of the supply chain reflects the size of the DRC and its poor infrastructure. The supply chain is large, complex, largely unregulated, and characterized by fragmentation and duplication. In 2009, there were 99 distribution channels for the public and nonprofit sector, with 85 percent of partners using their own procurement agencies, warehouses, and distribution systems, causing waste and duplication (Ntembwa and van Lerberghe 2015). Implementation of the National Supply Chain System in 2009 had not had a significant impact on this situation by 2014 (SIAPS et al. 2014).

The private sector plays a significant role in procuring and distributing medicines and supplies to private pharmacies, drug shops, clinics and hospitals but is even more fragmented than the public-sector distribution system. The government can only estimate the number of private importers, wholesalers and drug shops because registration and regulation are ineffective (Table 5). The government's need to estimate unauthorized wholesalers speaks to the lack of regulation. As a point of reference, in other francophone countries (Côte d'Ivoire and Senegal), there are only four to five authorized wholesalers (grossistes répartiteurs) serving the entire country, with over 1,000 verified authorized pharmacies. This economy of scale allows the wholesalers to invest in logistics for better storage and delivery directly to pharmacies at

Table 5. Pharmaceutical manufacturers, authorized private wholesalers, wholesalers, and authorized pharmacies in the DRC,* 2017

Province	Manufacturing Laboratories	Authorized and Unauthorized Wholesalers	Authorized Pharmacies
Total in the DRC	**30**	**171**	**109**
Kinshasa	21	90	90
Haut-Katanga	3	29	11
North Kivu	1	3	0
South Kivu	2	12	1
Kasai-Oriental	1	1	1
Kongo Central	2	8	1
Orientale	0	0	4

*Based on former provinces.
Sources: MSP 2017b, 2017c, 2017d, 2017e, 2017f.

short notice. The DRC represents an extreme case where diseconomies of scale result in greater challenges to regulators and lower quality.

Authorized pharmacies are outnumbered by unauthorized pharmaceutical retail outlets. A WHO study from 2015 estimated that there were approximately 4,000 unauthorized facilities dispensing drugs, which is much greater than the MSP numbers in Table 5. Another study found over 5,000 drug shops in Kinshasa with neither a permit nor a qualified pharmacist (Office Fédéral des Migrations [ODM] 2014, 7sur7.cd 2015). The presence of unauthorized pharmacies and wholesalers makes it difficult to accurately estimate the size and scope of the private sector supply chain. Although stakeholders condemn the dominance of unregulated drug shops, they also acknowledge the DRC's dependence on them for access to medicines and the inadequate number of trained pharmacists to replace them.

5.2 PUBLIC/NGO SUPPLY CHAIN

Since the collapse of the health system in the 1990s, the government has slowly rebuilt a supply chain that integrates CDRs with FEDECAME, the central procurement unit. However, regional and vertical aid programs have developed their own systems for critical supplies for emergency and priority programs. The FEDECAME model is a public–private mix—both the CDRs and FEDECAME are nongovernmental, nonprofit associations, and the national government gives them a mandate to supply public-sector facilities. The MSP aims to have at least one CDR per province. The government and its partners have helped establish most CDRs by providing office and storage space, technical assistance and training, and capital investment for vehicles and equipment. Many of the CDRs were converted from procurement units established by FBOs or international NGOs. For example, the Association Régionale d'Approvisionnement en Médicaments Essentiels (ASRAMES) in Goma was initially established by Doctors without Borders Holland and eventually converted into a CDR and integrated into the FEDECAME system.

ASMARES Warehouse, Goma

Although FEDECAME's primary mandate is to supply public facilities, the government envisions that FEDECAME will integrate the procurement and logistics functions of international and faith-based NGOs, thereby reducing fragmentation and duplication. Ideally, this consolidation would help the CDRs and FEDECAME achieve a scale that increases their prospects for financial sustainability. However, the current system does not cover the entire country, and parallel programs persist in the absence of a robust national supply chain. There are currently 19 authorized CDRs across the DRC, many of which are in heavily populated areas, such as Lubumbashi, Mbuji-Mayi, Kinshasa, Matadi, and Goma (MSP 2017b). These are at different levels of functionality, financial stability, and capacity. Although FEDECAME is supposed to pool procurement, several CDRs procure through other channels that they can access more easily, demonstrating the challenge of establishing a single procurement unit for the entire country.

In addition to logistical limitations, the FEDECAME and CDRs must also balance serving the public sector while operating as financially sustainable, independent nonprofit entities. Ideally, CDRs recover their operational costs on the sale of products to health zones, but public-sector facilities are not always well managed and may not pay their bills. Moreover, public-sector facilities do not always purchase their products through FEDECAME. The government provides some advance funding to FEDECAME to ensure sufficient funds for procurements, but ultimately the system still depends on cost recovery

from patients. This inhibits the ability of the CDRs to achieve scale, stabilize, or become solvent. For example, CAMESKIN, the CDR in Kinshasa province, incurred a loss of $561,037 in 2016 and carries $124,180 in debts on its balance sheet (CAMESKIN 2017).

CDRs earn no margin on the sale of products when they are provided for free by donors. Although only a few international programs have integrated their procurement into the FEDECAME system, many have supported CDRs by contracting them for the storage, tracking, and distribution of free products. Each contract is negotiated separately, but there are some common practices. Storage is never billed on the basis of weight, volume, or surface area occupied because such criteria are subject to dispute and difficult to monitor. Instead, CDRs bill 6–8 percent based on the product value as it is documented on official importation documents. Some programs also provide performance incentives to increase above the base percentage if CDRs meet standards for delivery times with minimal loss or damage. This income is an important source of additional revenue. For example, one CDR earned $84,392 from the sale of medicines in 2016, while in the same time period they earned $1,027,097 in contracted storage services and another $130,048 in delivery services.

Pharmacie Hekima Saint Etienne, Goma

FEDECAME also struggles with accurate procurement forecasting because many programs operate independently, importing products for HIV, malaria, and FP without consultation. If a CDR procures specific products without knowing that an international partner is planning to bring in large quantities for free, the CDR risks expired stocks and financial loss. CDRs are especially cautious in procuring medicines for priority programs, thus perpetuating the need for donor programs. One CDR, for example, has stopped procuring antimalarial drugs because the needs of the population are covered by donor and international NGO procurements.

Some international organizations interviewed as part of the assessment continue to procure quality medicines on the global market because they are working with larger volumes and can obtain better prices. FEDECAME also requires much longer lead times (10 months). At least one organization raised concern about FEDECAME's quality systems. Given these factors, it seems unlikely that international organizations will shift their medicine procurement to FEDECAME in the near future.

5.3 COMMERCIAL SECTOR SUPPLY CHAIN

5.3.1 Local manufacturing

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 (MSP 2011). Local pharmaceutical manufacturing is highly dependent on imported inputs and packaging equipment, and multiple import taxes increase costs and lower price competitiveness, which does not encourage local production (MSP 2011). Local manufacturers face other challenges, such as irregular and expensive utilities, high transportation costs, and corruption. Furthermore, the tax rate is the same on manufacturing inputs as finished products (see Box 20). Most local pharmaceutical manufacturers have not achieved Good Manufacturing Practices certification (MSP 2011), and as a result, FEDECAME procures little from them. For example, FEDECAME received submissions only from Pharmakina, which is Good Manufacturing Practices certified, in response to a recent request for quotations. Moreover, consumers perceive locally manufactured products as poor quality, so pharmacists are reluctant to stock them.

Box 20. Customs regulations and import duties and taxes

The Directorate of Customs and Excise (Direction Générale des Douanes et Accises) assesses and collects tariffs and duties for imports based on established rates under the DRC's tariff schedule. Import duties and taxes are the same for specialty and generic pharmaceutical products. The rates are the same for finished products, as well as manufacturing inputs. Importers pay a number of taxes and duties, including embarkation and disembarkation fees, import licenses, airport taxes, industry promotion funds, and others (MSP 2011, export.gov 2017a).

As with other pharmaceutical products, the importation of contraceptives and condoms into the DRC is subject to payment of customs duties, taxes, and other fees, including an administrative fee of 5 percent (UNFPA 2017a). This taxation results in an increase in the price of products, as demonstrated by the approximately 60 percent markup for contraceptives (UNFPA 2017a). Donor agencies such as UNFPA, USAID, Department for International Development, and some NGOs are exempted from customs duties but are not exempt from the 5 percent administrative fee.

5.3.2 Importers and wholesalers

The 2016–20 National Health Development Plan estimates that in 2015, the pharmaceutical market—including both public and private sectors—totaled US$457.4 million (MSP 2016). Many drugs are imported by international aid organizations implementing emergency assistance programs, and the value of their imports may not be captured in this analysis.

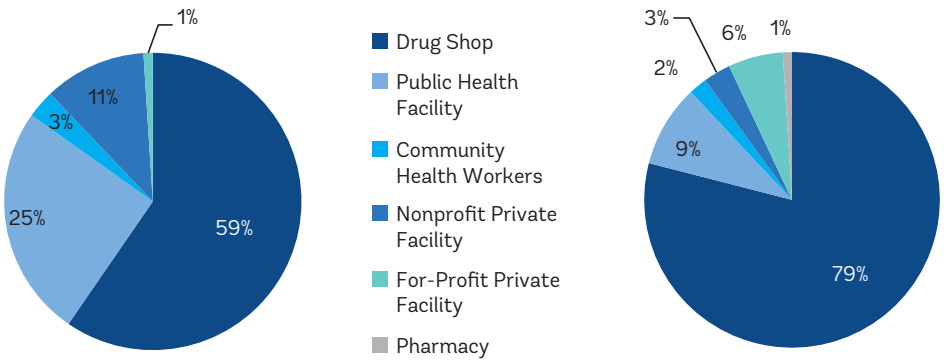
As noted, it is difficult to quantify the number of wholesalers/importers and retail outlets because of inadequate regulation and registration. The MSP estimates 171 wholesalers/importers are active in the DRC, but few have national presence or capacity, and most focus on selected markets in large towns or cities. The assessment team surveyed 34 pharmacies and drug shops in six cities, and no wholesaler was named as a principal source of supply in all. Few wholesalers offer credit to clients or deliver products to pharmacies or drug shops; most operate depots, selling to clients who come and purchase on a cash-and-carry basis. There is no system for verifying that purchasers are qualified pharmacists or even owners of pharmacies. In addition, many private importers sell medications of questionable quality (Office Fédéral des Migrations, 2014). Based on data collected by the assessment team from retail drug shops, imports seem to be sourced from different parts of the world depending on location in the DRC. In Kinshasa, for example, more imports were from Europe and the United States, whereas in the east, imports came from Tanzania and Rwanda, with suppliers bringing drugs through Dar es Salaam. In Lubumbashi, medicines were from Asia and South Africa, entering the country via Tanzania and Zambia. In Mbuji-Mayi, drugs were received primarily from the southern route via Lubumbashi.

5.3.3 Pharmacies and drug shops

The retail sector is dominated by unregistered drug shops calling themselves pharmacies—estimates vary from 8,000 to 10,000 compared to 109 registered pharmacies. Drug shops are typically operated by an owner or staff

Drug shop in Matete, Kinshasa

Figure 28. Outlets stocking modern contraceptive methods



N = 350 for Katanga and N = 433 for Kinshasa.
Source: PSI and FPwatch 2015; Bradley et al. 2017; PMI 2017.

member without any training in pharmacy; 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. The Order of Pharmacists indicated that this means pharmacists are seeking employment elsewhere, including other sectors and countries. Most drug shops receive little or no credit from wholesalers, and as a result, stockouts occur frequently because of the shops' lack of liquidity rather than unavailability of medicines. Despite these issues, drug shops are essential for ensuring the availability of medicines in the DRC, and closing them all would not be desirable or feasible. Figure 28 shows that drug shops represent between 59 percent and 79 percent of contraceptive selling outlets.

5.4 ACCESSIBILITY AND PRICING OF DRUGS

Drug prices are regulated by the Ministry of the National Economy (Ministère de l'Économie Nationale), which sets the profit margin at 20 percent for wholesalers and 33 percent for pharmacies. Although prices for generic drugs are almost the same in the public and private sectors, prices for branded drugs are higher in the private sector (MSP 2011). It is unclear whether pricing regulations are followed because there is no monitoring, and few medicines have prices on them. Lack of enforcement, the large number of drug brands, and market regionalization contribute to price variations. For example, in 2015, the range of prices for quality-assured ACT in Katanga was $1.10–$2.19; the range for similar or identical quality-assured ACTs in Kinshasa was $4.93–$8.77.

A major influence on price inflation is the lack of purchasing power of clients and the lack of effective health insurance programs to cover the cost of medicines. A number of key informants cited difficulties among their target groups in affording medicines and questioned the wisdom of the public sector's adoption of a cost recovery system. This is especially true in the eastern part of the country, where insecurity and unemployment are

Box 21. Informal survey results of 21 pharmacies and drug shops for child health products in Lubumbashi

The analysis of the data collected from 21 pharmacies and drug shops found:

- Eighty percent carried ACT. Twenty-seven different brands of ACT were found in the Lubumbashi retail audit, whereas only 29 percent of those surveyed stocked rapid diagnostic tests.
- Seventy percent of outlets carried ORS, the majority of which was the low-osmolarity formulation. Twelve brands were sold at a price range of CDF 100–3,000 (US$0.06–$1.87) per sachet.
- Forty-eight percent of outlets carried zinc as a stand-alone product, the majority of which was Pedzinc, manufactured by Beta Healthcare International Ltd. in Kenya. The price range for a 10-tablet blister was CDF 50–2,500 (US$0.03–$1.56).
- Twenty-nine percent of outlets carried pediatric zinc and ORS copack. Approximately half of the copacks were OraZinc, manufactured by Maharashtra, in India. The price range for the copack was CDF 0–10,000 (US$0–$6.25).
- No commercially branded therapeutic nutrition products were found.
- At one location in front of a large private clinic in Kinshasa, locally hand-packaged bags of a maize-like porridge were found. Ingredients included soy, corn, caterpillars, and kikalasa (a grain/vegetable product), prepared by mixing the ingredients, adding water with a spoonful of olive oil and some sugar and milk, if available, after cooking. The packet is prescribed to children who come to the clinic with signs of malnutrition (low weight, stationary weight, anorexia) and is sold for CDF 1,500 (US$1).

major challenges, especially in unstable or refugee situations. According to MSF Holland, fewer than one-seventh of people in their project areas can afford to pay for services or medicines (MSF 2017).

Sensitivity to high prices may also be a factor in driving demand for cheap but substandard medicines. An informal survey of drug shop outlets as part of this assessment showed that for some common medicines (amoxicillin and ciprofloxacin), there were as many as 20 different brands available with a large range in prices (see Box 22). For low-income consumers, pressure will be toward choosing the cheapest brands without regard to whether or not they are quality assured. Prescribing habits also contribute to cost. A prescription in the DRC includes on average seven different medicines, some of which perform the same function, but consumers lack the knowledge to know the difference. This tends to increase out-of-pocket expenditures on health, particularly among the poor (Ntembwa and van Lerberghe 2015).

5.5 REGISTRATION AND PHARMACOVIGILANCE

The MSP's reforms have improved the registration system by increasing the number of medicines registered, decreasing the number of days needed to process registration, and increasing the percentage of items listed in the national essential medicine list with registered products (Table 6).

However, there are still issues around registration costs. In most countries, the entity charged with registering drugs has some autonomy from the MSP, and the fees it charges for each application are used to defray the costs of assessing the application, including the costs of inspecting manufacturing facilities and verifying documentation submitted. In the DRC, fees are charged only for drugs that are actually registered, and the fees are paid directly to the treasury, so they do not support the increased burden of evaluating applications (MSP 2017j). In addition,

Table 6. Medicine registration efficiency and effectiveness

Indicator	Baseline	Current (2016)
Medicines registered with the DPM	400 (2011)	4,600
Days to process registration	84 (2013)	58
Percentage of items listed in National Essential Medicines List with registered products	44 (2011)	64

Source: SIAPS 2014

the DPM has not yet established clear criteria for refusing drug applications based on public health benefit. The DPM director noted that each pharmaceutical company can register its own brand of common molecules and market those brands to retail outlets regardless of how many similar products are on the market. The DPM is still responsible for ensuring that all imports meet quality standards, so this regulatory gap increases the burden of monitoring drugs, making it harder to establish a comprehensive database of all drugs registered in the country.

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 MSP lacks the resources to implement a strong quality assurance program (MSP 2011). The MSP does not have a national drug control laboratory of its own but relies on laboratories at the University of Kinshasa, the Congolese Office of Control (Office Congolais de Contrôle, OCC), and two private laboratories. Many of these lack adequate equipment and cannot perform specialized tests (MSP 2011). The OCC laboratory is the only one accredited to ISO 17025 standards (WHO 2015) and has primary responsibility for drug testing. With 24 labs throughout the country and an additional three planned, the OCC has significant capacity. However, the OCC also has a huge mandate to test drugs, food, construction equipment, and materials, and must test products being exported as well as imported. The system for notification of possible side effects or cases of suspected substandard or counterfeit drugs is still mostly ad hoc. The DPM director acknowledges this and has plans to establish a commission to improve post-marketing pharmacovigilance systems but currently the lacks the resources.

5.6 RECOMMENDATIONS

Recommendations to increase private sector provision of essential medicines include:

5.6.1 Reinforce the FEDECAME System

Continue to provide technical support to the FEDECAME system

Finding: Although the capacity of the FEDECAME network, as well as individual CDRs, is limited, strengthening this system is a critical strategy for improving access to quality medicines in the public, nonprofit, and faith-based sectors throughout the country. In particular, efforts are needed to see how the network can be more responsive to international NGO needs.

Recommendation: Through existing programs of the World Bank and other partners, provide technical support to FEDECAME beyond procurement, storage, and logistical issues to also include cost controls, marketing, and risk management around bad debt, overstocks, and competition (World Bank 2017b). Technical assistance should also target the governance of the FEDECAME system.

Support CDRs to better manage their bad debt risk

Finding: CDRs urgently need new strategies or systems for managing their bad debt risk from public-sector facilities and health zones. The current system of the public sector providing a line of credit from the national budget is suboptimal. For the FEDECAME network to expand, the level of capitalization should be increased significantly each year. Instead, the CDRs' bad debts undermine needed growth.

Recommendation: Technical assistance should be provided to the FEDECAME network to increase their access to operating capital and identify ways to minimize their risk from bad debts. As an example, the central purchasing unit in Senegal, rather than transferring title to medicines to health zones, established their own depot in the largest hospitals to sell medicines on a cash basis to consumers and health facilities. This combines the continued availability of medicines and the needed cost recovery.

Encourage collaboration among donors, international NGOs, and the FEDECAME system

Finding: Although Programme National d'Approvisionnement en Médicaments Essentiels (PNAME) would like more international organizations and large vertical programs (for example, PEPFAR, Global Fund, and PMI) to fully integrate into the FEDECAME system, this is not feasible at this stage.

Recommendations: International organizations can support the FEDECAME network by:

- Increasing efforts to coordinate their procurement and distribution with the FEDECAME network and PNAME, particularly to assist with forecasting of needs and improve CDR planning and risk reduction; and
- Continuing and/or expanding the existing practice of contracting storage and distribution to CDRs because

it is an important source of technical support and operational financing.

5.6.2 Reform Pharmaceutical Distribution

Comprehensive reform of the commercial pharmaceutical sector

Finding: The private sector supply chain needs major reforms. Stakeholders recommended a new scope for drug outlets based on the Tanzania Accredited Drug Dispensary Outlet model. This requires drug outlets to sell only to registered pharmacies or accredited drug outlets; track the lots of all medicines sold; deliver directly to approved points of sale; provide 30 days' credit on sales of essential medicines; and meet all global standards for space, storage conditions, and handling of medicines. This would require a new training program, with involvement of the Order of Pharmacists and medical schools, to ensure adequate supply of qualified staff and increase production of pharmacist candidates. However, multiple problems must be addressed. For example, DPM inspectors currently operate independently and can only make warnings or render technical recommendations—only law officers have the authority to close a business. Long-term enforcement is critical to sustaining progress. In addition, the chances of successfully reforming the private pharmaceutical sector are much lower if consumers still buy the lowest-priced medicine with no thought to quality. The Order of Pharmacists and others have conducted some small-scale awareness campaigns, but consumers do not necessarily know which shop or package of medicines is good. A campaign is needed to help consumers identify which shops have been certified and how to identify questionable drugs. In addition, if other investments are made for a web-based drug registration list and an easier-to-use alert system, consumers could be encouraged to check suspect drugs against the national registry and report unusual side effects or ineffective medicines into the pharmacovigilance system.

Madame Elodie, Pharmacie Kibaphar, Lubumbashi

Recommendations:

- Define a new scope of practice for drug shops to sell selected essential medicines (not the full range of medicines available from a registered pharmacy) and develop a curriculum and training program for all drug outlet operators. Put all drug shops on notice that they have one year to go through the retraining program and reregister. After the initial year, they would be subject to fines or closure.
- Raise drug wholesaler standards and put existing wholesalers on notice to reach the standards or be shut down within a year or less. The DPM could identify key wholesalers using import data from the Ministries of Commerce and Finance as well as data from the DPM's planned mapping of private pharmaceutical supply chain stakeholders. During the probationary year, the DPM and technical partners can provide technical assistance but should actively encourage consolidation and a reduction to a smaller number of wholesalers with greater capital investment and more logistical capacity that are easier to inspect and monitor.
- Invest in building the capacity of the Inspection Générale de la Santé to supervise and enforce drug regulations, including undertaking regular inspections and sanctioning of pharmaceutical premises. Create a special unit that includes duly authorized officers of the law, mandated by the Minister of Justice, to work closely with them to close down unregistered or noncompliant drug shops and wholesalers. Put in place the administrative procedures for this unit, recruit and train new inspectors, and define standard operating procedures.
- Design and implement a public awareness campaign to sensitize people about the dangers of buying

Box 22. Sproxil and mPedigree: pharmacovigilance through digital consumer engagement

Sproxil and mPedigree use mobile technology to combat drug counterfeiting, drive revenue, and engage consumers at the point of sale through brand assurance, fraud protection, and loyalty rewards. Sproxil and mPedigree partner with pharmaceutical companies to label products with codes that can be authenticated by text message at all points on the global supply chain, including by the consumer when purchasing a product. The codes can also be used as a loyalty program so that customers who verify their products can win prizes or rewards. With products in Mali, Nigeria, Tanzania, and Pakistan, Sproxil has demonstrated its ability to function in some of the most challenging settings. mPedigree's text-based mobile product authentication service system has already appeared on 6.5 million packs of medicine and has been adopted as the national standard in three different countries. Sproxil and mPedigree could potentially be used as tools to develop the market for the local pharmaceutical industry.

Source: Sproxil 2017; Cadwalladr 2012.

unregistered medicines and the importance of using registered drug shops. Partner with drug manufacturers to design a smartphone application that consumers could use to check the lot number of a package they are considering buying against the national registry of medicines (Box 22).

- Support the DPM to enforce new legislation by ensuring all shops adhere to the new scope of practice and that wholesalers are adhering to the new regulations. Focus the rollout of increased vigilance on major cities first and gradually expand throughout the country.
- Advocate for government and its financial partners to make long-term budget allocations to launch and maintain monitoring.

Encourage the creation of pharmacy and drug shop networks

Finding: Congolese law permits ownership of a pharmacy to nonpharmacists, provided the owner employs a pharmacist to oversee operations and follow professional standards. This regulation creates an opportunity for owners to develop networks of pharmacies. This could allow networks to achieve economies of scale and procure drugs in larger quantities, brand franchises, manage stocks better, and improve access. It could also facilitate regulation because authorities will be able to deal with a single legal entity and cover all of the drug shops owned by that entity. If corporate entities own drug shop networks, they will be more likely to mobilize capital through investors and bank loans. Current practice, though, continues to emphasize one pharmacy per pharmacist, limiting opportunities for any pharmacist to gather needed resources to open an additional shop in low-income neighborhoods, which is often where the need for improved access to quality medicines is greatest.

Recommendation: Encourage the creation of networks for pharmacist owners by giving them access to a guarantee fund for loans designated for the expansion of drug outlet networks. As a condition for receiving access to credit and additional technical assistance, the network owners would agree to respect national siting requirements and open some outlets in underserved areas. This would prevent concentration of pharmacies and drug outlets in wealthier urban areas and allow the network to cross-subsidize outlets in lower-income neighborhoods. The planned mapping of private supply chain actors could inform this activity by identifying current coverage of pharmacies and drug shops.

5.6.3 Encourage local manufacturing and support the development of the supply chain

Evaluate the feasibility of revising the customs and taxation regime to incentivize local manufacturing

Finding: The customs and taxation regime is not differentiated for the import of primary inputs and final products. This increases costs for local manufacturers, who have to import primary inputs, making their products more expensive and less competitive. To reduce dependence on foreign imports and promote economic growth, the government and donors should do more to encourage local production of high-quality medicines. This can be done through policy reform, technical support, and access to financing.

Recommendation: Assess the feasibility of revising the customs and taxation regime to incentivize local manufacturing by taxing imported drugs ready for sale at a higher rate than that for pharmaceutical ingredients imported for manufacturing and production.

Invest in the logistical capacity of the supply chain

Finding: Both existing CDRs and improved private wholesalers need to expand their capacity to deliver and handle medicines according to pharmaceutical norms. This can be done in-house or contracted out to private firms that specialize in this service. Some existing transportation companies may wish to add this service as a specialization to increase their scale. Under all such scenarios, new investment in developing or expanding this capacity is needed to improve the logistical capacity for CDRs and the private wholesalers and increase access to quality-assured medicines.

Recommendation: Conduct regional analyses of the transport sector to identify the main service providers and their reach, capacity, and constraints. Provide targeted capacity building to the companies with the largest and best-managed distribution networks regarding the transport of medicines (for example, disseminate requirements, build cold chain capacity, and so on). Once they are ready, prequalify them to work with the government and other stakeholders (for example, CDRs, private wholesalers, international NGOs).

Provide technical support to local and international manufacturers with the most potential

Finding: Given the numerous challenges to local manufacturing, it is unlikely that local manufacturers will greatly increase their contribution to commercial sector supply. However, with targeted support, the more able ones could supply higher-quality essential medicines**.** The major barrier for local manufacturers is their failure to achieve quality standards so they can participate in FEDECAME and international organization tenders.

Recommendation:

- Provide technical support through the WHO to manufacturers who are willing to invest in quality improvement.
- Conduct a market study to identify which medicines international organizations are most likely to procure locally and where local manufacturers have the greatest comparative advantages.
- Identify opportunities for international manufacturers to invest in opening a local manufacturing plant in the DRC. Other countries have experienced success developing local manufacturing through foreign direct investment (FDI). In 2017, the Bangladesh company Square Pharmaceuticals invested $75 million in Kenya to open a local manufacturing factory with the World Bank Group's technical assistance (BTOR 2017).

Establish a searchable web-based database of registered drugs

Finding: Stakeholders expressed concerns about the quality of pharmaceuticals in the private sector without a strong, easily accessible system to track commodities and supplies. As previously noted, 40–45 percent of drugs sold in the country are counterfeit. Increasing access to information about which drugs are registered is an important step in addressing this challenge. Thanks to the support of the World Bank-funded Human Development Systems Strengthening project, the DPM has set up a website that provides a directory of registered drugs in PDF format.

Recommendation: A user-friendly, more-interactive online database of registered drugs could serve as an effective regulatory tool; for example, mPedigree, a Ghana-based technology company, currently has mobile and online platforms and partnerships in 10 countries across Africa and Asia to track and report counterfeit pharmaceuticals (see Box 22). DPM and its partners should translate the existing PDF lists of registered drugs available on the DPM website into an interactive, searchable database that pharmacists, drug shop operators, and consumers can easily access. Additional partnerships with private sector actors could strengthen the functionality of such a database. Partnerships with manufacturers could generate additional financial support and necessary information on their medicines to support multiple levels of verification to consumers. Mobile network operators could also support the use of a mobile application to allow pharmacists, drug shop owners, and consumers to verify that a medicine is registered with the DPM and has been approved for sale following quality assurance testing.

6. Financing

Health financing is essential to improving access to health care services in the DRC. This section focuses on two components: 1) demand-side mechanisms, such as insurance, that 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.

6.1 HEALTH FINANCING

The 2017 Health Financing Strategy documents the current fragmented approach to health financing and spells out medium- and long-term visions for rationalizing mobilization and use of financial resources. This includes consolidating funding from public and private sources and creating a pool from which to purchase health services from public and private providers (MSP 2017h).

6.1.1 Health expenditure: sources, trends, and implications

Health in the DRC is underfunded. The percentage of government budget allocated to health has fluctuated in recent years from 3.5 percent in 2011, to 7.8 percent in 2012, to 4.6 percent in 2013, and is well below the 15 percent Abuja declaration threshold (WHO 2011). Budget spending also has been low—27.2 percent in 2012 and 37.6 percent in 2013 (ONRHS-RDC 2015). Households represent the largest proportion of health expenditure, followed by donors (Figure 29) (PNCNS 2016), and together the two account for 82 percent of total health expenditure. Almost two-thirds of expenditure is for curative services, with an additional 30 percent spent on pharmaceutical products and other nondurable medical goods (PNCNS 2016).

Out-of-pocket payments account for 93 percent of household expenditure, with just 7 percent used to pay health insurance premiums (PNCNS 2016). The share of out-of-pocket expenditure as a percentage of total health expenditure is high compared with that of other countries in the region (Figure 30).

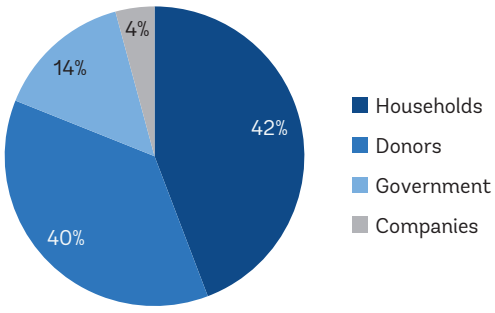
Out-of-pocket spending is much higher at private health facilities than at public ones (Table 7).

Given the reliance on out-of-pocket expenditure, many Congolese face catastrophic health expenditures. A 2017 study reported that 19 percent of households had incurred health expenditures that exceeded the resources available to them in the 12 months preceding the survey (PDSS and PVSBG 2017). Catastrophic expenditures on health disproportionately affect the poor (Barroy et al. 2014).

6.1.2 The DRC's approach to reaching UHC

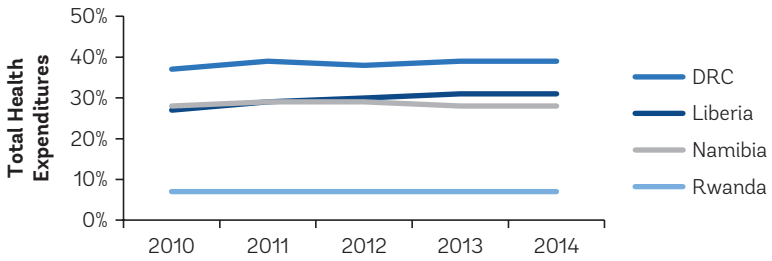
According to the country's PNDS, low allocation of public resources to health and insufficient risk-sharing and health financing mechanisms are major challenges that limit progress toward UHC. The PNDS estimates a funding

Figure 29. Current expenditure by source of financing, 2014



Source: PNCNS 2016.

Figure 30. Share of out-of-pocket expenditure as a percentage of total health expenditure, 2016



Source: Wang et al. 2016.

Table 7. Average out-of-pocket health expenditure by type of provider*

	Provider type			Average
	Public	Private	Other**	
Inpatient care	47.9	95.1	60.4	59.5
Outpatient care	15.9	19.1	10.4	16.9

* In constant 2010 US$ in the DRC for the most recent health care services received.
** Other includes shops, traditional practitioners, mobile vendors, and drug peddlers, among others.
Source: Wang et al. 2016.

deficit of CDF 325–488 billion (US$346–US$520 million)[2] for the 5-year period to provide essential health services to all. To close the funding gap, the DRC would need to triple existing financing, estimated at US$18–US$33 per person per year (Barroy et al. 2014). Other challenges cited in the PNDS include fragmentation of official development assistance, inefficiency, and weak application of financial management procedures.

To overcome these challenges and ensure affordable access to quality health care, the PNDS identifies four major programs: 1) resource mobilization, 2) pooling and streamlining the allocation of resources, 3) development of risk-sharing and health-financing mechanisms, and 4) improving management of financial resources in services and facilities.

The PNDS outlines several approaches to improve risk-sharing and expand health-financing mechanisms:

- Increasingly, funds for health will be pooled through prepayment mechanisms;
- Health mutuelles will be developed at the health zone level;
- Provincial governments will support studies on how to determine the ability of households to pay and how public and private stakeholders can collaborate to provide health insurance;
- Civil servants will be required to enroll in a health insurance scheme; and
- State subsidies are envisioned to pay contributions to health mutuelles on behalf of poor and vulnerable households (potentially a majority of citizens).

Each of these approaches has implications for private providers and private health-financing programs. Specifically, as private insurance programs, including mutuelles, receive subsidies and more people are required to enroll, their efficiency and financial sustainability should be strengthened. At the same time, contracted networks of providers, including private providers, will expand; contracted providers will rely less on out-of-pocket payment and more on insurance schemes for their revenue. The MSP aims to create a national social production fund

[2] Based on the exchange rate from January 1, 2016, 939 Congolese franc (CDF) = US$1.

that consolidates funds from the different health financing programs in the DRC, as described later.

6.1.3 Health-financing programs in the DRC

Private health-financing programs currently have a limited role in the DRC—they cover few citizens, and the country is only now opening up to private insurance companies. Current programs include health mutuelles and the organizations that support them and benefits 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 3–4 percent of the population (DHS 2013–14).

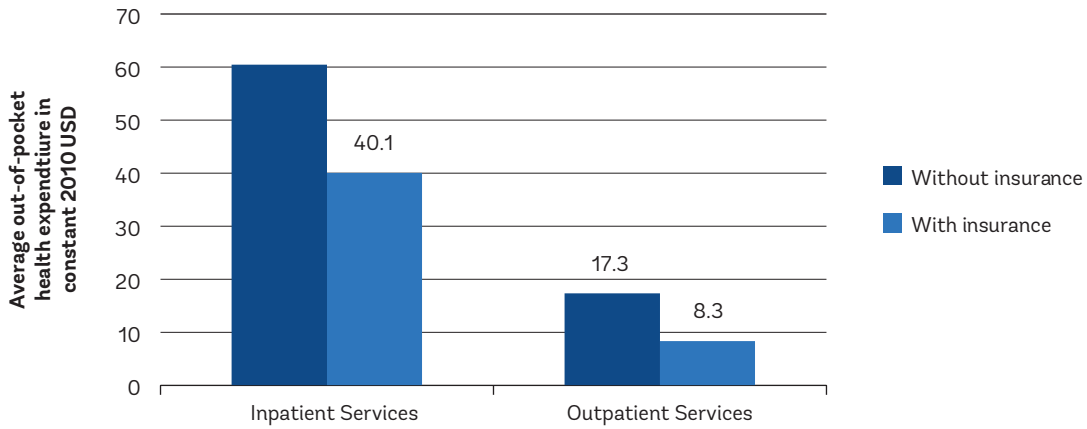
Insurance is one financing mechanism that pools health risks and uses regular payments to reduce out-of-pocket spending by individuals for both inpatient and outpatient services. Those who have insurance pay less out-of-pocket for services in the DRC (Figure 31)).

Insurance and other health financing programs in the DRC include general and special schemes for civil servants covering all health care expenses; employer-sponsored schemes covering medical, dental, and surgical care for workers and their families; and other schemes, such as private health insurance, including mutuelles that target informal sector households (Mbala and Bahati 2016). This assessment focused on mutuelles, employer-sponsored schemes, and other private health insurance programs.

Mutuelles

Mutuelles feature in the PNDS as a means for helping to achieve UHC. They are characterized by community-based ownership and governance. In February 2017, the government published a law clarifying the fundamental principles for organizing and governing mutuelles. However, mutuelles remain nascent (Mutabunga bin Lubula et al. 2017), with only 42 schemes in place, covering around 0.4 percent of the population and amounting to 300,000 members (Mbala and Bahati 2016). A few community-based mutuelles have demonstrated potential—for example, a mutuelle in Nyantende helped reduce out-of-pocket payments as a proportion of health expenditure by approximately 10 percent over five years (Soglohoun 2012). Some health mutuelles have improved their management capacity and ability to set up a scheme (see Box 23), although they still lack technical understanding of how insurance works, the necessary skills to price benefit packages, and skills to monitor and manage financial liabilities (Waelkens2017). Many mutuelles face persistent external constraints, including a lack of trust and understanding of insurance; irrational provision of care, which negatively affects quality and efficiency; and chronic health system underfunding and inability of people to pay for health care. (Waelkens 2017) recommend that mutuelles engage in broader collaboration with health system stakeholders, particularly the government, to address these problems and improve access to care through regulation, supervision, subsidy, standards of care, proper use

Figure 31. Average out-of-pocket health expenditure by insurance status, 2010



Source: Wang et al. 2016.

Box 23. Scaling up health mutuelles: the grassroots experience of the Mouvement Ouvrier Chrétien du Congo

The experience of one of POMUCO's members, the Mouvement Ouvrier Chrétien du Congo (MOCC), illustrates the challenges of health mutuelles to scale up and be financially sustainable. MOCC is a social and cooperative movement consisting of several civil society and religious networks that promote economic development, health, and programs for women and youth. It also includes UMUSAC, whose mission is to support and expand health mutuelles for members of MOCC. UMUSAC supports health mutuelles in Kinshasa, Kitanga, Ancien Bandundu, and Orientale. It helps set up mutuelles and train managers, many of whom may be volunteers. MOCC claims more than one million members across the country, mostly in major urban areas, yet less than 200,000 participate in a health mutuelle.

Each mutuelle contributes 5 percent of its revenues to a provincial federation in return for its support and to establish reserves at the provincial level. These reserves can provide some reinsurance to a mutuelle that runs a deficit. Based on experience, UMUSAC recommends a "slow and steady" approach to developing a health mutuelle, including a limited focus on primary care. It is able to offer portable benefits among its network of 60 mutuelles. On average, members contribute $5 per person per month in urban areas, with some use of in-kind contributions (for example, agricultural produce) in rural areas. Members face a 20 percent copayment for services, with some capacity from mutuelles to provide subsidies to those who cannot afford this amount. The scheme usually pays 80 percent of the claim cost.

Although UMUSAC fully supports efforts to achieve UHC, it also recognizes that many barriers must be addressed before mutuelles can scale up: limited awareness of insurance among citizens and their inability to pay, adverse selection, local government officials who are uninformed about health insurance, lack of quality health providers, lack of subsidies, and poor governance in the country.

Source: POMUCO 2017

of quality medicines, and promotion of better health and financial protection for all. Demonstration cases about what works and does not are needed for public and private actors to generate lessons, as are resources to stimulate understanding of the value of insurance.

There are two main support organizations for mutuelles in the DRC. The first, the Programme National de Promotion des Mutuelles de Santé (PNPMS) was established under the MSP in 2001 to promote health insurance through mutuelles. Key informants affiliated with the PNPMS noted that there are currently approximately 109 health mutuelles in the DRC, concentrated in Sud-Kivu, Kongo-Central, and Kinshasa. These cover approximately 17 percent of all health zones and 1–2 percent of the population. The PNPMS expects to assume licensing of mutuelles (currently done by regional ministries) and to play a role in supervising mutuelles, subject to a finalized regulatory structure under the 2017 law on mutuelles. PNPMS recognizes that the transfer of government subsidies to mutuelles based on member numbers and their ability to pay requires improvements in systems for membership and financial reporting and standardization of systems to link with government programs (MSP 2017j). The second is La Plateforme des Organisations Promotrices des Mutuelles de Santé du Congo (POMUCO), an umbrella platform for broader coordination and advocacy in support of social protection. POMUCO was established in 2014 by five civil society organizations (POMUCO 2015).[3] It aims to build the management capacity of health mutuelles and amplify their contribution toward UHC in the DRC. The target population and beneficiaries of mutuelles vary (Table 8).

Two well-known mutuelles in the DRC are the Mutuelle de Santé de l'Enseignement Primaire, Secondaire et Professional (MESP) and Solidarco, which are summarized later.

[3] POMUCO's members include the Centre de Gestion de risques et d'Accompagnement technique des mutuelles de santé (CGAT), the Centre National d'Appui au Développement et ‡ la Participation Populaire, the Mouvement Ouvrier Chrétien du Congo (MOCC), the Réseau pour la Promotion de la Démocratie et des Droits Economiques et Sociaux, the Réseau des Mutuelles de santé du Congo, and the CDI Bwamanda.

Table 8. Population coverage of selected health mutuelles

Mutuelle	Targeted population		Beneficiaries
LISANGA	Lingwala commune	94,886	2,219
MUSECCO	Catholic and salvationist network teachers, other populations of Kinshasa		9,000
MESP	Public sector teachers, the city of Kinshasa		193,000
Union des Mutuelles de Santé du Congo (UMUSAC)	Members of MOCC, other populations of Kikwit	500,000	44,922*
MAZOKS	Nurses from the Kikwit-Sud health zone	576	576
MULSALKI	People associated with the Bureau Diocésain des åuvres Médicales/catholiques (BDOM), the population of the city of Kitwit	±1,500,000	1,700
Kingo la Afya	Karisimbi health zone	521,987	3,119
MUSSRA	Goma health zone	345,007	2,145
MUSOSA	Butembo city	800,000	2,619
Nyatende	Nyatende zone	124,184	12,474
Walungu	Walungu zone	237,398	2,738

* For the union of 12 mutuelles; paying beneficiaries only, registered = 52,053.
Source: Waelkens 2017.

MESP

The most visible mutuelle in the DRC, MESP is a non-profit set up in 2011 to enroll all 450,000 active teachers and their families. Currently, MESP operates in Kinshasa, Equateur, and Katanga, covering more than 10 percent (47,000) of active teachers and their family members, and has a current membership of around 220,000. MESP secured a government subsidy of approximately $1.20 per person per month (approximately 40 percent of the current premium collected) to help finance its operations. It features mandatory enrollment in regions where it covers teachers, along with subsidies, both of which are essential to scale up health insurance and contribute toward achieving UHC. MESP contracts a network of about 81 facilities in Kinshasa, 20 in Lubumbashi, and 15 in Mbuji-Mayi. Approximately two-thirds of these are private providers, with preference given to FBOs. MESP pays providers a fee for service; rates are negotiated with each provider and reviewed every six months (MESP 2017).

According to a key informant, MESP may be fragile because of limited actuarial or financial management capacity; insufficient revenue at around $3 per person per month; mandatory contributions paid by all teachers, which are used to cover only 10 percent of teachers; depletion of MESP's financial reserves of approximately $2 million because of currency fluctuation in late 2016 (without reserves, the scheme is not expanding; each regional expansion is estimated to cost US$1.5 million); and generous benefits offered by MESP covering all health services at 100 percent. MESP now excludes costly services (chemotherapy, magnetic resonance imaging, and chronic diseases) to decrease claims costs.

Solidarco

Solidarco is a small mutuelle created by the Congolese diaspora with support from the BDOM and the Fondation Belge. The organization seeks regular, predictable prepayments for health care in lieu of ad hoc and unverifiable requests to pay for immediate needs as they occur. Currently, 382 sponsors cover costs for 2,672 beneficiaries in Kinshasa. Solidarco charges €30 per month per group (up to seven people). It contracts BDOM to manage a provider network and pay claims with a budget of €25 per group per month (Solidarco retains €5 for administration). The cost of care for members runs at around 50 percent below the €25 per group monthly payment, contrary to the experience of most other health financing programs. Solidarco is considering whether it should assume financial risk and administer the program directly without BDOM as a third-party administrator or whether to reduce rates and/or increase benefit levels. Over the longer term, Solidarco recognizes that covering larger numbers of

people will ultimately require substantial and stable subsidies well beyond what members of the diaspora can provide (SOLIDARCO 2017).

Privatization of insurance in the DRC

Legislation was passed in 2015 to privatize the insurance sector, and in 2016, a presidential decree authorized establishment of an insurance regulatory body, the Autorité de Régulation et de Contrôle des Assurance (ARCA). ARCA will oversee all aspects of the DRC's new private insurance sector, including financial requirements, reporting, compliance, and consumer education. Estimates put the potential market for all lines of insurance in the DRC at US$500 million, much higher than the US$80 million portfolio of the existing and single state-owned actor Société Nationale d'Assurances (SONAS) (Wilson 2017).

As demonstrated elsewhere, a robust insurance sector enables economic growth and stability—but developing a culture of insurance, where consumers demand and can obtain valued products from responsive insurance providers to help them manage risks, takes time. ARCA is expected to begin issuing licenses for private insurance companies to operate in the DRC in early 2018. Informants for this assessment stated that regional and global insurance companies, as well as local companies such as banks, are cautiously optimistic about the potential to enter the private insurance market in the DRC. They consistently mentioned that SONAS has a poor reputation in the DRC and is widely believed to "not pay claims." As a result, new entrants to the insurance market will need to demonstrate the value of insurance to a public that may have negative perceptions. At this early stage, ARCA does not have an articulated plan for how it will regulate private health insurance, including for unregulated mutuelles and other community-based schemes that target low-income and informal populations (ARCA 2017).

Employer-sponsored health programs

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, either directly or through a third-party administrator, with a health care provider or network of providers (see Box 24). Some corporate programs transfer financial risk of employee health costs to providers using capitation, whereby a provider is paid a fixed amount per person per period for a package of benefits. For some sponsors, these arrangements function more as a prepayment mechanism, with periodic reconciliation of actual costs. Often a sponsor and a provider will agree to ad hoc negotiation of high-cost cases.

The type and amount of health benefits provided by companies vary. According to a key informant, companies provide varying levels of health care and do not typically cover serious illnesses. Companies also provide different levels of coverage for primary care services, with some capping coverage or choosing to exclude specific services (for example, maternity care and FP—one informant suggested that these services are "not related to an illness"). Although some schemes offer the same benefits for all employees, others offer additional benefits to managers (for example, for medical evacuation or services outside the DRC) or cover only services that are obtained in the employee's home province (or in the DRC). This limitation effectively excludes high-cost tertiary care that may be delivered only outside an area. One key informant observed that to limit costs, a company may choose to terminate an employee who incurs high health care costs.

Third-party administrators

International and local TPAs develop and manage provider networks, and some broker insurance through foreign insurers. Many corporate sponsors use a TPA to administer their health benefits. TPAs that were interviewed indicated that private providers often deliver better quality of care but raised concerns about challenges to manage

Box 24. Spotlight on a clinic's experience contracting with companies

Doctors at a private clinic in Kinshasa noted that although they have agreements with companies to care for their employees, the clinic sought multiple contracts at the same time because companies were slow to make payments. Doctors commented that eventually companies usually pay, but it is a protracted process that requires a lot of effort from both parties. At this clinic, companies paid on average $40 per family (two parents and four children) per month. This clinic did not offer any FP products or services, suggesting that these were not a priority for clients.

fraud and moral hazard. Two examples of private organizations brokering health benefits and TPA services in the DRC are described here.

Global Access Health Network

The Global Access Health Network (GAHN) is a DRC subsidiary of a South Africa-based joint venture between Medical Services Organization International and Axihealth. GAHN manages health benefit programs and coordinates international medical evacuations when needed. Approximately 60 percent of GAHN's business is through direct contracts with eight corporations comprising 3,000 employees plus family members; the remaining 40 percent of GAHN's business is through international insurers, such as Aetna International, Bupa, and AXA. Foreign insurance contracts are permitted in the DRC upon acceptance by the state insurer, SONAS, of an application for the policy and payment of a fee equal to 5 percent of the premium. GAHN sees the impending privatization of the insurance sector as a big opportunity but has adopted a wait-and-see attitude (GAHN 2017).

LISUNGI

LISUNGI is a local broker that partners with Oracle Health. In Kinshasa, LISUNGI covers around 7,700 families. Most of these are part of a low-cost government scheme; about 700 others are covered by 20 to 25 corporate sponsors. In Katanga, LUSINGI works with about 50 corporate clients comprising 3,000 families; an additional 600 to 700 families are covered under the government scheme. The company is growing at about 3 percent per month, and adding two new corporate clients per month in Katanga. LISUNGI Lubumbashi offers five benefit plans at different price points, ranging from US$25 to US$90 per family (up to six) per month to corporate clients; most clients chose the second least-expensive option (US$35 per family per month). This option covers medical consultations for general services, obstetrics and gynecology, and pediatrics, plus simple surgical procedures such as hernia repair. Essential medicines are covered, with basic services for laboratory, radiology, and obstetric ultrasound. FP services are not explicitly listed in the benefit package but may be covered under the broader categories of care mentioned. LISUNGI offers a low-cost option to government employees that costs $20 per month per family ($10 from the employee and $10 as a subsidy from the government). This product is a loss leader (actual costs are closer to $25 per person per month). LISUNGI pays providers by advancing them 80 percent of the premium, retaining 20 percent for administration. Providers can keep any unspent premium, but when health costs exceed the premium received, they negotiate with LISUNGI and its corporate clients to authorize additional funds for that patient (LISUNGI 2017).

Performance-based financing

The MSP, with support from the World Bank, USAID, and other donors, has gained experience with performance-based financing (PBF), and in 2011, the DRC government with its partners harmonized PBF approaches (see Box 25). A number of PBF strategies aimed at improving

Box 25. Performance-based financing in the DRC

The World Bank–funded Health System Strengthening for Better Maternal and Child Health Results project (Projet de Développement du Secteur de la Santé; PDSS) was introduced in 2014 and scaled up in 2016, and is now a supply-side effort to improve utilization and quality of MCH services in 11 provinces in the DRC. Administered through provincial purchasing agencies contracted by the MSP, it provides incentives for public and private health centers to provide quality services and for health center administrations to consolidate and improve their governance and accountability. The project also provides additional incentives under a community PBF scheme to stimulate demand through household visits conducted by the CODESA. PBF incentives are paid quarterly upon verification. They can be used by the CODESA to support operations or other community health projects and to incentivize CODESA members to conduct community service (World Bank n.d.).

A study from the DRC suggests that the design and implementation of PBF schemes in a fragile and fragmented financing environment is critical and should be embedded into larger health system reforms (Fox et al. 2014). The study found that PBF incentives paid to workers in Katanga Province to offset lower user fees may not motivate health workers when it requires them to assume an increased workload. Although health worker salaries might be low and delayed, workers were dissatisfied to not receive them, perhaps because of the status the salary infers.

service quality, increasing the availability of services, and improving MCH outcomes have been tested. Results are mixed and underline fragility in the health system (World Bank n.d.). Although programs to date have largely focused on improving public health system performance, stakeholders indicate that about 20 percent of participating providers are in the private for-profit or FBO sectors. Informants indicate that outcomes depend on the design of incentives, availability of sufficient funding, and gaining sufficient stakeholder support. Emerging lessons from PBF schemes that engage community actors to increase access (or even provide) health services show the importance and role of program components, such as training, monitoring, timeliness of payments, and engaging community counterparts (Falisse et al. 2015). The overall success of these initiatives and how to improve them deserve further research.

6.1.4 Relevant lessons learned from global experience

To expand population and service coverage and provide adequate financial protection, health insurance schemes that aim to contribute toward UHC require adequate and stable government subsidies, scale (through mandatory enrollment), and improved efficiency. These requirements are reflected by the experience of government-sponsored programs, such as Ghana's National Health Insurance Scheme. Ghana's scheme also demonstrates the importance of offering a benefit package that the scheme is able to finance and closely monitoring scheme performance so that timely action can be taken when needed to mitigate operating deficits.

Global experience shows that purely voluntary, private health insurance schemes offered by licensed insurance companies and community-based schemes (such as mutuelles) are not scalable or self-sustaining and do not contribute materially to UHC (Kimball et al. 2013). However, private health insurance has a role in a country's health-financing efforts because no government can provide all services to everyone for free. Usually voluntary private health financing is an option for limited numbers of affluent clients who can afford to pay for better protection and access. In addition, formal sector households may benefit from employer-sponsored health coverage—in the DRC, employers are mandated to provide benefits, and they may be motivated by a desire for a stable, healthy workforce. The amount of coverage provided by corporate sponsors can vary from basic to comprehensive levels.

In developed countries, private health-financing schemes have evolved over time alongside government schemes (Kimball et al. 2013). In many low- and middle-income countries in Africa and Asia (see Box 27 for example from India), simple private health insurance products complement public programs. These products pay a fixed amount to clients who are hospitalized to offset indirect costs of care (for example, for transportation or to replace lost wages). Such products include Caregiver, a product offered to clients of Microfund for Women, a microfinance institution in Jordan, and underwritten by Jordan Insurance Company (Women's World Banking 2012).

Community-based schemes, mutuelles, in Francophone countries are often a first foray into health insurance. Eventually these may merge into a government-sponsored program that uses subsidies to scale up coverage and provides capacity building and regulation, as occurred in Ghana (see Box 26). Private schemes also contribute by leading innovation and testing new products and business models. Elsewhere private actors have catalyzed new technology, especially mobile phones, to distribute

Box 26. Learning from Ghana: Mutuelles as a foundation to advance toward UHC

Since the launch of community-based health insurance schemes in Ghana in 1999, coverage in the country has scaled up in two phases. First, schemes proliferated organically throughout the country, motivated by community solidarity, increasing from three schemes in 1999 to 258 by 2003. Despite limited coverage, this fostered a culture of health insurance. In 2000, Ghana passed the National Health Insurance law, which ordered a new health insurance scheme with a standard benefit package to be set up and administered at the district level. This melding of existing community-based insurance capacity with a top-down, national framework increased population coverage rates 30-fold over a relatively short period of time, reaching the present coverage of more than 40 percent.

Source: Adapted from Atim 2010, and Joint Learning Network 2012.

Box 27. Learning from India: enabling inclusive private health insurance

India's experience in privatizing its insurance sector in the 1990s may shed light on options for the DRC to consider. Today, India has a robust private insurance market, with more than 50 licensed general and life insurance companies. Notably, the Insurance Regulatory and Development Authority, established in 2000, stipulates that private health insurance companies must invest 2 percent of their profits, increasing to 5 percent after three years, in the rural sector and also serve increasing numbers of vulnerable clients to spur financial inclusion for underserved populations. The Authority implemented microinsurance regulations in 2005 and again in 2015 to improve the enabling environment for insurance providers serving low-income clients. A key lesson is that one size does not fit all. For example, insurance programs for low-income clients do not require the same level of financial reserves as programs with greater claims exposure or the same rules to license insurance agents. More generally, India's experience demonstrates that government can catalyze investment in insurance for low-income consumers by setting up a favorable enabling environment that includes incentives and reasonable rules.

Source: Insurance Regulation and Development Authority of India.

and administer insurance in more efficient "low touch" ways. An example of this is Antoka, the simple mobile-enabled insurance product relaunched in Madagascar in 2016 by Airtel and Allianz (Midi-Madagasikara 2017).

6.1.5 Recommendations

Recommendations in health financing include the following.

6.1.5.1 Include private providers in national health-financing initiatives

Strengthen private providers' ability to participate in health-financing initiatives

Finding: Private providers have limited experience and know-how in working with health-financing programs, and their clinical and service standards vary widely. Administrative know-how is basic.

Recommendation: Strengthen readiness of private providers to participate in mutuelles and other health-financing initiatives by developing a viable network of providers who commit to common quality and pricing and treatment standards and can share financial risk with programs, including mutuelles; and establishing a partnership between a private provider network and a corporate sponsor of a health benefit program.

Identify the role of PBF in improving the performance of private providers

Finding: The DRC and the larger global community are learning whether and how PBF can improve the performance of a health system. To date, results of PBF programs in the DRC have been mixed, possibly in part because of the fragility of the health system. These programs have largely excluded private providers while focusing on the public sector.

Recommendation: Validate successes and challenges of PBF programs in the DRC and summarize how these programs are evolving and the extent to which they have engaged private providers. Test whether and how PBF programs can more fully engage private providers to deliver more-efficient, higher-quality services.

6.1.5.2 Strengthen and clarify the role of mutuelles

Increase engagement of mutuelles and other health-financing mechanisms

Finding: The DRC plans to scale up coverage in community-based mutuelles and other mechanisms, such as mandatory health insurance for civil servants, but has had limited success in doing so. Recent enabling legislation and strengthened structures to support mutuelles should accelerate health coverage over time. Research suggests that collaboration with a broader range of stakeholders, including government and private actors, remains a critical gap (Waelkens 2017).

Recommendation: Establish an advocacy forum for mutuelles and other health-financing mechanisms to engage government and other key stakeholders (for example, civil society, employers) in implementing and monitoring adherence to common performance standards, focusing

on clinical care (including use of medicines, service mix, pricing and billing practices, reporting, and patient service standards).

Build on lessons from existing health-financing programs

Finding: A few of the DRC's health-financing programs have had some degree of success. For example, although the scheme remains fragile, the MESP has demonstrated potential in accessing government subsidies and implementing mandatory contributions.

Recommendations:

- Document and disseminate lessons learned from existing health-financing programs and develop a stronger demonstration case for coverage.
- Investigate how existing health-financing programs can be scaled up and financially sustained in the DRC context, and provide technical assistance to these programs to address current challenges (for example, revising benefits and pricing).

Strengthen health-financing programs

Finding: Some health-financing programs are administered by TPAs, whereas others are administered by the sponsor (for example, mutuelle or employer sponsor). Payment arrangements and administrative processes are largely ad hoc and manual. For example, current pricing of benefit packages covered by programs varies widely and may be actuarially unsound. Programs usually pay with a fee-for-service plan and struggle to manage the risks of moral hazard and fraud. In some cases, programs share financial risk with health providers by paying per capita rates, but often these are adjusted on a case-by-case basis.

Recommendations:

- Support organizations, such as le Centre de Gestion des Risques et d'Accompagnement Techniques des Mutuelles de Santé, to build capacity of mutuelles and other health-financing programs in areas such as product design, pricing, and risk management, and strengthen back office operations, such as enrollment, premium collections, and claims management.
- Test models for scaling mutuelles and other health-financing programs in partnership with aggregators, such as microfinance institutions, associations, or cooperatives (agri-workers), with the capacity to enroll and collect contributions from members.
- Support expansion of strategic purchasing for health financing programs—contracting, provider payment mechanisms, and monitoring.
- Develop and test models for quality assurance of contracted providers, entailing accreditation, site assessments, audits, and routine monitoring.
- Explore ways to use technology (for example, biometric identification cards or mobile-enabled transactions) to improve the efficiency of health-financing programs.
- Support a TPA or employer sponsor to develop and scale up an improved model to administer an employee benefit program, with improved product design, pricing, provider network, payment mechanisms, and claims management.

Work with health-financing programs to cover FP and preventive services

Finding: Most health-financing programs (including mutuelles and employer-sponsored ones) focus on curative care and not preventive services such as FP. For example, although most programs cover maternal services surrounding pregnancy and childbirth, they may not cover postpartum FP. Increased access to FP can prevent unplanned pregnancies, lead to fewer and lower-risk pregnancies, and help achieve broader development goals. Covering FP can be a cost-effective investment for sponsors of health-financing programs.

Recommendation: Collaborate with mutuelles and corporate sponsors to cover FP and broader preventive services by assessing coverage of FP and other preventive services by main health-financing programs and developing a business case and advocacy material for investment in (covering) these services.

Develop a culture of insurance

Finding: The DRC lacks a culture of insurance among its citizens, limiting demand and understanding of the role it can play. Changing this norm requires continuous, long-term investment in consumer education. The newly established regulator, ARCA, is nascent—its regulation and

stewardship of private insurers and the impact on private service providers working with insurers have yet to be tested. More specifically, it is unclear how ARCA intends to oversee community-based mutuelles or other insurance programs that target low-income households. It is also uncertain how ARCA will educate the public about insurance, and this will link to broader efforts promoting social protection and resilience.

Recommendations:

- Collaborate with ARCA to educate consumers about health insurance (for example, conduct media campaigns to inform consumers that health insurance can be a valuable way to be protected against catastrophic costs for health care).
- Collaborate with ARCA to engage insurance companies, mutuelles, health providers, and other actors, such as the Federation Entreprises du Congo or the ASPS in support of enabling regulation and supervision of private sector health insurance stakeholders.
- Collaborate with a private insurer to pilot an insurance program that targets informal, vulnerable groups; complements government-sponsored services; contributes to building awareness of the potential value of insurance; is simple and modeled on the Caregiver or Antoka products described earlier; and focuses on coverage of incidental costs to access hospital services.

6.2 ACCESS TO FINANCE

6.2.1 Overview of the supply of financing—the banking and microfinance sector

All businesses in the DRC face challenges, including fragile infrastructure, lack of transparency, shortage of skilled labor, difficulty enforcing contracts, political uncertainty, a weak judicial system, and limited access to capital. However, the government of DRC is working to improve the business climate. In 2014, the DRC joined the Organization for the Harmonization of Business Laws in Africa (OHADA). OHADA provides multiple incentives for foreign investment by standardizing and streamlining enterprise creation and contract enforcement as well as providing investor protection and harmonization of accounting principles. Moreover, investment reforms and investor protections make PPPs more secure and attractive for outside investors. Current investment regulations prohibit foreign investors from engaging in informal small retail commerce, referred to locally as petit commerce (U.S. Department of State 2016).

FDI in the DRC has been falling in recent years (Table 9). FDI in the DRC reached a peak of US$3.3 billion in 2012 but fell to US$1.2 billion in 2016 (World Bank 2017c). A more stable political environment could present new opportunities for foreign investment in the future.

The DRC's financial sector comprises 19 licensed banks and 120 microfinance institutions (MFIs) and cooperatives (export.gov 2017c). Their presence is unevenly distributed across the territory, as shown in Figures 32 and 33).

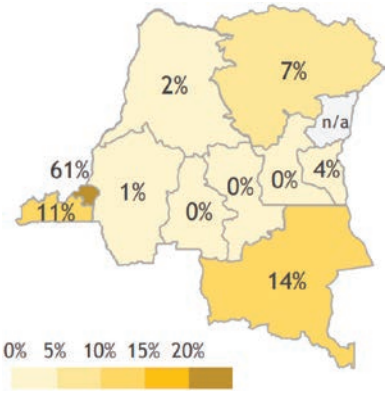
The five largest banks hold about 65 percent of bank deposits and 60 percent of total bank assets (International Monetary Fund 2014). Banks hold 90 percent of deposits, and MFIs hold the rest. There are roughly $3.6 billion of deposits in the banking system but an estimated $10 billion of savings exist outside banks. The DRC has one of the lowest bank penetration rates in the world—only 11 percent of the population has a bank account (World Bank 2017f). According to the Congolese

Table 9. Foreign direct investment, net inflows as percentage of GDP

	2012 (%)	2013 (%)	2014 (%)	2015(%)	2016 (%)
DRC	12.06	6.99	5.42	4.62	3.77
Low-income countries	5.73	5.20	4.16	4.17	4.53
Sub-Saharan Africa	2.45	2.39	2.41	2.71	2.56
Organisation for Economic Co-operation and Development (OECD) members	2.43	2.28	1.74	2.95	3.06
World	2.72	2.56	2.20	3.04	2.92

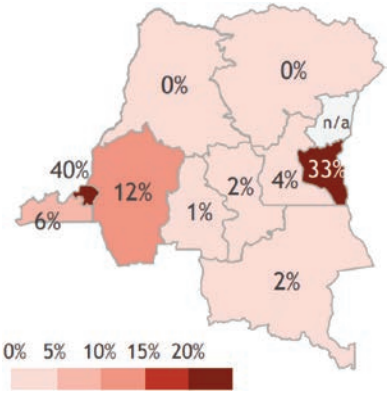
Source: World Bank 2017c.

Figure 32. Distribution of banks (percentage of total number of branches and bank windows)



Source: Altai Consulting 2016.

Figure 33. Distribution of MFIs (percentage of total number of branches and MFI windows)



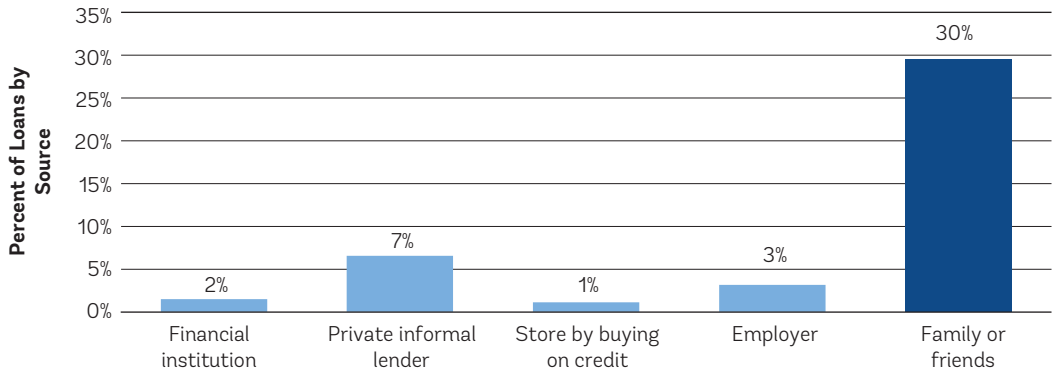
Source: Altai Consulting 2016.

Association of Banks (Association Congolaise des Banques), an estimated 65 percent of the population has savings, but only 4.7 percent of these save at a bank (export.gov 2017c). Family members and friends are the main source of loans in the DRC, followed by private informal lenders who may not be trustworthy or may have higher interest rates. See Figure 34.

The Foundation for International Community Assistance (FINCA) is the only microfinance institution currently listed on the Central Bank's website as being in the regulatory category authorized both to make loans and collect deposits (Banque Centrale du Congo n.d.). Financial institutions are generally concentrated in the eastern part of the country, although larger banks and FINCA have branches in most major cities. Many MFIs and savings and loan cooperatives (coopératives d'épargne et de crédit) operate only in the province in which they are based. The Central Bank lists authorized MFIs and cooperatives in only seven provinces (Banque Centrale du Congo n.d.).

Agent banking is a growing channel, providing financial services to remote or underserved populations. For

Figure 34. Borrowing by source (age 15+), 2011



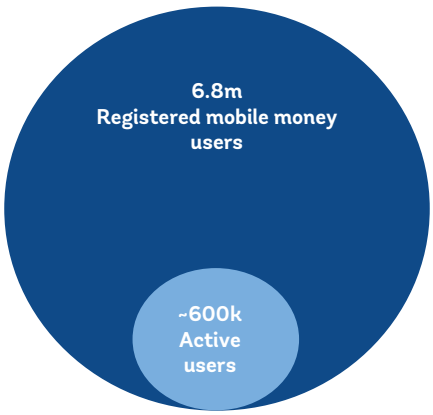
Source: The World Bank 2017.

example, almost 60 percent of all of FINCA's transactions are through agents. FINCA does not charge clients for transactions but aims to cover costs through balance sheet growth. FINCA is also exploring agent incentive mechanisms, such as expanding services offered by agents (for example, payments and other transfers) to increase revenue sources (MasterCard Foundation and BFA March 2017).

The number of active mobile users in the DRC is growing based on data provided by network operators offering mobile money services. Given the DRC's large rural population and concentration of financial institutions in urban centers, mobile money offers significant potential. However, those with mobile money accounts rarely use them; in 2016, only 600,000 of 6.8 million registered mobile money users accessed their account in the previous 90 days (Figure 35)) (CENFRI 2016).

Consumers currently lack understanding about how mobile money products work, limiting their uptake (Finmark Trust et al 2015, GSMA 2013, Élan RDC 2015). This is exacerbated by poor quality network coverage and limited coverage of the mobile agent network (Élan RDC 2015). As a result, mobile money needs to gain more market share to be an effective digital tool in accessing health services and products as well as contribute to resilience to health shocks by expanding accessible networks for credit.

Figure 35. Use of mobile money accounts in the DRC, 2016



Source: CENFRI 2016.

6.2.2 Role of financial institutions in the private health sector

Most private health care providers in the DRC are considered micro, small, or medium enterprises (MSMEs). To expand and improve the services offered, providers need access to financial resources. In many countries, financial institutions are not accustomed to thinking of private health providers as businesses. However, banks interviewed during this assessment stated that private health providers are eligible for loans under the same conditions as any MSME, and banks are willing to consider health care businesses as potential borrowers. Unfortunately, Congolese MSMEs in general face a number of well-documented constraints in accessing financing; for example, loan maturities are frequently limited to six months or less, with interest rates around 16–18 percent. Banks avoid longer-term loans because of weakness in the legal system and difficulties obtaining interbank financing (export.gov 2017c). Table 10 summarizes demand- and supply-side barriers to financing for MSMEs in the DRC.

During interviews, financial institutions described their credit products available to health MSMEs, including loans for working capital, assets or equipment, and real estate or construction (see Box 28). Loan terms are generally 12 to 60 months, and annual interest rates are 10–36 percent (averaging 15–25 percent). Most banks ask for collateral—usually property title—for loans over US$10,000 and require the title to be registered (that is, an official mortgage) for loans over US$30,000. Banks seek collateral value of 120–200 percent of the loan amount. Although health care businesses are eligible for MSME financing, the health sector makes up a small portion (between 1 and 5 percent) of the current loan portfolio of the banks interviewed. Reasons include:

- Weak business and financial management skills of health providers, who are unable to provide financial statements or account history to prove repayment capacity;
- Issues with accepting a mortgage on a hospital because it would be socially impossible to repossess or a lien on specialized medical equipment, which may not have a strong resale market; and
- Difficulties verifying health facility registration or ownership status, making it impossible to ascertain

Table 10. Demand- and supply-side barriers to engagement of micro, small, and medium enterprises by financial institutions

Demand-side: MSMEs	Supply-side: financial institutions
• Do not know the criteria for accessing loans. • Lack understanding of financial terminology. • Do not seek the "best deal" by comparing institutions to identify the best terms. • Think they need to pay high taxes and expose themselves to informal facilitation fees if they get a loan equal to or larger than US$10,000.	• Assume the MSME segment means high costs for loan analysis and administration and lower credit volume, which is less attractive. • Lack transparency on credit conditions, with no explanation for rejecting or delaying MSME loan applications. • Have a low tolerance for negotiating with MSMEs or adapting to their needs because the amount of credit provided is not significant.

Source: Shwarz 2011.

whether the facility has the authority to borrow money.

MFIs offer smaller loans (from US$20 to US$150,000 for one MFI interviewed), with higher interest rates (24–60 percent per year) and shorter loan terms (3–36 months). Of the four MFIs interviewed, two provided incidental lending to the health sector, whereas two had specialized (but limited) health lending activities.

Vision Fund, a partner of World Vision, provides microloans to support activities previously funded by World Vision. Vision Fund currently has a portfolio of a few hundred health loans, with the majority being to pharmacies. Table 11 summarizes the issues Vision Fund has identified in lending to the private health sector as an MFI.

Box 28. Snapshot of two health loan portfolios

Two banks interviewed stated that health loans made up roughly 2 percent of their total loan portfolios. In one case, two or three large health borrowers make up about half of the bank's health loan portfolio. Another bank stated that its health loans are concentrated in Kinshasa and Lubumbashi, with most loans being for real estate or construction, followed by working capital and equipment loans. One bank indicated that generally, small providers request loans for equipment and working capital, but pharmacies may seek larger loans.

Source: 2017. Primary Data. DRC: Field Interview.

6.2.3 Demand for access to finance

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 or friend. Providers who were interviewed said it was difficult to access formal financing and mentioned high interest rates, significant collateral requirements, and restrictively short loan terms. The Order of Pharmacists said that banks were concerned that pharmacies were not profitable given the large number of outlets, and some FBOs and nonprofits said commercial banks would not lend to not-for-profit entities. Providers also mentioned not understanding what information was needed to prepare a loan proposal. Health care businesses are typically run by clinicians who often lack business and financial management skills, making it more difficult to assess the potential return on investment or present successful loan requests to banks and MFIs. In Senegal and Madagascar, after receiving business training and coaching through USAID's Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project, providers have been able to improve their book-keeping and cash management sufficiently to save and invest in new equipment and obtain loans for additional expansion.

Some providers know about the availability of credit from financial institutions and have been successful in obtaining loans (Box 29). Private providers in Lubumbashi may

Table 11. Private health sector lending issues

Strengths	Stable activity, health care practices usually exist for a long time compared with other types of activities, and owners are easy to find.
Weaknesses	Difficult to authenticate the owner of the activity because many pharmacies and health centers register as an NGO, sometimes illegitimately. The law stipulates that activities related to the health sector are carried out only by technicians and specialists in the sector, which is not the case; merchants who embark on these activities pay "rights of sponsorship" to specialists to obtain licenses to operate. Providers have small margins and profits, especially small pharmacies that have slow inventory turnover because of competition from traditional practitioners and self-medication. The relationship between quality and price is still not balanced. When quality services are not provided, negative communication spreads in the community, and the health center will lose business. In addition, health centers are often located in places where the community has weak purchasing power.
Financing risks	Providers can be subjected to tax penalties if the activity does not have all the required authorizations. Penalties could be significant, which may lead to nonrepayment of loans granted. Sponsorship payments can be significant, affecting the operator's revenue and making repayment difficult. The minimum sponsorship amount is $500. In addition, there are some sponsors who require payment every month, threatening to withdraw their authorization number otherwise. Some hospitals are denied the right to operate when health inspectors discover that unauthorized activities are taking place, and the owner is at risk of being imprisoned. Uncertain profitability and difficulty in ensuring cash flow.

Source: Vision Fund 2017.

face slightly different challenges to those in other cities. The economy in Katanga is linked to the mines and foreign-owned companies, most of which contract with medical centers to provide health care for employees. This has led to a proliferation of medical centers, with some guaranteed revenue from their corporate contracts. However, they still struggle to be profitable given the high level of competition. Facilities such as the Centre Médical du Centre Ville have been able to negotiate reasonable prices and keep their corporate clients based on the quality of their services.

Lack of access to financing negatively affects health providers in several important ways. Without financing, providers struggle to make quality improvements or expand

Box 29. Examples of financing

Clinique Medécin de Nuit (Kinshasa) has taken out three bank loans each for equipment purchases, with interest rates at 33–40 percent. It has borrowed from International Bank for Africa in Congo for working capital and now has access to private equity through an IFC program.

Centre Médical du Centre Ville's (Lubumbashi) first loan was for the construction of a new site. They have 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. The Centre considers the loan size and three-year limit to be too constrictive and said that the Centre occasionally has experienced repayment problems and had to pay penalties.

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

Box 30. Health enterprise and innovation

Encouraging business creation and innovation has become a priority in the DRC, and President Kabila sees small business as the motor of the economy (ACP 2016). In September 2017, the Minister of Small and Medium Sized Enterprises announced an experiment with business incubators to accelerate business growth and job creation in key economic sectors (ACP 2017a). Several business incubators have opened to help start-ups thrive. The I&F Entrepreneuriat incubator in Kinshasa provides business plan assistance and supports new companies and entrepreneurs (ADIAC 2014). In addition, the African Development Bank Private Sector Operations and the Fund for African Private Sector Assistance (FAPA) are supporting Advans Banque Congo to provide loans and financial services to small and medium scale enterprises in Kinshasa (AfDB 2013). Kivu Entrepreneurs, a business incubator in Goma, provides business plan assistance and training to young entrepreneurs (Kivu Entrepreneurs n.d.).

These new initiatives rarely include health entrepreneurs. Social enterprises in the health sector are distinct because they seek to operate on a sustainable basis while achieving social impact. This often means targeting low-income or otherwise underserved populations, seeking to address barriers these populations may face in accessing health. This can mean developing new business models that can scale in low-income markets. If these enterprises can demonstrate the potential for sustainability at scale, this creates an opportunity for private investment capital to enter the market and contribute to increased access to and usage of priority health services.

Successfully reaching investor readiness requires that enterprises have access to appropriate sources of capital and technical assistance to enable innovation, experimentation, and learning. Health enterprises may also need assistance in addressing barriers, such as a challenging regulatory environment, shortage of available and qualified talent, or a lack of suitable partners. Health enterprises must rely on a strong ecosystem of supporting organizations that can address these scaling barriers.

In the DRC, the ecosystem that supports scaling of health enterprises is nascent. Accessing financing is challenging for entrepreneurs. Commercial lending rates are high, making it extremely difficult to access the type of capital necessary to start and grow a business. One promising social enterprise is Asili, a start-up cocreated by the American Refugee Committee and supported by USAID and international partners. Asili looks like a strip mall with a health clinic, a clean water distribution system, and an agricultural cooperative for farmers grouped together. Services are linked through a monthly membership, allowing members access at reduced prices (ARC n.d.).

their practice. Equipment financing is also challenging—many hospitals and clinics in remote areas lack the funds to purchase and maintain necessary medical equipment for quality care (export.gov 2017d). Because of difficulties maintaining imported equipment, in particular, machines can quickly become unusable. Providers shared stories of complicated financing arrangements with European suppliers with effective interest rates as high as 86 percent. Although financing from friends and family is important, it is limited, thus restricting growth in the private health sector.

An important potential resource is the ASPS, which is seeking ways to offer the highest-impact support to private health providers. The ASPS could also be an important partner in helping expand financing for its members.

6.2.4 Recommendations

Provide business and financial management training and counseling for private health providers

Finding: In addition to the weaknesses noted in the Health Workforce section, health providers often have weak business and financial management skills and are generally unable to provide financial statements or accounts history to prove repayment capacity. These management weaknesses can be detrimental to health outcomes in various ways. For example, poor inventory management leads to stockouts, and lack of access to finance can limit the growth of the health facility and thus limit the number of patients it can serve. Basic business and financial management training can help improve the overall viability of a private health practice and enable providers to access financing. In addition, business counseling helps

reinforce key learning and can support implementation of recommendations, including accessing financing.

Recommendations:

- Offer business training courses to private health providers, covering topics such as business and financial management and reporting, marketing, inventory management, financial literacy, and access to finance.
- Provide individual, one-on-one counseling for selected providers who demonstrate the highest potential for implementing changes and growing their practices.
- Coordinate business training and counseling with clinical training and accreditation steps recommended in the Health Workforce section to reinforce the overall quality of health businesses in the DRC.

Work with financial institutions to expand lending to the health sector and increase private providers' access to capital

Finding: It is difficult for many private health providers in the DRC to access formal financing, and providers who are able to borrow from banks and MFIs may face significant collateral requirements, restrictively short loan terms, and high interest rates. Providers' available collateral may be insufficient or unacceptable.

Recommendations:

- Establish a risk-sharing mechanism or mechanisms, such as a USAID Development Credit Authority portfolio guarantee (see Box 31), to encourage financial institutions to lend to health care businesses, such as local pharmaceutical manufacturing businesses or wholesalers, who do not meet standard collateral requirements. This could also include a loan guarantee fund to encourage the expansion of drug outlet networks, as mentioned in the Access to essential medicines section.
- Explore options to identify medium- or longer-term funding to assist banks to grant longer-term loans that better meet the financing needs of the health sector.
- Support financial institutions to reduce costs of lending to the health sector. Assist financial institutions to conduct process evaluations to improve efficiency by identifying and addressing operational weaknesses to reduce overall costs.
- Work with financial institutions to develop financial products adapted to the health sector.
- Provide training, information on the private health sector, and technical assistance to financial institutions. This could include topics such as supporting the evaluation of business opportunities in the private health sector and market segmentation or marketing.

Box 31. USAID Development Credit Authority (DCA) Guarantee

A DCA is a guarantee that is backed by the full faith and credit of the U.S. Treasury. It typically covers 50 percent of the loan principal (not fees or interests) for term loans. The DCA has the flexibility to guarantee local or foreign currency. Preapproval is typically not required for individual loans placed under the DCA. Guarantees may be paired with USAID or other technical assistance projects that can strengthen the borrower's ability to repay and support the financial institution's lending capacity in a new sector.

Source: USAID 2018.

Establish partnerships to increase access to finance for key investments

Finding: Lack of financing can have a negative impact on a private health practice, such as preventing health businesses from obtaining and properly maintaining medical equipment. It can also limit the private health sector's ability to make quality improvements to better serve patients, grow their health facilities to reach more patients, or develop new facilities. Partnerships between equipment suppliers and banks can develop (for the bank) a pipeline of clients needing loans to purchase equipment and (for the supplier) a source of financing.

Recommendation: Evaluate the potential to develop partnerships and market links within the health ecosystem that would generate benefits to all parties.

Link health to health enterprise and innovation activities

Finding: There are few organizations in the DRC positioned to provide technical assistance to health enter-

Box 32. The Nigeria Health Innovation Marketplace

The Private Sector Health Alliance of Nigeria (PHN) successfully launched the Nigeria Health Innovation Marketplace (NHIM), a platform for key actors in the country's healthcare innovation ecosystem. The NHIM's objectives are to identify promising innovations, incubate and create links that will enable scale, build a sustainable convergence platform around health innovation, and invest for impact in selected opportunities. It offers a variety of services, including an innovation hub, competitions and hackathons, a data and knowledge repository, an innovation map, and innovative partnerships. The NHIM has 799 innovators, 20 investors, 423 medical professionals, academia, NGO, and other participants.

Sources: NHIM 2018; PHN 2018.

prises that would enable them to be investor ready, and current incubator efforts do not focus on health.

Recommendation: Assess the landscape for health enterprises and determine the most promising activities to jump-start health companies, potentially including a seed fund for promising entrepreneurs, technical assistance, and help identifying investors and growing to scale. As part of the assessment, priority health areas could be identified, such as health technology or medical devices. A health enterprise conference in Kinshasa could build on the innovation activities in other sectors (see Box 32 for example from Nigeria).

7. Health Workforce

There is little publicly available data on the size and scope of the private health workforce in the DRC. However, the data that are available and anecdotal evidence suggest that the private sector trains and employs a large number of health workers. This section explores private training institutions and the number of private health sector workers by cadre.

7.1 DEVELOPMENT AND REGULATION OF THE PRIVATE HEALTH WORKFORCE

The public sector plays a significant role in the development, supervision, and regulation of the private health workforce. Important organizations include the Ministère de l'Éducation Nationale, Ministère de l'Enseignement Supérieur, Ministère de Commerce, and local provincial governments. There are multiple private sector actors involved in the regulation of HRH. Cadre-specific orders are responsible for ensuring members respect ethics rules and advocating for the medical profession. In addition, health unions and associations are key stakeholders in the development, implementation, and evaluation of HRH policies. These organizations seek to address issues related to improved remuneration, development of professional career profiles, integration of new HRH job positions, and improved health worker safety. They are also involved in efforts to develop an inventory of all HRH in both the public and private sectors.

7.2 PRIVATE MEDICAL TRAINING INSTITUTES

7.2.1 Types of training institutions

There are three main types of training institutions in the DRC: secondary education institutions (Institutions de formation du niveau secondaire), higher education institutions for technical medicine (Institutions supérieures de techniques médicales), and universities with faculties of medicine and pharmacy (universités avec des facultés de médecine et de pharmacie). Under the government's decentralization reforms, medical training institutes fall under the control 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. As a result, the amount and quality of available information vary by province.

Secondary-level institutions

Secondary-level institutions train birth attendants, pharmacy assistants, physiotherapy assistants, nurses, community health staff, medical laboratory technicians, and other health technicians. According to the 2017 HRH Yearbook of the DRC, there are 477 secondary-level institutions (Table 12). Seven of 10 of these are managed by a private institution, either FBOs or other private organizations, and just under one-third are managed by the state (30.4 percent) (MSP 2017i).

The number of institutions grew significantly between 2013 and 2017, with 71 opening in the last three years, and of these, 55 were in the private sector (nine FBO and 46 privately managed). Secondary-level institutions are distributed across all provinces. The three provinces with the most training institutions are South Kivu (54 schools), Kinshasa (53 schools), and Kwilu (34 schools). The availability of different training programs varies significantly. Nursing training is offered by 95 percent of secondary-training institutions; only 6 percent and 5 percent train birth attendants and laboratory technicians, respectively (MSP 2017i). Of the 29,054 students enrolled in these institutions, 18,142 graduated with a secondary school diploma between 2008 and 2013, a graduation rate of 62.44 percent (ONRHS-RDC 2015). Because of the rapid growth of these and other training institutions, provincial governments have had trouble monitoring the performance of these schools, including the total number of

Table 12. Secondary level institutions by ownership and province

Province	Ownership			Total
	Public	FBO	Other Private	
Bas-Uele	4	2	0	6
Equateur	5	3	2	10
Haut-Katanga	2	3	9	14
Haut-Lomami	3	6	0	9
Haut-Uele	8	3	1	12
Ituri	6	11	0	17
Kasai	5	10	10	25
Kasai Central	2	13	6	21
Kasai Oriental	4	2	6	12
Kinshasa	6	2	38	46
Kongo Central	8	21	20	49
Kwango	8	5	6	19
Kwilu	8	12	13	33
Lomami	4	6	4	14
Lualaba	2	3	5	10
Mai-Ndombe	9	2	1	12
Maniema	4	2	0	6
Mongala	4	7	4	15
North Kivu	8	16	3	27
North Ubangi	2	2	4	8
Sankuru	5	6	0	11
South Kivu	15	12	23	50
South Ubangi	4	4	5	13
Tanganyika	4	3	1	8
Tshopo	12	4	5	21
Tshuapa	3	4	2	9
Total	145	164	168	477

Source: MSP 2017i.

health workers trained. For this reason, comprehensive data are not available about the number of health workers trained in the private—or even the public—sectors.

Higher education institutions for technical medicine

Higher education institutions for technical medicine are public and private higher education training institutions and universities whose mission is to train specialized managers in the fields of science, medical, and paramedical techniques while researching how to adapt new techniques and technologies to the DRC context. Training programs include nursing, management of health institutions, laboratory management, imaging, physiotherapy, nutrition, community health, hygiene and sanitation, pharmaceutical technician, and midwifery.

There were 128 higher education institutions in 2017, almost evenly split between the public and private sector (Table 13). Private institutions are mostly concentrated in North Kivu, Kwilu, and Kasai Central. Between 2013 and 2017, 25 new higher education institutions opened, including eight in the private sector. As with secondary-level institutions, this growth has caused difficulties

Table 13. Higher education institutions for technical medicine by ownership and province

Province	Ownership		Total
	Public	Other Private	
Bas-Uele	0	2	2
Equateur	2		2
Haut-Katanga	2	2	4
Haut-Lomami	0	2	2
Haut-Uele	2	1	3
Ituri	1	2	3
Kasai	4		4
Kasai Central	7	5	12
Kasai Oriental	1	1	2
Kinshasa	1	10	11
Kongo Central	6	4	10
Kwango	4	1	5
Kwilu	6	6	12
Lomami	3	2	5
Lualaba	0	2	2
Mai-Ndombe	1	2	3
Maniema	4	1	5
Mongala	2		2
North Kivu	8	7	15
North Ubangi	2		2
Sankuru	1	3	4
South Kivu	7	2	9
South Ubangi	2		2
Tanganyika	1	1	2
Tshopo	3		3
Tshuapa	2		2
Total	72	56	128

Source: MSP 2017i.

in compiling information on their performance, and no training numbers are available (MSP 2017i).

Universities with faculties of medicine and pharmacy

Based on the 2017 National Directory of HRH, there are 107 faculties of medicine and pharmacy, of which 30 are public and 77 are private (Table 14). Of these, Kinshasa, North Kivu, and South Kivu have the most faculties, with 12, 19, and 16, respectively. There are 102 faculties of medicine and only five faculties of pharmacy across the DRC, three public and two private, located in the provinces of Haut-Katanga, Kinshasa, North Kivu, and South Kivu (MSP 2017i)

Table 14. Universities with faculties of medicine and pharmacy by ownership and province.

Province	Ownership			Total
	Public	FBO	Other Private	
Bas-Uele	0	1	0	1
Equateur	1	0	1	2
Haut-Katanga	3	1	4	8
Haut-Lomami	1	1	2	4
Haut-Uele	1	0	0	1
Ituri	1	1	1	3
Kasai	1	0	2	3
Kasai Central	2	1	2	5
Kasai Oriental	1	1	1	3
Kinshasa	2	4	6	12
Kongo Central	1	0	2	3
Kwango	0	0	0	0
Kwilu	2	0	1	3
Lomami	2	0	1	3
Lualaba	1	0	0	1
Mai-Ndombe	1	0	0	1
Maniema	1	1	2	4
Mongala	0	0	1	1
North Kivu	2	5	12	19
North Ubangi	1	0	0	1
Sankuru	2	1	0	3
South Kivu	2	3	11	16
South Ubangi	0	1	0	1
Tanganyika	1	0	3	4
Tshopo	1	0	4	5
Tshuapa	0	0	0	0
Total	30	21	56	107

Source: MSP 2017i.

7.2.2 Quality of training

There are several organizations involved in the accreditation of training institutions, some with overlapping mandates. Stakeholders interviewed highlighted that these overlaps create problems for the accreditation system. For example, some stakeholders had heard of municipalities accrediting training institutions that did not meet the necessary standards. The multiplicity of stakeholders and the rapidly growing number of private training institutions has complicated compliance. If the MSP identifies a training institution that does not respect training prerogatives, it can recommend closure, but it cannot enforce that recommendation. Stakeholders stated that often authorities from the Ministry of Commerce and municipalities ignore the MSP's recommendations and do not close training institutions because of political concerns, as well as misunderstandings about roles and competencies in the accreditation process. In addition, the lack of a federation or association of private training

Centre de santé Medicare

institutions makes it more difficult for the MSP to formally integrate them into the Human Resource Information Solution (iHRIS).

Although the MSP would like to play a larger role in enforcing its recommendations, it lacks the means to do so, as highlighted by the case of Haut-Katanga. The MSP currently has 35 inspectors to cover the former province of Katanga, which includes Haut-Katanga's 25 training institutions of various levels and health professionals (MSP 2017j). These inspectors also still cover the entirety of the former Katanga province, bringing their total responsibility to 43 training institutes and an associated 11,312 health professionals (ONRHS-RDC 2015). This added burden dilutes their ability to follow up and enforce MSP decisions (MSP 2017j).

Quality of training programs

Although training institutions are supposed to be at different technical levels, stakeholders could not confirm there were significant differences in the content of training programs (for example, training models, syllabi, and curricula) delivered by secondary and higher-level training institutions or universities. Most of the private training institutions also lack infrastructure, equipment, qualified teachers, and sites suitable for practical training.

One-fifth of the medical schools created between 1998 and 2008 did not meet the required standards set by regional bodies to deliver diplomas to graduates. For example, Conseil Africain et Malgache pour l'Enseignement Supérieur cites a lack of senior lecturers in private training institutes as a serious concern. Despite that, these institutions continued to produce more than 2,000 new physicians each year and more than 4,000 new nurses, albeit without formal diplomas, leading to a health workforce of varying quality (Durham et al. 2015). The Orders were quick to note the impact on service delivery. For example, the Order of Pharmacists in Kolwezi informed the team that they had received several complaints regarding training institutions, in particular the lack of laboratory equipment that led to students graduating with incomplete training. The poor quality of training in certain schools has also led some Orders to refuse to register graduates and grant them licenses.

Despite challenges with the quality of their programs, training institutions continue to provide certificates to their students. Stakeholders highlighted that private as well as public schools are motivated to acquire, train, and graduate students, even if they do not have the necessary skills to practice, because most of the institutions' operating budgets come from the schooling of students.

Both the Orders and the ASPS expressed interest in supporting the MSP to improve the quality of HRH training. The Orders especially would like to play a larger role in accreditation, supervision, and compliance processes for both training institutions and providers but lack the authority and human resources to do so.

Continuing education

Quality of care is a serious concern to the MSP, and it has set up a Directorate of Continuing Education in response. To increase efficiencies, the MSP has organized thematic trainings within the framework of specific programs. To roll these out nationwide, the Directorate plans to hold a training-of-trainers event and send trainers to the provinces to create provincial training mentors. However, the Directorate is underfunded and has only successfully rolled out these reforms in four of the 26 provinces (MSP 2017j). Beyond this internal organization, the MSP uses higher education institutions and universities to train clinical specialists and conducts on-the-job training at the School of Public Health in Kinshasa and Lubumbashi (MSP 2017j). Anecdotally, these continuing education efforts are open to private providers, but little data are available about their uptake.

7.3 HRH IN THE PRIVATE SECTOR

7.3.1 Data on HRH in the private sector

Data regarding HRH numbers in the private sector are difficult to obtain. Most of the HRH data in the DRC come from the public sector. However, the MSP is progressively involving the private sector in more HRH data activities. For example, the private sector was invited to participate in training sessions on different HRH management modules when the Observatory for HRH was established. These efforts have had some success—the Monkolé Health Center, which is a training and research institute with its own hospital, shares its data with the MSP's Directorate of Human Resources and is a member of the Observatory for HRH (MSP 2017j).

Data on HRH in the private sector also remain limited because of a lack of reporting. The 2015 Country Profile

indicated that most health providers worked in the public sector, with only 7 percent of the total HRH working in other sectors, including the private sector, parastatals, the army, and the police (Table 15). Other sources present conflicting data, which seem to indicate higher HRH numbers in the private sector. A 2015 study indicated about 11,000 physicians were registered nationwide, with fewer than half (~5,000) working in the public sector, significantly more than the numbers in Table 15 (Durham et al. 2015). The numbers registered with the Order of Pharmacists are also significantly higher than the 303 pharmacists reported in Table 15. The Order of Pharmacists stated they had 2,000 registered pharmacists in 2017, of whom 1,300 practice (7sur7.cd 2017; Order of Pharmacists 2017).

Contracting between the public sector and FBOs also makes it difficult to obtain clear data about HRH numbers in the private sector (see Box 33). For example, an estimated 65 percent of staff working in health facilities supported by the Catholic Church are also registered as health personnel with the MSP, and 30 percent are on MSP payroll registers through agreements between the two parties (Barroy et al. 2014). Likewise, delays in registration affect data on HRH. The Order of Doctors in Katanga indicated that there were 1,300 public and private doctors in 2017, 871 of whom were registered with the Order. Ninety-four percent of doctors are generalists, and 70 percent are based in Lubumbashi (Order of Doctors 2017). The significant difference between the number of doctors in the province and the number registered with the Order is caused by a month-long delay between when new doctors graduate and when they receive final degrees, thereby allowing them to register to become a member of the Order. For doctors waiting for registration, the Order has established a six-month tutoring system that is renewable once (Order of Doctors 2017).

Box 33. The limits of contracting for HRH

Though contracting can improve the distribution of HRH, non-compliance has led to some dissatisfaction with this practice. Several stakeholders stated that the MSP did not consistently pay salaries in a timely manner, which impacted on the ability of facilities to operate as they used funds to pay for salaries rather than other costs or investments. Others stated that there were issues with transparency, traceability, and accountability, with providers not implementing recommendations following audit missions.

Table 15. Human resources for health by category and by sector in the DRC, 2015

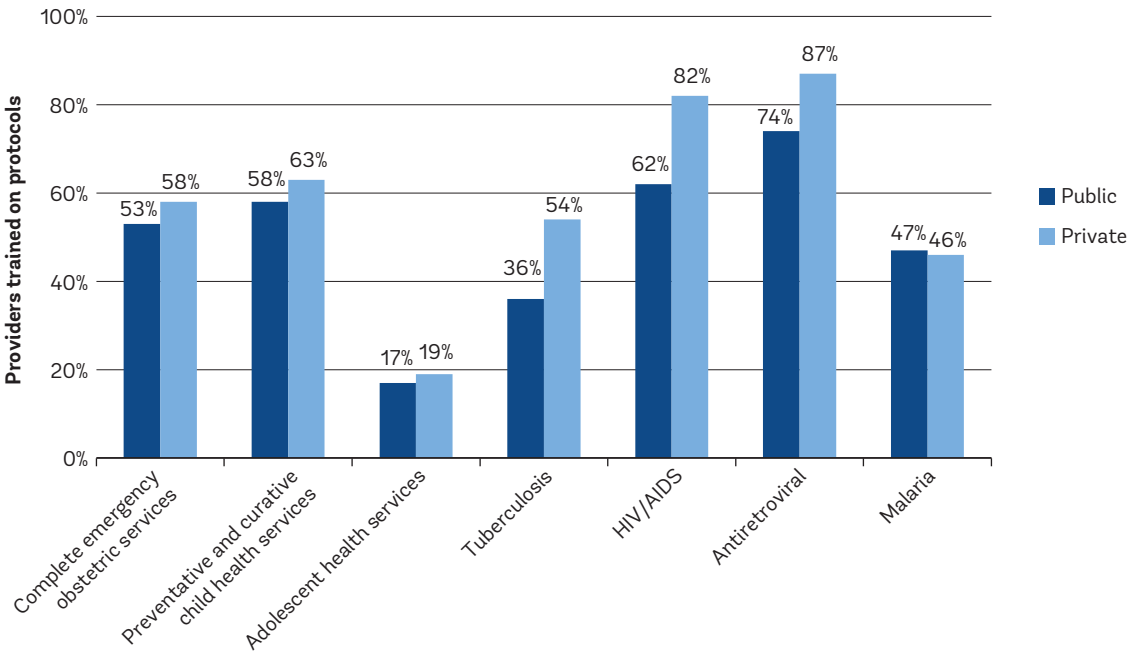
Categories	Public Sector	Other Sectors*	Total
Doctors	6,246	1,259	7,505
Dental surgeons	51	19	70
Administrators	2,366	53	2,419
Pharmacists	288	15	303
Nurses	60,332	3,350	63,682
Midwives	1,555	282	1 837
Physical therapists	302	62	364
Laboratory technicians	2,160	155	2,315
Radiology technicians	287	20	307
Nutritionists	586	19	605
License in physical medicine	0	7	7
Pharmacy assistants	212	12	224
Sanitation technicians	207	18	225
Dentist (odonatologist)	2	2	4
Other health professionals	5,339	756	6,095
Total	**79,933**	**5,797**	**85,730**

* The Other Sectors category includes private, parastatal, denominational, army, and police.
Source: ONRHS–RDC 2015.

Although accurate data on the numbers of private sector providers are difficult to obtain, 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 (Figure 36).

The geographic distribution of health workers shows large disparities between Kinshasa and the rest of the country, especially for physicians. Kinshasa had 1.3 physicians per 10,000 inhabitants in 2013, whereas most other provinces had half that ratio. For nurses, the former province of Bandundu and Equateur seemed better off than Kinshasa, with over 13,000 nurses each compared with Kinshasa's fewer than 4,000 (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. National norms per 10,000 inhabitants for

Figure 36. Availability of trained HRH and protocols by type of service and sector



Source: MSP 2014a.

health center staffing are seven health workers (five nurses and two nonprofessional staff). In practice, many urban health centers have more than 30 nurses for about five outpatient clients per day (Ntembwa and van Lerberghe 2015). In addition to the shortage of physicians, the DRC has a lack of pharmacists and midwives. In Kinshasa, for example, there is one qualified pharmacist for every 42,662 inhabitants (Office Fédéral des Migrations 2014). A census completed by the UNFPA found there were only 4,200 midwives for the entire country (UNFPA 2014).

An analysis of the labor pool suggests that the number of HRH working in the private sector has grown significantly in recent years as well. This may be attributable to the 10-year hiring freeze on civil servants and the growing number of private facilities. In addition, the private sector offers opportunities for both generalists and specialists, with some specialties available only in the private sector (for example, physiotherapy).

7.3.2 Dual practice

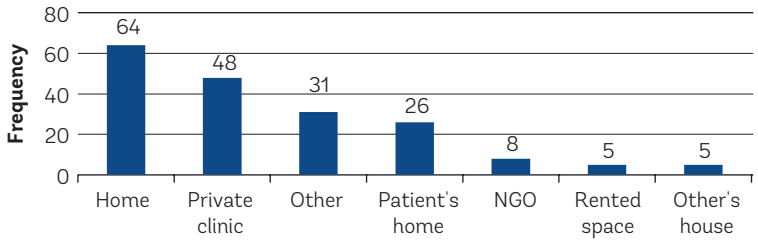
Although dual practice is not legally authorized, it is commonplace in the DRC. Wage payments in the public sector are irregular, and the pension system has not been functioning for a long time. As a result, dual practice has expanded, despite its illegality. A study by the Observatory for HRH found that almost half of all public-sector health workers engaged in additional, nonclinical activities to supplement their income, whereas fewer than 10 percent conducted clinical work in the private sector (ONRHS-RDC, 2015). Of the public-sector health workers conducting dual practice, many do so from home or in a private clinic (Figure 37). Health workers are likely to earn more working in the private sector, making dual practice financially attractive (Bertone and Lurton 2015).

7.4 RECOMMENDATIONS

Improve coordination between stakeholders involved in HRH management

Finding: The accreditation process for training institutions, the limited resources in training schools in the public sector, and training schools in the private sector that do not meet quality standards have led to significant variations in the quality of HRH produced. There is an urgent need to clean up the training system, especially

Figure 37. Location of private practice among surveyed public health workers who conduct dual practice, 2015



Source: ONRHS-RDC 2015.

in the private sector, and establish and strengthen the framework and accreditation process for training institutions for health personnel.

Recommendation: Support the new Directorate of Human Resources at the MSP in collaboration with the Ministry of Education (Ministère de l'Enseignement Primaire, Secondaire et Professionnel) and the Ministry of Higher Education (Ministère de l'Enseignement Supérieur et Universitaire) to institute a coordinating body to facilitate the regulation and standardization of training programs to improve the quality of HRH. The coordinating body should begin by improving the quality and standardization of training by making an inventory of educational institutions (materials, infrastructure, staff, level of recruitment); revising and aligning training curricula (models and syllabi); and prioritizing training needs based on the availability of HRH and epidemiological needs. Stakeholders involved in the management of HRH, such as associations (for example, ASPS) and orders, should be an integral part of training program development, including the design of curricula and implementation of the accreditation system.

Establish and enforce the accreditation system for training institutions

Finding: The accreditation process for training institutions is unclear because of the multiplicity of actors involved (that is, the MSP, Ministry of Commerce, and municipalities).

Recommendation: Develop in collaboration with relevant stakeholders a formal structure for the accreditation system and define regulations, roles, responsibilities, and authorities of the different stakeholders at the national, provincial, and local levels. Donors, the government, the Orders, and other partners should then assist the training institutions to upgrade the quality of their programs to meet the newly defined accreditation standards.

Build public–private links to facilitate practical training

Finding: To ensure the quality of health services in the DRC, it is critical that health sciences students such as doctors, nurses, and midwives receive sufficient practical hands-on training as part of their preservice academics. Assessment informants indicated some students are entering post-graduation clinical care without sufficient practical training. This negatively affects the quality of care. Historically, students studying at private medical training institutes (PMTIs) have had to rely on securing practicum opportunities within public health facilities, but these are limited. PMTIs and private students have contended with unclear private-to-public student placement procedures, fluctuating costs for placements, and payments demanded from hospital administrations.

Recommendation: To address the lack of practical training, public and private stakeholders should clarify and codify standard operating procedures related to placement of private students (all cadres and disciplines) in public facilities. As alternatives to public practicum sites, private-to-private practicum approaches have been offered to PMTI students, but these are even more limited than public ones. It is important to work with a broad range of PMTIs and private provider networks to design and demonstrate a private sector preferred practicum model (featuring private-to-private student placement as an alternative to public practicum sites). The goal is to design

a preferred model for private-to-private student placement, including the identification of a student cohort with PMTI student rotation through practice areas, including reproductive and child health clinics, labor and delivery, and general medical practice.

Increase the quality and accessibility of training

Finding: Training plans exist for all HRH levels, but the quality and accessibility of trainings varies because of a lack of resources, a lack of quality trainers, and geographic/financial constraints. The Yaoundé training centers in Cameroon and Dakar, with the support of Japan International Cooperation Agency (JICA) and the National School of Health and Social Development, are being transformed into a regional center for nurses and midwives of French-speaking countries.

Recommendations:

- Support the MSP with partners to set up training institutions for trainers modeled on the Yaoundé training centers.
- Support the MSP to work with partners and develop and implement an integrated strategy to improve the quality and accessibility of trainings; this could include facilitating financing for equipment and infrastructure, developing a scholarship scheme to enable providers to acquire relevant complementary skills in targeted health zones, sponsoring health area-specific training courses, or developing an e-Learning platform accessible to the public and private sector.

Identify and address HRH gaps in collaboration with partners

Finding: Data on HRH in the private sector are limited because not all stakeholders report to the MSP. Based on available data, HRH availability, especially specialists such as laboratory technicians, varies significantly between urban and rural areas, as well as between provinces.

Recommendation: Undertake a mapping with the MSP's Directorate of Human Resources, stakeholders from the public and private sector, and the National HRH Observatory, of the available HRH in the private sector for key health areas to identify and address HRH gaps.

Incorporate the private for-profit sector in the MSP's HRH staffing planning

Finding: Private providers say that NGOs (including FBOs) are favored by the MSP above for-profit health facilities for HRH staffing.

Recommendation: Explore in collaboration with the MSP and ASPS opportunities to integrate the private for-profit in HRH staffing plans, including opportunities to establish contracting mechanisms in exchange for tax relief, as is done with the nonprofit sector.

Implement a systematic approach to increase HRH motivation

Finding: Initiatives to increase HRH motivation are limited by the MSP's inability to pay the salaries of its staff in public facilities and private facilities they are contracting with. This creates an incentive for dual practice, with some providers recommending clients at their public facilities to visit their private facilities for treatment to increase revenue. One option to explore is use PBF, being careful not to accidentally create incentives for providers to work in one health zone rather than another, as has happened previously with PBF programs.

Recommendation: Develop and implement with the MSP's Directorate of Human Resources a systematic approach to improve HRH motivation in both the public and private sector in collaboration with partners, taking into account internal initiatives, such as the ongoing reform of the pension system in collaboration with the World Bank, as well as external mechanisms such as PBF programs.

8. Health Information Systems

The DRC continues to struggle with underdeveloped infrastructure. For example, only 16 percent of the population has access to electricity, despite hydroelectric dams in the DRC that have the potential to generate enough power for most of the continent (Lightening Africa 2017). The lack of basic power poses significant challenges for industries, such as telecommunications, which are a building block for development.

The telecommunications sector is loosely regulated, and the national operator Société Congolaise des Postes et des Télécommunications provides minimal services (Budde.com 2017). Six mobile network operators (Vodacom, Orange, Airtel, Africell, Supercell, and Tatem Telecom) are the principal providers of telecom services in the DRC, demonstrating strong private sector participation. Despite a market with multiple competitive international service providers, the mobile SIM penetration (unique subscribers) is only 26 percent of the population, making the DRC one of the most poorly connected countries in the region (GSMA 2017). This low penetration is attributable to persistent social and political instability, security threats, and a high poverty rate.

The DRC's Internet and broadband market has been slow to grow. In 2013, the DRC was connected to low-cost, high-quality international bandwidth through a submarine fiber-optic cable. The national operator is rolling out a fiber-optic national backbone network with support from China (Budde.com 2017). Despite this progress, international bandwidth is extremely limited, with mobile broadband available to only 7 percent of the population (GSMA 2015). However, mobile operators are keen to grow mobile data services and capitalize on smartphone usage and capabilities.

8.1 NATIONAL HEALTH INFORMATION SYSTEM AND THE PRIVATE SECTOR

The lack of telecommunications and power infrastructure has posed significant challenges to digital implementation and scale up of the national health information system, Système National d'Information Sanitaire (SNIS), and other digital health initiatives. However, significant progress has been made, and strong private sector participation has bolstered efforts, holding promise for future advances.

8.1.1 DHIS2

DHIS2 is the preferred open source, electronic health management information system in 60 countries, including the DRC. DHIS2 is currently used as 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 budget for the SNIS Strategy for 2018–20 is US$30.5 million, some of which could be used to bolster digital implementation, improve private sector participation, or match private sector investments.

At the end of 2017, there were 17,859 facilities registered in DHIS2 across the DRC. Facilities in DHIS2 are categorized as public, FBO, or private. Of all facilities registered in DHIS2, 20 percent (3,501) are categorized as private, 10 percent (1,872) as FBO, and 53 percent (9,493) as public. Seventeen percent (2,993) are not defined in any category. This means that 30 percent (5,373) of all registered facilities across DRC are in the private sector (FBO and private). Over half (53 percent or 2,848) of these are private health centers, 26 percent (1,414) are private health posts, and 14 percent (771) are private hospitals.

Implementing a health management information system at scale is complex, requiring close collaboration between private and public actors, as well as updates to policies, procedures, and tools. In collaboration with many partners, the MSP rolled out DHIS2 across all 516 health zones in 2016. The zones have moved from paper-based reporting at all levels to electronic reporting at the health zone level (IMA World Health n.d.). Integrated and modular approaches across health programs are used in the revised paper data collection tools. These documents are

then brought to the health area for a monthly preliminary validation event, which gives each facility the opportunity to report and discuss key indicators. The paper-based documents then move up the Central Bureau of the health zone, where they are further validated at the monitoring meeting (réunion de monitorage) and entered electronically into DHIS2 by Central Bureau staff. The rollout has resulted in more than 89 percent of the country using the new platform (MSP 2017j).

Across the provinces examined in this assessment, there are differences in private sector participation (Table 16). In Kasai Oriental, Kinshasa, and Haut-Katanga, private providers participate in large numbers (70 percent, 68 percent, and 60 percent, respectively) of registered facilities. This is likely due to greater urbanization in these three provinces. There are few registered private sector facilities in Tshopo, and there are too many undefined facilities in North Kivu to describe private sector participation.

One of the biggest achievements of the DHIS2 transition is registry of private sector facilities as part of the public health reporting system. Like public facilities, private facilities that register receive training on the new, streamlined, paper-based data collection tools, and receive many of the same free products (for example, vaccines and malaria medications) for public distribution. In return, registered private facilities summarize key health indicators monthly and participate in public health service delivery (for example, administration of vaccines on monthly vaccine days).

Private and FBO facilities that are registered in the health system have slightly better reporting rates than do public facilities (Figure 38). There is substantial variation in reporting rates by province but less across facility type within the province. Three-quarters (75.1 percent) of private facilities registered nationally submitted a report in November 2017 on their basic services, compared with 74.7 percent of registered FBOs and 71.1 percent of public facilities. Across all of the DRC, Kinshasa has the worst reporting rates for all facility types. One limitation of DHIS2 data is there is no indicator for the quality or completeness of reporting (although there is an indicator for timeliness). The reporting indicators provided are binary (did or did not report); knowing whether the quality of the data is worse in the public or private sector would be useful in targeting technical assistance.

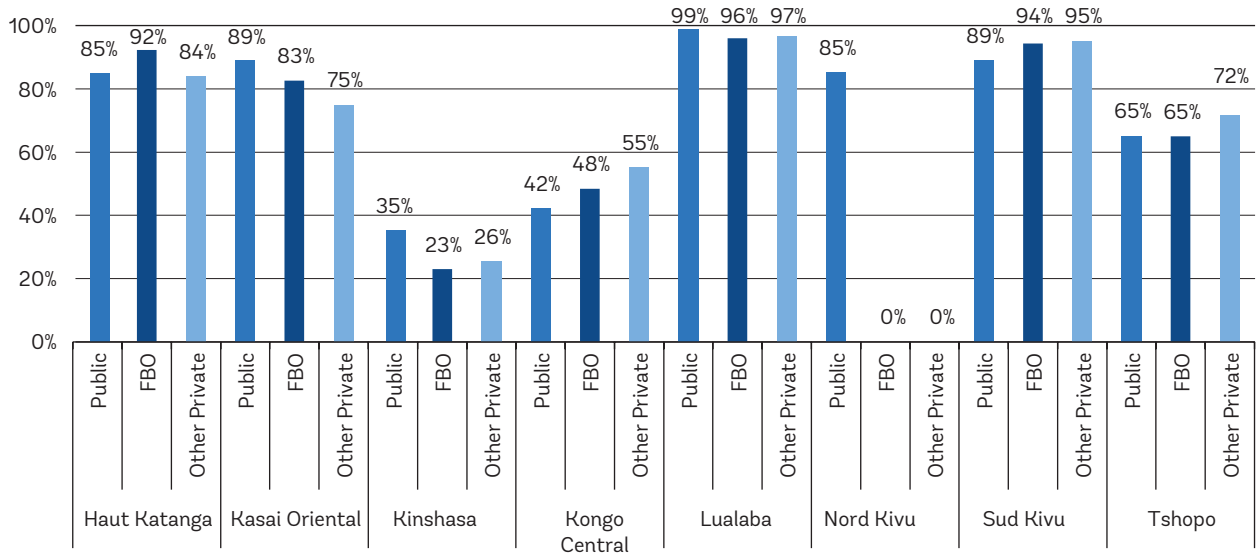
The high private sector reporting levels in DHIS2 were reflected in interviews with private providers across provinces. Although several challenges were mentioned, all private providers interviewed were adamant about their adherence to their monthly reporting commitment (quality of reporting was not discussed). Among private providers, there seemed to be a clear understanding of the necessity of reporting and attendance at the monthly validation events. Although transport and per diem costs of the monthly reporting event were mentioned as a financial inconvenience, private providers seemed resigned to covering these costs for the near future. They were more vocal about the need for the Central Bureau to more

Table 16. Number and type of facilities registered in DHIS2 in selected provinces, 2017

Province	Private Sector		State	Not Defined	Total	Percent (%) of DHIS2 Facilities that Are Private Sector
	Other Private*	FBO				
Kasai Oriental	360	46	127	45	578	70
Kinshasa	567	76	100	204	947	68
Haut-Katanga	556	72	283	138	1,049	60
Kongo Central	499	204	677	63	1,443	49
South Kivu	126	340	459	81	1,006	46
Lualaba	123	79	166	70	438	46
Tshopo	68	44	477	99	688	16
North Kivu	0	0	316	699	1,015	0

*Includes NGO, for-profit, and nonprofit.
Source: MSP 2018.

Figure 38. Reporting rate for November 2017, by facility type



Source: MSP 2018.

consistently provide paper-based reporting tools, which they photocopied themselves regularly.

Implementation challenges

As with all new health information systems, challenges remain, particularly with regard to private sector inclusion. First, it is not apparent what percentage of private facilities in the DRC is registered in DHIS2. This makes it difficult to know whether the registered private facilities are representative of the whole private sector. National standards on physical infrastructure, equipment, and service provision required for registration can be difficult to meet for smaller, poorer facilities in the private sector. This means that these facilities are not able to formally register and are therefore not included in the facility registry, despite continuing to provide important health services to low-income, rural, and/or vulnerable populations. Second, of the private facilities that are registered in DHIS2, nearly 3,000 (17 percent) are not categorized as public, private, or FBO, and therefore it is difficult to assess differences in public versus private participation and health indicators. Third, there are no recurring reports that are generated to offer insight into differences in public and private service delivery. Collecting more-nuanced data will not be helpful if indicators are not tracked and data are not used for decision making. Finally, updates to the facility registry purportedly are made only once per year, which potentially creates a large data lag.

Another challenge that both private providers and implementing partners highlighted was the lack of feedback offered to private providers. Presumably issues that are

Kalebu Espoir

identified in public facilities through routine reporting are corrected through action by the MSP in its role as steward of public health facilities. However, private facilities do not receive any kind of feedback or report on how they are performing relative to other facilities or over time. It may be that public facilities are not receiving this kind of feedback either. IMA World Health is working on simple autogenerated dashboards that can be shared with facilities; this could address the concern that the current flow data for decision making is one directional.

DHIS2 data entry and transmission currently occur at the health zone level, and therefore Internet and mobile data connectivity is not a pressing issue for private providers. However, the SNIS Division and provincial leadership both repeatedly cited the challenge of connectivity for transmitting data. The tardiness or complete absence of data can significantly delay decision making and is particularly problematic in rapidly evolving epidemics. MEASURE Evaluation is exploring the possibility of decentralizing data entry and transmission to the health facility level, which means that a more-expansive connectivity solution will likely be needed in the next five years. One solution IMA World Health is currently exploring is the reprogramming of data packets so that they are smaller in size and easier to transmit. A PPP between mobile network operators, implementing partners, and the MSP may help address the complex challenge of data connectivity.

A final limitation of the current DHIS2 system in the DRC is that it does not collect information on pharmacies, supply chain, stock, HRH, or medical records. This is a limitation both because pharmacies constitute a major component of the private sector and because these data are critical to managing the health workforce, distributing products efficiently, and understanding population health longitudinally. Although DHIS2 does have the potential to support these types of data collection, other platforms that are specifically developed for logistics management, HRH management, and medical record management may offer more-nuanced insights for decision making.

8.2 OTHER INFORMATION SYSTEMS

8.2.1 Logistics management and information system

Reliable data about health products are a weak link in the SNIS (Office Fédéral des Migrations 2014). There are significant challenges in the current data flow because of the complexities of the supply chain, as described in Section 5. For example, none of the CDRs are aware of the items and quantities ordered from implementing partners (SIAPS et al. 2014). In a 2014 study of the DRC LMIS, health facilities in the public and private sector reported that they spend up to four days a month preparing reports (SIAPS et al. 2014). Electricity is unreliable or not available, which means manual forms are used to capture data; poor data availability and accuracy are therefore serious concerns.

Although DHIS2 has the capacity to aggregate health service data and aggregate public health indicators, it may not be sufficiently adept at managing complex, subnational inventory, ordering, quality assurance, fleet management, distribution, pharmacovigilance, and other logistics tasks that are needed to support a well-functioning LMIS. Therefore, many countries are moving toward the use of a separate yet interoperable platform for stock management, such as OpenLMIS. An interoperable LMIS platform can easily transfer information to other systems without complex data restructuring or recoding. An electronic LMIS automates redundant hard copy processes and can feed stock levels and inventory data into the DHIS2, where it can be compared against coverage information.

An improved pharmaceutical information management system could also address other challenges, such as clustering of private pharmacies in areas with sufficient population, which leads to a dearth of clients in one geographic area with underserved populations elsewhere. These inefficiencies could be identified by strong private sector participation in a new electronic LMIS.

UNFPA in the DRC is a strong proponent of establishing an interoperable electronic LMIS. There are several ongoing attempts to initiate an electronic LMIS through the piloting of the UNFPA Channel software in 14 health zones from 2011 to 2014 and the DHIS2 drug module that was piloted in 40 health zones in Kinshasa, Kongo Central, and Kisangani more recently (UNFPA 2017b). However, none of these initiatives has yet been evaluated. UNFPA is in the process of evaluating the VillageReach implementation of OpenLMIS, and that evaluation should be available in 2018. UNFPA plans to leverage these results to develop an operational plan for an electronic LMIS. The current (June 2017) road map for an LMIS would benefit from lessons learned on how to incentivize and engage with the private sector during this process, particularly as such a substantial proportion of health products and other drugs flow

Lab at Clinique IK, Kinshasa

through the private sector, NGO networks or social marketing organizations, or private wholesalers, drug shops, and pharmacies.

8.2.2 Health workforce information systems

In 2014, IMA World Health and IntraHealth began piloting an electronic, open source iHRIS in Kasai Province. iHRIS helps health systems in low-resource settings collect and manage data on HRH numbers, skills, qualifications, locations, and other important factors for decision making. These data can help countries address HRH shortages and other barriers across the health sector (see Box 34 for example of interoperability with mobile platforms). As one early 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 private for-profit and nonprofit providers. Private facilities that are registered in DHIS2 could have their staff registered in iHRIS as well, and this could facilitate contracting between the public-sector and private providers and facilities. Although they are not yet integrated, iHRIS is interoperable with DHIS2, and the two systems can complement each other in useful ways.

8.2.3 Integrated Health Project data dashboard

In 2018, the USAID Integrated Health Project (IHP) was awarded in the DRC, which proposes to build on existing national and subnational systems to offer a data dashboard for health program decision making. This system will use advanced visualization and organization techniques to provide actionable timely data from central, provincial, health zone, facility, and community levels, while keeping its commitment to avoid parallel systems and not duplicate effort. Although IHP is largely focused on the public sector, it would be useful to explore how to integrate the private sector at the conception of this dashboard so that it is useful and applicable to the total health system.

Box 34: mHero

mHero is a mobile phone-based communication system that uses basic text messaging to connect ministries of health and health workers without the need for a smartphone or tablet. mHero was the "hero" of the Ebola crisis in Liberia in 2014, where it was used to collect and communicate critical epidemiological information between the health information system and health workers. Developed by IntraHealth and UNICEF, mHero can also support ongoing health communication and is useful for bringing together existing components of a country's health information system, such as DHIS2 and iHRIS, using international interoperability standards. Although not currently used in the DRC, mHero is a communication system that could build on data from iHRIS and DHIS2, particularly in the context of the private sector, where two-way communication between private providers and Central Bureaus is more limited.

8.3 DIGITAL AND TELECOMMUNICATIONS OVERVIEW

8.3.1 Mobile network operators

The top four mobile network operators (MNOs) by market share in the DRC are Vodacom, Orange, Airtel, and Africell (Table 17). Each offers a mobile money service in addition to standard voice and data services. All are interested in expanding brand awareness, market share, and geographic presence and can offer discounted or bundled data, voice, and other media and communications services. MNOs have had varying experiences collaborating with government partners but are all willing to explore digital health partnerships and address MSP and health implementer needs. The geographic areas of particular commercial interest to MNOs inter-

Table 17. Mobile Network Operator (MNO) User Base and Market Share

MNO Name	Mobile Subscribers	Market Share (%)	Mobile Money Name (Number of Subscribers)
Vodacom	13 million	~38	M-Pesa (2.5 million)
Orange	9.5 million	~30	Orange Money (1.2 million)
w	8 million	~24	Airtel Money (1 million)
Africell	3.5 million	~11	Africell Money (N/A)

Source: Based on MNO self-report in interviews.

viewed include Kinshasa, Kongo Central, Haut-Katanga, and North Kivu because of their relatively dense populations and economic activity.

Vodacom

Vodacom Congo, established in 2002, is the national subsidiary of Vodafone International. Vodacom has the largest share of the mobile market, with 13 million subscribers. M-Pesa is the Vodacom mobile money service in the DRC, which offers financial services, including savings and loans programs. Vodacom is in the process of establishing a local, cloud-based platform called Mezzanine that can support a wide array of data collection, communication, and other digital services. Among other applications, Mezzanine has a stock visibility solution that tracks the availability of vaccines in Mozambique, malaria medicine in Tanzania, and medicine for extreme drug-resistant TB in South Africa. The Mezzanine platform has also supported projects focused on community care management, patient management, and workforce management in sub-Saharan Africa. Vodacom plans to start building Mezzanine in the DRC in April 2018 and expects to have it completed in October 2018. Vodacom is actively looking for potential clients who are interested in such services and already has ongoing partnerships and contracts with the MSP and implementing partners, such as Management Services for Health (MSH) (Vodacom 2017).

Orange

Orange established itself in the DRC in 2012, when it purchased CCT, a Chinese telecom, and then further expanded its presence with the purchase of Tigo in 2016. By 2017, Orange reported approximately 9.5 million active users and a 30 percent mobile subscription market share. Orange Money, the mobile money branch of Orange, reports 1.2 million subscribers, which constitutes a quarter of the mobile money market. As one of its competitive advantages, Orange points to a strong regional presence in francophone West Africa that offers resources other operators cannot access. Bolstered by the acquisition of Tigo, Orange has a fairly strong presence in many provinces but a weak presence in the central region of the DRC (for example, Bandundu and Twshwapa). Orange plans to invest more heavily in infrastructure in rural areas, an interest that would converge with the MSP's desire to improve connectivity for rural health areas and zones. Orange has also worked on a number of development projects, including a malaria project with Soins de Santé Primaires en milieu Rural (SANRU) and a mobile data collection education project (Orange 2017).

Airtel

Airtel has eight million active users and estimates that it has 24 percent of the mobile market. Airtel currently focuses its client development efforts on enterprises and NGOs, where the company says there is stronger predictability and stability compared with government clients. In addition, Airtel is trying to distinguish itself as "The Smartphones Network," and its business strategy is focused more on data, broadband, and Internet access. Airtel was the first operator to establish a mobile money branch in the DRC in 2013. By the end of 2017, Airtel reported approximately one million mobile money users, of which approximately 700,000 were active. By Airtel's accounting, the company has the most cash-in–cash-out locations in the nation. Geographically, Airtel noted that the company has a particularly strong

usership and presence in the east, Katanga, and Kinshasa, and a moderate presence in Kongo Central, Matadi, and Kivu/Goma. Airtel's investments in data infrastructure have been slowed by political instability. Airtel also has some development partnerships but does not seem to have a strong corporate social responsibility or foundation presence in the DRC (Airtel 2017).

Africell

Africell DRC was established at the end of 2012, but they did not receive authorization as a telecom until 2014. It is therefore a relative newcomer to the DRC, with operations in Uganda, the Gambia, and Sierra Leone, making it much smaller and more locally focused than the other three large international operators. Marketed as "The People's Network" (le réseau du peuple), Africell advertises low-cost data and voice services, allowing the company to reach lower-income market segments. Africell has approximately 3.5 million subscriptions and is looking to grow its market share. Africell Money, launched in 2017, offers classic mobile money services. Geographically, Africell operates mostly in the Kinshasa and Haut Katanga geographic areas, with some additional services in Kongo Central. Although there is not a foundation or corporate social responsibility division at Africell, the company has supported a number of development projects, including for HIV, gender-based violence, education, and Ebola (working with the WHO in Sierra Leone). Africell's support is often channeled through its production house, which supports broadcasts, events, and other communication through television, radio, and other telecommunications channels (Africell 2017).

8.4 DIGITAL INNOVATIONS IN HEALTH

This section contains two case studies in the DRC and across the region to stimulate creative thinking on possibilities for innovative health care in low-resource settings.

8.4.1 WapiMed: a digital solution for identifying and accessing health services

WapiMed is an app-based health facility mapping and appointment tool developed in 2016 for the DRC ("wapi" means "where" in Swahili). Currently being piloted in five hospitals in Kinshasa and Lubumbashi, WapiMed helps people seeking medical treatment locate public or private facilities, providers, and pharmacies in their geographic area and secure appointments and consultations. All appointments are currently made by phone, so providers do not even need to have a smartphone or the Internet, but more digitization is planned so that appointments can be made online.

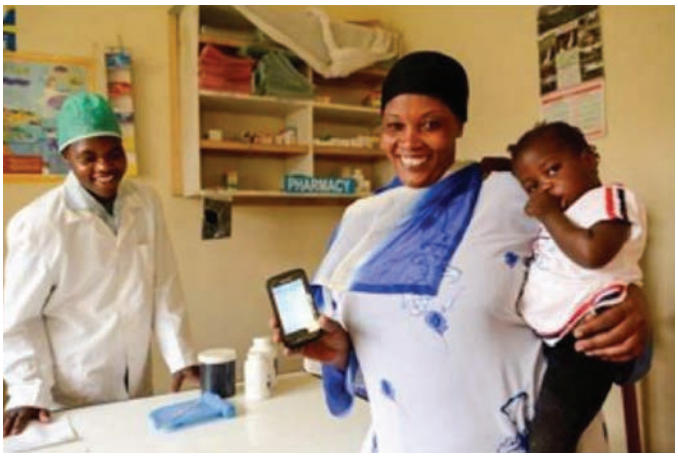
WapiMed's approach to identifying and adding facilities has been to work with the Order of Doctors and map networks of referral hospitals and health centers. Often the Order does not have location data for its member physicians, so this partnership is benefiting both the Order and WapiMed. WapiMed would benefit from further partnership with the MSP, which has more-extensive lists of public and private facilities.

The intended business model of WapiMed is for health providers and facilities to subscribe to the service. Currently, joining and using the app is free while a client base is developed. Ultimately, WapiMed wants to limit participation to facilities that have a certain level of quality, but right now they do not have clear quality criteria and admit that facility acceptance is currently subjective.

In addition to geolocation and appointment services, WapiMed is interested in developing a mobile wallet for health that can facilitate the US$12–US$15 million in remittances that are sent by the diaspora annually to pay for health services of friends and family in the DRC. WapiMed is also expanding into Côte d'Ivoire and has a vision for all of francophone West Africa.

8.4.2 M-Tiba: a digital foundation for health financing

M-Tiba is a mobile health wallet that allows people to use their phones to send, save, and receive digital money that can be used only for health services and related payments. Developed in Kenya, this product was launched in 2016 through the partnership of four important stakeholders: Safaricom, the dominant operator in Kenya; CarePay, a Kenyan social venture that manages payments among



Clinic piloting M-Tiba in Kenya

funders, patients, and health care providers and developed and administers the openCarePool digital platform on which M-Tiba runs; PharmAccess, the coordinating NGO; and Pfizer Foundation, which financially supported the pilot and voucher payments.

In 2017, M-Tiba began to evolve beyond a simple mobile health wallet with vouchers, to include more-sophisticated partnerships with private health insurers, including Kenya's National Health Insurance Fund, and a platform that integrates payment with medical data. By December 2017, M-Tiba had 805,421 beneficiaries and 465 providers enrolled in the system (PharmAccess 2017). Additional applications supported by M-Tiba rolled out in 2017 include HealthConnect, which enables individuals in the diaspora to channel funds to cover health insurance costs for Kenyan families, and a mobile cash-advance product that facilitates digital access to finance for providers.

One factor in M-Tiba's success is the digital environment in Kenya, which is much more favorable than that in the DRC. In Kenya, mobile phone penetration is 89 percent, mobile money penetration is 58 percent, and the dominant operator (Safaricom) has 73 percent of the mobile market (Communications Authority of Kenya 2017). In contrast, mobile phone penetration in the DRC is 26 percent, mobile money penetration is 9 percent, and the dominant operator (Vodacom) has 38 percent of the mobile market. A product such as M-Tiba could be successful as a long-term goal in the DRC, but it would require a phased approach with appropriate pilots, training, and networking of private providers and rapid-cycle learning. When the digital infrastructure and health system readiness has made additional progress, the steps to piloting a mobile health wallet in the DRC would be to 1) identify stakeholders, including public and private providers in existing networks, PharmAccess, CarePay, WapiMed, mobile network operators, and other technical partners, for participation in a pilot of the mobile health wallet; 2) pilot a mobile health wallet in a setting such as Kinshasa or Lubumbashi; and 3) continuously monitor and assess achievements, challenges, and potential for replication and scale of a mobile health wallet.

8.5 RECOMMENDATIONS

Review and improve FP and child health indicators in DHIS2

Finding: Currently, DHIS2 FP indicators include the number of specific contraceptive products delivered, some program-related data, and the number of new and renewing users. The information provided by these indicators is limited and does not paint a complete picture of FP commodity supply or demand. Because DHIS2 is relatively new and continues to evolve, there are opportunities to add and improve variables and collect systematic and actionable data to improve services, reduce stockouts, and track contraceptive prevalence and demand. Tulane University and UNFPA have indicated that FP indicators are priorities for SNIS updates and are working to improve FP indicators. Similarly, child health indicators may warrant review and updating, which could be done in partnership with United Nations Children's Fund (UNICEF) and in the context of WHO IMNCI guidelines.

Recommendation: With stakeholders, conduct a multidisciplinary review of DHIS2 to identify where additional indicators can be added for FP and child health. Consider which indicators are most critical and feasible for private sector reporting and use.

Survey, map, and register unregistered private facilities

Finding: It is not clear what percentage of private facilities in the DRC is actually registered in DHIS2, making it difficult to collect complete information or to know whether private facilities that currently participate are representative of the whole country. Smaller, poorer facilities in the private sector are not able to meet

national registration requirements and are therefore not included in the facility registry. Additionally, updates to the facility registry are made only once per year, which creates a long lag for getting newer facilities into the DHIS2.

Recommendations:

- Support a private sector survey to identify, geo-locate, and gather key information about private health facilities in the DRC, including pharmacies and drug shops, to facilitate their participation in the DHIS2. This could be done as part of the planned DPM mapping of private supply chain stakeholders.
- Collect information on barriers to formal facility registration and identify reforms needed to more regularly update the national facility register with new, moved, and closed facilities; this information can be used to quickly link new facilities into DHIS2 and support implementation of a new electronic LMIS.

These activities could be implemented in partnership with the ASPS, as was done in Senegal.

Increase usability and relevance of DHIS2 data for private sector monitoring

Finding: Of the facilities that are registered in DHIS2, a significant number are not categorized as public, private, or FBO. The current options (public, private, FBO) also limit insight into differences between the private for-profit and nonprofit sectors. In addition, there are no recurring reports that are generated internally to offer decision makers insight into differences in public and private service delivery. The Health Data Collaborative supports country efforts to improve quality and use of health data and has resources to support activities such as harmonization of incompatible data sets, development of training packages, and effective use of data.

Recommendations:

- Work with DHIS2 stakeholders to create more-specific categories for facilities currently listed as "private" (for example, nonprofit and for-profit), and ensure that all facilities in DHIS2 are correctly tagged as public, FBO, nonprofit, or for-profit.
- Work with MSP to develop regular reports that highlight sector differences and private sector-specific challenges and successes. The MSP could reach out to the Health Data Collaborative for additional resources to improve the overall functionality and use of the DHIS2 system.

Develop and distribute simple, actionable data dashboards for decision making in the private sector

Finding: Private providers and implementing partner program managers highlighted the lack of feedback. Presumably, issues that are identified in public facilities through routine reporting are corrected through action by the MSP in its role as steward of public health facilities. However, private facilities do not receive any kind of feedback or report on how they are performing relative to other facilities or over time. IMA World Health is working on simple dashboards that can be autogenerated and shared with facilities to address concerns about the current flow data for decision making. Providing feedback to private providers helps motivate them to participate in reporting and allows them to learn from their own data.

Recommendation: Support the development and distribution of simple, actionable data dashboards for private facilities as an incentive to improve the quality and timeliness of reporting by the private sector, and work with IMA World Health to identify indicators that are most desired, relevant, and actionable for individual private facilities.

Establish an LMIS and consider how to integrate private sector

Finding: Current private sector reporting into the LMIS is limited, burdensome, and largely paper-based, leading to poor data availability and accuracy. Although DHIS2 reforms can help address some data-related issues, DHIS2 is not a universal solution. It is less adept at managing complex, subnational inventory, ordering, quality assurance, fleet management, distribution, and other logistics tasks. To address data gaps related to logistics and stock management, many countries are moving toward the use of a separate, interoperable platform for LMIS, such as OpenLMIS. Developing an LMIS platform and integrating it with the DHIS2 system provides a more-nuanced picture of the complex interaction between commodity supply/distribution and service delivery. Although the public sector could manage the LMIS, it would need to engage the private sector to make the effort a success

and improve the system's utility. Government and donors would need to explore private sector incentives to ensure their participation. They can build on lessons from Village Reach implementation of OpenLMIS and work with UNFPA to evaluate any ongoing electronic LMIS pilots.

Recommendation: Strengthen the LMIS platform and integrate it with the DHIS2 to help address pervasive supply chain difficulties, such as fraud, stockouts, and waste in both the public and private sectors.

Assess, harmonize, and aggregate demand for digital health services in the health sector

Finding: There are many implementing partners in the DRC who use digital approaches for communicating with beneficiaries, data collection and transmission, supportive supervision and training of health workers and community agents, and financial services. However, there does not appear to be a coordinated approach to partnering with telecommunications agencies in these efforts, and there are many small-scale contracts for digital services for health. Companies such as Orange, Vodacom, Airtel, and Africell are rarely engaged to help develop digital solutions to pervasive health challenges but instead are approached by each organization independently for individual needs. This creates inefficiencies for both the health organization, which could otherwise coordinate and aggregate demand for digital services and products, and the mobile operator, who must reinvent or retailor small-scale services and manage many discrete contracts. One potential area for collaboration is the creation of dual roles for health workers as mobile money agents. This could boost income and promote digital financial inclusion while providing community sensitization around critical health topics. Projects could commit to promoting and using specific operator services, and operators could provide lower fees in exchange for exclusive use of their platform.

Recommendation: Survey health stakeholders to identify and prioritize interests, challenges, capacity, and needs for digital health solutions. Convene implementing partners, telecommunications agencies, and public and private providers to establish a Digital Health Network, a coordinating body that harmonizes approaches to digital communication and outreach strategies for key health priorities. Support the MSP and donors to convene biannual meetings of the Digital Health Network to prioritize and harmonize digital solutions to aggregated health needs for data collection, data transmission, supportive supervision, and health communication, among others. The Digital Health Network could also facilitate the development and/or harmonization of interoperable platforms for data collection, analysis, communication, supportive supervision, and other key health priorities.

Explore opportunities to partner with telecommunications companies to improve awareness and understanding of health emergencies, products, and services

Finding: Companies such as Orange, Vodacom, Airtel, and Africell have physical, virtual, and human networks across the DRC that could be leveraged to improve national communications on urgent health priorities, such as Ebola, or other essential health products and services. However, there is little coordination across public and private actors in health for communicating with beneficiaries and disseminating information in key health areas. This can lead to unclear or redundant messaging and reduction of the behavior impact of these messages.

Recommendation: After the first DRC Digital Health Workshop, host a more focused session to discuss digital service needs for the communication of health information and what a partnership might entail.

Explore opportunities to partner with telecommunications companies to improve data collection and transmission

Finding: DHIS2 data entry and transmission currently occurs at the health zone level (516 sites), and therefore Internet and mobile connectivity is not a pressing issue for private providers. However, connectivity for transmitting data was one of the most pervasive challenges noted by the SNIS Division, as well as provincial leadership. The tardiness or absence of data caused by poor connectivity can significantly delay decision making and is particularly problematic in rapidly evolving epidemics. Furthermore, MEASURE Evaluation is exploring the possibility of decentralizing data entry and transmission to the health facility level, which means that a more-expansive connectivity solution will likely be needed in the next five years. Improved telecommunications infrastructure must be a priority for negotiations between MNOs and MSP. A PPP between mobile network operators, implementing

partners, and the MSP may help address the complex challenge of data connectivity.

Recommendation: After the first DRC Digital Health Workshop, host a more-focused session to discuss digital service needs for the collection and transmission of health data and what a partnership might entail.

Ensure private sector integration in new IHP data dashboard

Finding: The IHP project is initiating a data dashboard for health program decision making. This system will use advanced visualization and organization techniques to provide actionable and timely data from the central, provincial, health zone, facility, and community levels while keeping its commitment to avoid parallel systems and not duplicate effort. The IHP project is focused on public sector, so private sector data may not have been as fully considered during the proposal period.

Recommendation: Consider how to integrate relevant private sector indicators into this dashboard at its conception so that the dashboard is applicable to the total health system.

9. Three-Year Road Map for Action

During the validation workshop in Kinshasa, participants from the public and private stakeholders validated the Three-Year Road Map for Action developed based on the recommendations noted previously. The participants prioritized a few key activities by pillar, which are highlighted in blue.

Three-year road map for action to engage the private sector in improving the performance of the health system in the DRC

No.	Activity	Lead Organization	Year 1				Year 2				Year 3			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Leadership and Governance													
1	**Support the establishment of an Order of Midwives**													
1.1	Convene advocacy meetings with the Société Congolaise de la Practice de Sages-Femmes (SCPSF) and MSP	SCPSF, MSP	X	X	X	X								
1.2	Assist with the Order's legal cadre	SCPSF, MSP					X	X						
1.3	Launch the Order in Kinshasa	SCPSF, MSP							X	X				
1.4	Roll out the Order to provinces	SCPSF, MSP									X	X	X	X
1.5	Create a database and a website for the Order of Midwives	SCPSF, MSP							X	X	X	X	X	X
1.6	Organize meetings to encourage midwives to register in the Order	SCPSF, MSP							X	X	X	X	X	X
2	**Conduct a legal and regulatory review**													
2.1	Develop and approve the scope of work for the legal and regulatory review	ASPS, MSP		X										
2.2	Conduct the legal and regulatory research	ASPS, MSP			X									
2.3	Convene the MSP, ASPS to prioritize legal changes and identify next steps	ASPS				X	X							
2.4	Convene MSP/ASPS advocacy meetings to change laws	ASPS, MSP					X	X	X	X	X	X	X	
2.5	Assist the ASPS to disseminate new laws and regulations to the private sector	ASPS											X	X
3	**Support the ASPS to assume a stronger leadership role within the private sector and with the government**													
3.1	Conduct institutional analysis and benchmarking to assess ASPS's financial, programmatic, and organizational performance and needs	ASPS		X	X									
3.2	Develop a tailored capacity-building plan	ASPS, MSP					X	X						
3.3	Develop ASPS's advocacy plan focused on priority issues such as quality, taxes, and shared resources with public sector	ASPS							X	X	X			
3.4	Create a database, a website, and social media accounts for the ASPS	ASPS, MSP							X	X	X			

3.5	Review ASPS's membership to identify constituencies lacking representation	ASPS		X	X									
3.6	Develop a resource mobilization plan	ASPS				X	X							
3.7	Establish regional ASPS branches to address health priorities in each province	ASPS, MSP					X		X		X		X	
3.8	Link the ASPS with the Central Africa Healthcare Federation and the Africa Healthcare Federation	ASPS						X				X		
4	**Leverage and build the capacity of the ASPS in adding value to the private health sector (including through business training activities detailed here)**													
4.1	Develop guidelines and checklists for providers to understand regulatory requirements to maintain their professional accreditation and ensure that their health care businesses are properly registered	MSP, Orders, ASPS	X	X										
4.2	Maintain a member database that financial institutions (FIs) can consult to verify licensing/certification status of health providers seeking to borrow from the FI	ASPS			X	X	X	X	X	X	X	X	X	X
4.3	Offer a forum for FIs and private providers to discuss concerns	ASPS, Orders	X	X	X	X	X	X	X	X	X	X	X	X
4.4	Organize trade fairs to connect health providers to FIs and other business input suppliers	ASPS, FI, companies			X			X			X			X
4.5	Support sectoral studies on topics such as how to improve the supply and maintenance of medical equipment in the DRC or identifying specific financing needs of female providers or FBOs	ASPS				X			X			X		
4.6	Evaluate the potential to structure a risk mitigation instrument, such as a mutual guarantee fund, that would be available to members of the ASPS that meet minimum requirements	ASPS						X	X	X				
5	**Launch national- and district-level public–private dialogue forums**													
5.1	Establish a small technical committee at the national level to meet monthly or quarterly	CNP-SS, ASPS	X	X	X	X	X	X	X	X	X	X	X	X
5.2	Establish public–private dialogue forums at the health zone level by 1) conducting training of trainers with DPS staff, who then 2) repurpose existing health zone (HZ) level platforms with public and private sector stakeholders	DPS, ASPS, HZ	X	X	X	X	X	X	X	X	X	X	X	X

(*continues on page 88*)

Three-year road map for action to engage the private sector in improving the performance of the health system in the DRC (*Continued*)

No.	Activity	Lead Organization	Year 1				Year 2				Year 3			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
5.3	Create communication and awareness-raising tools to support the forums	ASPS, MSP	X	X	X	X	X	X	X	X	X	X	X	X
6	**Move forward with finalizing the FBO convention**													
6.1	Convene FBO-MSP meetings to finalize memorandum of understanding (MOU) negotiations with FBOs	FBOs, MSP		X	X									
7	**Build the MSP's capacity to better leverage PPPs**													
7.1	Launch a private sector cellule that reports directly to the Secrétaire General	MSP—Dir. Partenariat	X	X	X									
7.2	Clarify the role of the Division Partenariat et Contractualisation within the Direction de Soins et Partenariat and with the proposed private sector cellule	MSP—Dir. Partenariat			X	X	X							
8	**Develop a health PPP strategy to guide MSP's partnership activities**													
8.1	Convene meetings to develop a PPP strategy for health aligned with the Vadé Mécum du Partenariat	MSP, ASPS	X	X	X	X	X							
8.2	Develop a template to rate potential PPPs and train MSP staff on use	MSP, ASPS		X	X									
8.3	Develop a preliminary list of PPPs to consider	MSP, ASPS			X	X								
9	**Collaborate with pharmaceutical and medical device companies to improve access to and delivery of health services**													
9.1	Assess promising pharma and medical devices to bring/scale up	MSP, companies	X	X										
9.2	Convene one-on-one meetings with promising pharma and medical device makers to discuss partnership opportunities (as needed)	MSP, companies			X	X	X	X	X	X	X	X	X	X
10	**Partner with companies piloting and developing technologies with potential applications in the health system**													
10.1	Convene meetings as needed to consult with technology companies when considering the implementation of new programs and/or reforms across the health system (specific collaboration opportunities are outlined in Activities 41, 47, 48, and 49)	MSP, ASPS		X		X		X		X		X		X

	Service Delivery														
11	**Collect additional information on service delivery in the private sector**														
11.1	Integrate questions regarding the private sector in upcoming studies and invest in complementary studies	MSP, ASPS, Conseil National des ONG de santé (CNOS), international NGO (INGO)	X	X	X	X	X	X	X	X	X	X	X	X	
12	**Strengthen private provider access to clinical trainings, especially for FP**														
12.1	Through the eproductive, maternal, newborn and child health (RMNCH) indicators developed in DHIS2 or, through another identification approach, identify private providers that may need clinical training in FP and/or other health priority areas	MSP, ASPS, CNOS	X	X											
12.2	Establish a "target and train" pilot program in partnership with PSI and ABEF for rapid, clustered clinical training that is equitably distributed across regions and provider types	MSP, ABEF			X	X									
12.3	Implement training program and monitor change in key outcome indicators	MSP, ABEF					X	X	X	X					
13	**Invest in programs that address cost barriers to FP services in the private sector**														
13.1	Assess feasibility and cost–benefit of implementing a FP voucher program to encourage both the offer of and demand for FP services in private facilities	MSP, ASPS	X	X	X	X									
13.2	Partner with private providers to determine how they can contribute to and participate in a voucher program	MSP, ASPS			X	X									
13.3	Pilot, monitor/evaluate the success, and adjust/scale of program(s), tracking key FP indicators	MSP, ASPS					X	X	X	X	X	X	X	X	
14	**Leverage an integrated four-pronged approach to improve child health case management (Lubumbashi)**														
14.1	Supply														
14.1.1	Conduct a private sector supply chain bottleneck assessment for IMNCI commodities to private providers, pharmacies, and drug shops to determine availability of IMCNI products in the private sector	MSP, ASPS, Fédération des Entreprises du Congo (FEC)	X	X											

(*continues on page 90*)

Three-year road map for action to engage the private sector in improving the performance of the health system in the DRC (*Continued*)

No.	Activity	Lead Organization	Year 1				Year 2				Year 3			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
14.1.2	Based on the results from the supply chain assessment, work with the private sector manufacturers/importers/distributers/wholesalers (identified in landscape assessment mentioned in Activity 13.1.5) to develop/improve standard resupply systems to ensure that products flow efficiently through the supply chain based on private sector need	MSP, FEDECAME, ASPS, FEC			X	X								
14.1.3	Train private sector providers, pharmacists, and drug shop counter agents in supply chain fundamentals and resupply processes	MSP					X	X						
14.1.4	Provide support to FEDECAME to strengthen national quantification and procurement coordination for IMNCI commodities	PNAME, FEDECAME, INGOs					X	X						
14.1.5	Conduct a landscape assessment of local manufacturers/importers/distributers/wholesalers of IMNCI commodities, including a mapping of major suppliers/distributors and the distribution process, including key barriers to availability	MSP, ASPS	X	X										
14.1.6	Present a business case to local manufacturers/importers/distributers/wholesalers highlighting estimates of demand of IMNCI commodities, including government/institutional procurement	MSP, INGOs, ASPS			X	X								
14.1.7	Create and organize a yearly supplier forum consisting of local manufacturers/importers/distributers/wholesalers/retailers (drug shop owners) of IMNCI commodities	MSP				X			X			X		
14.2	Demand generation													
14.2.1	Conduct a situation analysis to understand both provider and caregiver knowledge on IMNCI caregiving practices	MSP	X	X										
14.2.2	Identify target audience and specific behavior change goals	MSP			X	X								
14.2.3	Develop key messages	MSP				X	X							
14.2.4	Select activities and interventions	MSP					X							
14.2.5	Conduct and assess the IMNCI demand generation campaign	MSP						X	X	X	X	X	X	X
14.3	Capacity building													
14.3.1	Ensure that all health zones have the IMNCI guidelines and materials for all private health facilities	MSP, ASPS	X	X										

14.3.2	Conduct trainings by health professional cadre (private providers, pharmacists, and counter agents)	MSP, ASPS	X	X	X										
14.3.3	Ensure/establish a system of supportive supervision for private sector health care to improve knowledge and skills of pharmacists and counter agents specifically	MSP, ASPS			X	X									
14.3.4	Gather data through the supportive supervision activity, which will be used to follow up with pharmacists and counter agents in need of additional training	MSP, ASPS				X	X	X	X	X	X	X	X	X	
14.3.5	Roll out an accreditation process for the trained pharmacists and counter agents	MSP, ASPS				X	X	X	X	X	X	X	X	X	
15	**Increase private sector engagement in nutrition programs (Lubumbashi)**														
15.1	Organize and launch a private sector nutrition network with yearly meetings to encourage involvement in locally manufactured nutrition products, which could also lead to private sector engagement in transporting therapeutic products to difficult-to-access areas and the promotion of local food fortification	MSP—PRONANUT/ UNICEF, ASPS, FEC	X				X				X				
15.2	Conduct an analysis to determine existing prepackaged local nutrition foods presently sold in Lubumbashi private clinics	MSP—PRONANUT, ASPS, FEC, companies	X	X											
15.3	Based on analysis conducted, determine the viability of engaging private suppliers to package high-quality, nutritious products in small quantities in exchange for government-supported, demand-generation activities promoting such foods	MSP—PRONANUT, companies			X	X									
15.4	Based on results of viability analysis, organize one-on-one meetings to discuss specific partnership opportunities (as needed)	MSP—PRONANUT, FEC, companies					X	X	X	X	X	X	X	X	
		Access to Essential Medicines													
16	**Continue to provide technical support to the FEDECAME system**														
16.1	Convene meetings, as needed, to identify opportunities to include technical assistance in cost controls, marketing, and risk management around bad debt, overstocks, and competition; and governance in partners' programs of support	MSP—DPM		X		X		X		X		X		X	

(*continues on page 92*)

Three-year road map for action to engage the private sector in improving the performance of the health system in the DRC (*Continued*)

No.	Activity	Lead Organization	Year 1				Year 2				Year 3			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
17	**Support CDRs to better manage their bad debt risk**													
17.1	Convene meetings with FEDECAME network and partners to explore ways to increase their access to operating capital and identify ways to minimize their risk from bad debts	MSP—DPM		X				X				X		
18	**Encourage collaboration among donors, international NGOs, and the FEDECAME system**													
18.1	Convene coordination meetings, as needed, with FEDECAME, PNAME, and other stakeholders to assist with forecasting of needs, procurement, and distribution and improve CDR planning and risk reduction	PNAME, FEDECAME, international NGOs			X				X				X	
18.2	Continue and/or expand the existing practice of contracting storage and distribution to CDRs	PNAME, FEDECAME, international NGOs	X	X	X	X	X	X	X	X	X	X	X	X
19	**Invest in the logistical capacity of the supply chain**													
19.1	Conduct regional analyses of the transport sector	MSP—DPM, PNAME	X	X	X									
19.2	Provide targeted capacity-building to the companies with the largest and best-managed distribution networks regarding the transport of medicines (for example, disseminate requirements, build cold chain capacity, and so on)	MSP—DPM, PNAM				X	X	X	X	X	X	X	X	X
19.3	Prequalify these companies to work with the government and other stakeholders (for example, CDRs, private wholesalers, international NGOs)	MSP—DPM, PNAM						X		X		X		
20	**Comprehensive reform of the commercial pharmaceutical sector**													
20.1	Define new scope of practice for second-tier drug shops, including training curriculum for drug shop operators	MSP—DPM, Order of Pharmacists, medical schools, ASPS	X	X	X	X								
20.2	Conduct participatory review and development of regulations on pharmaceutical wholesaler practice to support the new scope of practice for second-tier drug shops	MSP—DPM					X	X	X	X				

20.3	Provide training and support to help existing drug shops adapt to the new scope of practice	MSP—DPM, Order of Pharmacists, ASPS									X	X	X	X
20.4	Design and implement communications campaign to the public about the new drug shop scope and the risks of substandard medicines	MSP—DPM, contracted communications agencies									X	X	X	X
20.5	Strengthen the logistical and enforcement capacity of the DPM	MSP, Inspection Générale de la Santé (IGS), Ministry of Justice						X	X	X	X	X	X	X
20.6	Inspect and close noncompliant drug shops and wholesalers	MSP, IGS, Ministry of Justice									X	X	X	X
20.7	Advocate for long-term budget allocations to launch and maintain monitoring of drug shops by the government	MSP, IGS, Ministry of Finance					X	X	X	X	X	X	X	X
21	**Encourage the creation of pharmacy and drug shop networks**													
21.1	Convene meetings, as needed, with large pharmacies to advocate for the expansion of drug outlet networks	MSP, Order of Pharmacists, ASPS	X		X		X		X					
21.2	Advocate with banks and donors to increase access to financing to support the expansion of drug outlet networks (as needed)	Order of Pharmacists, ASPS, Commercial Banks		X		X		X		X				
22	**Evaluate the feasibility of revising the customs and taxation regime to incentivize local manufacturing**													
22.1	Assess the feasibility of revising the customs and taxation regime to incentivize local manufacturing	Ministry of Finance, MSP, ASPS	X	X										
22.2	Advocate for the reform of the customs/import tax regime	Ministry of Finance, MSP, ASPS			X				X				X	
23	**Provide technical support to local and international manufacturers with the most potential**													
23.1	Conduct a market study to identify medicines that international organizations are most likely to procure locally and determine where local manufacturers have the greatest comparative advantages	MSP—DPM, WHO			X	X								
23.2	Identify opportunities for international manufacturers to invest in opening a local manufacturing plant in the DRC	MSP—DPM, WHO, IFC												

(*continues on page 94*)

Three-year road map for action to engage the private sector in improving the performance of the health system in the DRC (*Continued*)

No.	Activity	Lead Organization	Year 1				Year 2				Year 3			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
23.3	Provide technical assistance and technical quality assurance support to local and international manufacturers	MSP - DPM, WHO, IFC					X	X	X	X	X	X	X	X
24	**Establish a searchable web-based database of registered drugs and develop anticounterfeit approach**													
24.1	Translate existing PDF list of registered drugs available on the DPM website into interactive, searchable database	MSP—DPM, PNAME	X	X	X									
24.2	Convene key pharmaceutical manufacturers, regulatory/ pharmacovigilance authorities, and potential technology partners (mPedigree) to discuss the size, scope, and specific needs for an improved tracking and anticounterfeit solution	MSP–DPM, PNAME				X	X	X						
24.3	Invest in and deploy an anticounterfeit and pharmaceutical monitoring solution	MSP—DPM							X	X	X	X	X	X
		Financing												
HEALTH FINANCING														
25	**Increase engagement of mutuelles and other health-financing mechanisms**													
25.1	Review relevant regulation and policies and summarize main topics/areas for engagement of mutuelles and other health-financing mechanisms	MSP—PNPMS, POMUCO, UMUSAC	X											
25.2	Identify stakeholders (government, civil society, employers, mutuelles and other health-financing programs, development partners, and so on) to participate in advocacy forums	MSP—PNPMS, POMUCO, UMUSAC	X	X										
25.3	Conduct survey/interviews with stakeholders to establish priorities to increase private sector participation in mutuelles and other health-financing programs	MSP—PNPMS, POMUCO, UMUSAC		X	X									
25.4	Draft/validate action plan and objectives to advocate for engagement of mutuelles and other health-financing programs	MSP—PNPMS, POMUCO, UMUSAC			X	X								
25.5	Convene/participate in advocacy forums and activities	MSP—PNPMS, POMUCO, UMUSAC				X				X				X

26	**Strengthen health-financing programs**														
26.1	Convene stakeholders to prioritize capacity-building needs for mutuelles and other health-financing programs and relevant support organizations	MSP, POMUCO (CGAT), UMUSAC	X												
26.2	Develop technical assistance interventions in partnership with mutuelle and other health financing support organizations	MSP, POMUCO (Centre de Gestion de Risque et d'Accompagnement Technique des Mutuelles de Santé - CGAT), UMUSAC		X	X										
26.3	Implement technical assistance for mutuelles and other health financing programs	MSP, POMUCO (CGAT), UMUSAC				X	X	X	X	X	X	X	X	X	X
26.4	Identify employer sponsor and/or TPA to support improved coverage and efficiency of employee benefit programs	MSP, FEC or employer, To Be Determined (TBD) ; TPA TBD						X	X						
26.5	Develop technical assistance interventions with corporate benefit plan sponsor	MSP, FEC or employer, TBD; TPA TBD							X	X					
26.6	Implement technical assistance with corporate health plan sponsor/TPA	MSP, FEC or employer, TBD; TPA TBD									X	X	X	X	
27	**Work with health-financing programs to cover FP and preventive health services**														
27.1	Survey major mutuelle programs and employers to document coverage of FP and preventive health services	MSP, POMUCO, UMUSAC, FEC		X	X										
27.2	Develop/assess the business case to expand coverage of FP and preventive health services	MSP, POMUCO, UMUSAC, FEC				X	X								
27.3	Develop and implement advocacy plan to support expanding coverage of FP and preventive health services	MSP, POMUCO, UMUSAC, FEC, ASPS					X	X	X	X	X	X	X	X	

(*continues on page 96*)

Three-year road map for action to engage the private sector in improving the performance of the health system in the DRC (*Continued*)

No.	Activity	Lead Organization	Year 1				Year 2				Year 3			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
28	**Build on lessons from existing health-financing programs**													
28.1	Document experience of existing health-financing programs, including MESP	POMUCO, UMUSAC, MESP, MSP, ASPS, Orders	X											
28.2	Synthesize and disseminate lessons learned by existing health-financing programs, including MESP, to develop and scale up coverage	POMUCO, UMUSAC, MESP, MSP, ASPS, Orders		X										
28.3	Identify potential areas of technical assistance to support health-financing programs, including MESP, to expand coverage and strengthen its financial sustainability	POMUCO, UMUSAC, MESP, MSP			X	X								
28.4	Implement technical assistance	POMUCO, UMUSAC, MESP, MSP					X	X	X	X	X	X	X	
28.5	Develop demonstration case for expanding insurance coverage based on experience of existing health-financing programs	POMUCO, UMUSAC, MESP, MSP										X	X	
28.6	Disseminate demonstration case	POMUCO, UMUSAC, MESP, MSP												X
29	**Strengthen private providers' ability to participate in health-financing initiatives**													
29.1	Select location to pilot private provider (and/or for-profit) engagement in health-financing initiatives	MSP, ASPS, FBOs		X										
29.2	Identify group(s) of providers who could form a private provider network	MSP, ASPS, FBOs			X	X								
29.3	Determine objectives and focus of technical assistance with selected providers	MSP, ASPS, FBOs					X							
29.4	Develop work plan and design technical assistance (for example, interventions for treatment protocols, payment mechanisms, billing standards)	MSP, ASPS, FBOs					X							
29.5	Implement technical assistance	MSP, ASPS, FBOs						X	X	X	X	X	X	X
29.6	Conduct a rapid assessment to identify corporate sponsor of health benefit program and/or TPA to collaborate with private provider network to deliver better-quality, more-efficient health services	MSP, corporate sponsor, TPA, provider network								X	X			

29.7	Establish MOU for partnership between a private provider network and a corporate sponsor of a health benefit program and/or TPA	MSP, corporate sponsor, TPA, provider network								X				
29.8	Provide technical assistance to support partnership	MSP, corporate sponsor, TPA, provider network									X	X	X	
30	**Develop a culture of insurance**													
30.1	Establish point of contact at ARCA and working group to promote development of demand/supply of insurance	ARCA, MSP, ASPS, Orders	X											
30.2	Convene working group and develop MOU for activities	ARCA, MSP, ASPS, Orders	X	X	X									
30.3	Collaborate with ARCA to educate consumers about health insurance (for example, develop/conduct media campaigns to inform consumers that health insurance can be a valuable way to be protected against catastrophic costs for health care)	ARCA, MSP, ASPS, Orders				X	X	X	X	X	X	X	X	
30.4	Identify private sector champion(s) and develop advocacy plan to promote purpose and value of insurance	ARCA, MSP, ASPS, Orders				X								
30.5	Identify insurance and potential insurance distribution partner(s) to provide technical assistance (for example, market research, market sensitization) to launch a simple health insurance product	Private insurer, and potential distribution/ technology partner(s) (telecom, MFI, cooperative)						X	X					
30.6	Provide technical assistance to launch the health insurance product	Private insurer, and potential distribution/ technology partner(s) (telecom, MFIs, cooperative)								X	X	X	X	
31	**Identify the role of PBF in improving the performance of private providers**													
31.1	Conduct desk research, interviews to confirm existing and planned efforts for PBF, including role of private providers	MSP, ASPS			X	X								
31.2	Identify opportunities for existing programs to engage private providers	MSP, ASPS				X								
31.3	Test whether and how PBF programs can promote quality and efficiency among private providers	MSP, ASPS					X	X	X	X	X	X		
31.4	Disseminate findings	MSP, ASPS											X	

(*continues on page 98*)

Three-year road map for action to engage the private sector in improving the performance of the health system in the DRC (*Continued*)

No.	Activity	Lead Organization	Year 1				Year 2				Year 3			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	ACCESS TO FINANCE													
32	**Provide business and financial management training and counseling for private health providers.**													
32.1	Conduct an assessment of the needs of private health providers for business training	ASPS, Orders, Business development service (BDS) provider	X	X										
32.2	Develop a training program based on the needs assessment and the results of initial training sessions	ASPS, Orders, BDS provider		X	X	X								
32.3	Provide business training courses to private health providers and training of trainers within professional organizations	ASPS, Orders, BDS provider				X	X	X	X	X	X	X	X	X
32.4	Provide individual, one-on-one counseling for selected providers who demonstrate the highest potential for improving quality and growing their practices	ASPS, Orders, BDS provider					X	X	X	X	X	X	X	X
32.5	Coordinate business training and counseling with clinical training and accreditation steps recommended under the Health Workforce section	ASPS, Orders, BDS provider					X	X	X	X	X	X	X	X
33	**Work with financial institutions to expand lending to the health sector**													
33.1	Establish and implement a risk-sharing mechanism or mechanisms, such as a USAID DCA portfolio guarantee or other type(s) of guarantee fund	Donors, financial institutions, ASPS, MSP, Ministry of Finance	X	X	X	X	X	X	X	X	X	X	X	X
33.2	Explore options to identify and implement medium- or longer-term funding for financial institutions to better meet the financing needs of the health sector	Donors, financial institutions, ASPS			X	X	X	X						
33.3	Assist financial institutions to conduct process evaluations to improve efficiency by identifying and addressing operational weaknesses to reduce overall costs	Financial institutions, Implementing partners (IPs)			X	X	X	X	X	X				

33.4	Work with financial institutions to develop financial products adapted to the needs of private health providers	Financial institutions, IP			X	X	X	X	X	X				
33.5	Provide training, information on the private health sector, and technical assistance to financial institutions	Financial institutions, IP, ASPS, MSP		X	X	X	X	X	X	X				
34	**Establish partnerships to increase access to finance for key investments**													
34.1	Evaluate the potential to develop partnerships and market links (for example, between financial institutions and medical equipment suppliers) within the health ecosystem that would generate benefits to all parties	Financial institutions, companies, IP, ASPS, MSP					X	X	X	X	X	X	X	X
34.2	Convene one-on-one meetings with interested stakeholders to discuss specific partnership opportunities (as needed)	Financial institutions, MSP, companies, IP					X	X	X	X	X	X	X	X
35	**Link health to health enterprise and innovation activities**													
35.1	Assess the landscape for health enterprises and determine the most promising activities to jump-start health companies	ASPS, MSP			X	X								
35.2	Convene workshop to determine next steps and develop an action plan	ASPS, MSP					X							
		Health Workforce												
36	**Improve coordination among stakeholders involved in HRH management**													
36.1	Establish a formal collaboration framework between MSP's new Human Resource Office, Ministry of Education (MOE), and Ministry of Higher Education (MHE)	MSP, MOE, MHE	X	X	X	X								
36.2	Develop and implement a collaboration framework between the Orders, private health associations (for example, ASPS) and MSP	Orders, private health associations, MSP					X	X	X	X	X	X	X	X

(*continues on page 100*)

Three-year road map for action to engage the private sector in improving the performance of the health system in the DRC (*Continued*)

No.	Activity	Lead Organization	Year 1				Year 2				Year 3			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
37	**Establish and enforce the accreditation system for training institutions**													
37.1	Support the MSP, MOE, and MHE to revise norms for the accreditation of health training schools	MSP, MOE, MHE			X	X	X							
37.2	Support the MSP, MOE, and MHE to implement the revised norms	MSP, MOE, MHE					X	X	X	X	X	X	X	X
38	**Build public–private links to facilitate practical training**													
38.1	Convene meetings with the MSP, MOE, MHE, and PMTIs to clarify and codify standard operating procedures related to the placement of students from PMTI in public facilities	MSP, MOE, MHE, PMTI					X	X	X	X				
38.2	Convene meetings with the MSP, MOE, MHE, PMTI, and provider networks (FBOs and ASPS) to design and pilot a practicum model for the private sector	MSP, MOE, MHE, PMTI, FBOs, ASPS						X	X	X	X			
39	**Increase the quality and accessibility of training**													
39.1	Support the MSP to revise and harmonize health training schools' curricula	MSP, MOE, MHE, Orders				X	X	X	X					
39.2	Support the MSP, MOE, and MHE to set up training institutions for trainers based on the Yaoundé training centers	MSP, MOE, MHE, Orders							X	X	X			
39.3	Support the MOE, MHE, and MSP to develop and pilot a scholarship program to enable providers to acquire relevant skills in targeted health zones	MSP, MOE, MHE							X	X	X	X	X	X
39.4	Support the MOE, MHE, and MSP to explore opportunities to increase the accessibility of training through the development of an e-Learning platform	MSP, MOE, MHE, Orders, ASPS							X	X	X	X	X	X
40	**Identify and address HRH gaps in collaboration with partners**													
40.1	Convene workshop with all relevant partners to develop a road map to address HRH gaps in the public and private sector based on the findings of the mapping of public facilities and the survey of private facilities (Activity 43)	MSP, ASPS											X	X
40.2	Support the Orders and private health professional associations to establish and/or update their member databases based on the findings of the survey (Activity 43)	MSP, Orders, Health professional associations											X	X

41	**Incorporate the private for-profit sector in the MSP's HRH staffing planning**													
41.1	Convene meetings to integrate the private for-profit sector in HRH staffing plans	MSP, ASPS					X		X		X		X	X
41.2	Establish and develop contracting mechanisms in exchange for tax relief, as is done with the nonprofit sector, based on the HRH road map (Activity 38.1)	MSP, Ministry of Finance										X	X	X
42	**Implement a systematic approach to increase HRH motivation**													
42.1	Convene meetings, as needed, to develop and implement a systematic approach to increase HRH motivation to improve quality in the public and private sector	MSP, MOE, MHE, Orders, ASPS			X				X				X	
	Health Information Systems													
43	**Improve and add FP and child health indicators in DHIS2**													
43.1	Convene workshop to include MSP–Division Système National d'Information Sanitaire (DSNIS), UNICEF, UNFPA, and WHO to identify, prioritize, and operationalize key RMNCH indicators to include in DHIS2	MSP-DSNIS, Orders, ASPS	X	X	X									
43.2	Work with implementing partners and health programs to further integrate and operationalize indicators in routine data collection	MSP-DSNIS			X	X								
44	**Survey, map, and register in DHIS2 newly identified private facilities**													
44.1	Develop sampling strategy and identify priority data points for a nationally representative survey of pharmacies, drug shops, and unregistered private health facilities	MSP-DSNIS/DPS, Orders, ASPS, FBOs	X	X	X	X								
44.2	Conduct the survey	MSP-DSNIS/DPS, Orders, ASPS, FBOs					X	X	X	X	X	X		
44.3	Disseminate survey results and establish a strategy for improved integration of private sector in national health information systems	MSP-DSNIS/DPS, Orders, ASPS, FBOs										X	X	X
45	**Increase usability and relevance of DHIS2 data for private sector actors**													
45.1	Conduct stakeholder interviews to better understand the functional differences between for-profit, nonprofit, FBO, NGO, and public facility classifications; finalize and publish clear definitions for each category	MSP-DSNIS/DPS, Orders, ASPS, FBOs	X	X	X	X								
45.2	Require facilities to self-identify based on official published categories	MSP-DPS/DSNIS					X	X	X	X				

(*continues on page 102*)

Three-year road map for action to engage the private sector in improving the performance of the health system in the DRC (*Continued*)

No.	Activity	Lead Organization	Year 1				Year 2				Year 3			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
45.3	Revise and complete the classification of private sector facilities registered in DHIS2	MSP-DSNIS/DPS					X	X	X	X				
45.4	Develop dashboard for key variables and disparities between public and private facilities that are important to track over time based on strategy for private sector inclusion	MSP-DSNIS/DPS									X	X	X	X
46	**Develop and distribute simple, actionable data dashboards for decision making in the private sector**													
46.1	Convene a sample of providers at different facility levels and across FBO/private/public types registered in DHIS2 and pilot sample dashboards for dissemination to facilities	MSP-DSNIS, ASPS, IMA World Health	X	X	X	X								
46.2	Integrate dashboard restitution into existing monthly validation meetings at the HZ level	MSP-DSNIS, IMA World Health					X	X	X	X	X	X	X	X
47	**Establish an LMIS and consider how to include private sector actors**													
47.1	Convene key supply chain stakeholders (MSP-DPM, CDR, VillageReach, UNFPA, FEDECAME, technology partners) to develop a road map for selecting a national LMIS platform, developing national policies and protocols, establishing an empowered implementation oversight committee, and ensuring integration with DHIS2 and inclusion of private sector	MSP-DPM, PNAME, ASPS	X	X	X	X	X	X						
47.2	Pilot LMIS platform with subset of priority products and essential medicines	MSP-DPM					X	X	X	X	X	X		
47.3	Continue rapid cycle monitoring, evaluation, and improvement activities; revise reporting, distribution, and monitoring functions accordingly	MSP-DPM								X	X	X	X	X
48	**Assess, harmonize, and aggregate demand for digital health services in the health sector**													
48.1	Design and conduct a baseline survey on current digital services use and needs among public and private health stakeholders, focusing on the domains of communication with beneficiaries, data collection/transmission, supportive supervision of health agents and providers, and digital financial services	MSP	X	X	X	X								

48.2	Convene public and private health stakeholders and telecommunications agencies in a Digital Health Workshop to 1) share survey results and identify priority area for digital service investment and harmonization across health stakeholders and 2) determine interest in establishing a working group to support interoperable, harmonized digital systems across health stakeholders	MSP					X							
48.3	Convene the digital health working group to continue to support digital investments and harmonization across health stakeholders and facilitate the development of MOU with MNO to establish priority partnership	MSP						X		X		X		X
49	**Explore opportunities to partner with telecommunications companies to improve awareness and understanding of health emergencies, products, and services**													
49.1	After the first DRC Digital Health Workshop, host a more-focused session to discuss MNO-MSP-IP partnership for health communication across DRC	MSP					X	X						
49.2	Organize one-on-one meetings to discuss specific partnership opportunities (as needed)	MSP							X	X	X	X	X	X
50	**Explore opportunities to partner with telecommunications companies to improve data collection and transmission**													
50.1	After the first DRC Digital Health Workshop, host a more-focused session to discuss MNO-MSP-IP partnership for data collection and transmission	MSP					X	X						
50.2	Organize one-on-one meetings to discuss specific partnership opportunities (as needed)	MSP							X	X	X	X	X	X
51	**Ensure private sector integration in new IHP data dashboard**													
51.1	Convene public and private stakeholders to shape the development, implementation, and use of the IHP data dashboard	MSP, IHP, ASPS	X	X	X	X								

10. Conclusion

This document, *The Role of the Private Sector in Improving the Performance of the Health System in the Democratic Republic of Congo*, has three parts: 1) a current state assessment based on desk research, which provides a snapshot of the current role of the private sector using the WHO building blocks (leadership/governance, service delivery, access to essential medicines, financing, health workforce, and health information systems); 2) findings and recommendations using the WHO health pillars as a framework; and 3) the Three-Year Road Map for Action, which is to be used as an implementation guide.

Taken together, these three deliverables help clarify the role of the private sector in improving the health system to support the MSP, the World Bank, USAID, donors, and other key stakeholders in enhancing public–private engagement at all levels of the health system. The information presented in this report is intended to create an opportunity for multisectoral dialogue, fostering a health system that leverages the skills, resources, and talents of all health actors to achieve the goal of high-quality health care accessible to all in the DRC.

Appendices

ANNEX A. SCOPE OF WORK

Contexte

Le gouvernement s'est engagé depuis de nombreuses d'années à renforcer le système de santé en lançant un certain nombre de réformes adressant les défis liés aux piliers du système congolais, à savoir, les faiblesses au niveau des prestations de services de santé, de l'accessibilité des produits et technologies pharmaceutiques et médicaux, des solutions de financement de la santé, des systèmes d'information sanitaires, des ressources humaines, et enfin, de la gouvernance générale du système.

Dans la perspective de mieux orienter le Ministère et les partenaires de développement dans leurs stratégies et investissements en vue du renforcement du système de santé de la RDC, la Banque Mondiale, en partenariat avec IFC, la Fondation Bill et Melinda Gates et l'USAID, a mis en úuvre une étude portant sur l'évaluation du secteur privé de la santé. Cette évaluation est conduite par Abt Associates en collaboration étroite avec le Ministère de la Santé Publique.

Objectifs

L'évaluation du secteur privé s'inscrit pleinement dans la lignée des réformes en cours. En effet, le secteur privé (lucratif, confessionnel et associatif) qui fait déjà partie intégrante du système sanitaire congolais, a un rôle essentiel à jouer dans la matérialisation de la vision du gouvernement de services de santé abordables et de qualité, accessibles à tous. En soutenant cette évaluation, le gouvernement entend ainsi:

- comprendre les dynamiques et la structure du secteur privé afin de mieux l'intégrer dans la mise en úuvre des programmes de renforcement du système de santé,
- identifier les mesures à prendre pour créer un cadre réglementaire propice au développement d'un secteur privé partenaire du public dans la santé,
- évaluer la contribution du secteur privé à l'économie nationale et au budget national,
- stimuler les investissements privés dans le secteur de la santé.

Étapes

L'approche d'Abt Associates divise les activités de l'évaluation du secteur privé en quatre étapes principales :

1. **Planification** : Au cours de cette étape, l'équipe RDC de la Banque Mondiale a finalisé la portée de l'évaluation, le calendrier de mise en úuvre et la liste des principaux intervenants pour les entrevues avec les informateurs clés.
2. **Revue de la littérature et analyse des données** : l'équipe a effectué une revue documentaire, complété une analyse de segmentation de marché basée sur cette revue, développé des questions adaptées aux différentes parties prenantes pour les entrevues et rédigé le plan et l'ébauche de l'Évaluation de l'état actuel, qui comprend les conclusions initiales sur les contributions du secteur privé aux domaines de santé clés.
3. **Travail sur le terrain :** la troisième étape de l'évaluation se concentre sur la collecte et l'analyse d'informations supplémentaires. L'équipe technique d'Abt Associates se rendra en RDC fin novembre/début décembre pour mener des entrevues avec des informateurs clés et des visites sur le terrain pour combler les lacunes d'information identifiées durant la recherche documentaire et commencer à élaborer des recommandations.
4. **Validation, priorisation et finalisation** : les activités de cette étape sont la finalisation de l'Évaluation de l'opportunité, des priorités stratégiques et de la Feuille de route pour l'action. Au cours de l'atelier, les intervenants des secteurs public, privé et bailleurs valideront les résultats de l'évaluation, prioriseront

les recommandations, élaboreront un plan pour la mise en úuvre des recommandations et finaliseront le rapport.

Entrevues avec les parties prenantes

Lors des entrevues avec les parties prenantes du 20 novembre au 15 décembre, l'équipe d'Abt Associates posera une vaste gamme de questions adaptées aux différentes catégories de parties prenantes, comme l'illustre la liste de questions ci-dessous.

Liste de questions à titre illustratif

Gouvernance

- *Quelles sont les politiques du gouvernement face aux prestataires privés offrant des services de planification familiale, santé maternelle et infantile et autres services ?*
- *Quels types de collaboration existent-ils entre le gouvernement, les confessionnelles/ONG, et les autres structures du secteur privé, particulièrement en ce qui concerne la planification familiale et la sante maternelle et infantile ?*
- *Existe-t-il actuellement des partenariats public–privé mis en place avec des entités du secteur privé qui se focalisent sur la planification familiale, la santé maternelle et infantile, l'innovation numérique ou mobile pour la santé ou d'autres domaines ?*
- *Les investissements sociaux actuels des entreprises en RDC sont-ils liés à la pénétration et au développement de nouveaux marchés ? Comment se perçoivent-ils en tant que partie prenante dans le système de santé de la RDC ?*

Prestation de services

- *Quelles sont les lacunes du secteur public que le secteur prive remplit en matière de prestation de services et/ou distribution/vente de produits ?*
- *Quels sont les facteurs qui affectent la provision de produits et services par le secteur privé en matière de planification familiale, santé maternelle et infantile, et autres domaines de la santé ?*
- *Quelles sont les contraintes à l'augmentation de la demande et de l'utilisation de produits et services du secteur privé ?*

Médicaments et technologies

- *La vente ou la distribution de produits pharmaceutiques est-elle suffisamment règlementée (particulièrement en ce qui concerne la planification familiale et la santé maternelle et infantile) ?*
- *Quels sont les principaux défis et opportunités dans le secteur privé par rapport à la vente/distribution et la généralisation de produits de planification familiale, santé maternelle et infantile, et autres ?*

Financement

- *Quels sont les défis et les opportunités pour les différents programmes de financement de la santé (publics et privés) ? Quelles sont les prochaines étapes immédiates envisagées pour progresser ?*
- *Est-ce que les prestataires privés participent dans les différents programmes de financement de la santé ? Pourquoi ou pourquoi pas ?*
- *Les prestataires privés ont-ils accès à des financements ou des formations en gestion ? Si oui, d'où proviennent-ils ?*
- *Quelles sont les contraintes principales auxquels font face les institutions financières qui empêchent/limitent les prêts au secteur privé de la santé ?*

Ressources humaines

- *Quel est le profil des prestataires de sante privés dans le pays (y compris les docteurs, gynécologues obstétriciens, médecins généralistes, infirmiers, sages-femmes, pharmaciens, soigneurs traditionnels et autres) ?*
- *Quels sont les besoins en termes de ressources humaines dans le secteur privé de la santé ?*
- *Quelles sont les structures qui contribuent à la formation des prestataires du secteur privé (initiale et continu) et quel est le processus d'accréditation pour ces structures ?*

Information

- *Quelles sont les contraintes clés qui limitent les contributions du secteur privé au système d'information sanitaire ?*
- *Veuillez décrire vos initiatives mobiles ou numériques pour la santé. Avez-vous utilisé l'argent mobile pour les activités de santé ?*

ANNEX B. KEY STAKEHOLDER LIST

The assessment field team met with the following stakeholders by city.

	Bukavu
Implementing Partner	American Refugee Committee—ASILI Project
Private Sector (FBO)	BDOM
Private Sector (FBO)	Hôpital Général de Référence Dr. Rau-Ciriri
Private Sector (FBO)	Hospital/Foundation PANZI and 8eme CEPAK
Private Sector (For-Profit)	Pharmakina
Private Sector (For-Profit)	Skyborn Hospital
Public Sector	Division Provinciale de la Santé (DPS)
	Goma
Implementing Partner	Cordaid
Implementing Partner	Medecins Sans Frontieres Holland
Implementing Partner	Save the Children
Implementing Partner	UNICEF
Private Sector (FBO)	Charité Maternelle Hospital
Private Sector (FBO)	Hôpital de Kyeshero
Private Sector (For-Profit)	CIMAK Hospital
Private Sector (NGO/Nonprofit)	ASRAMES
Private Sector (NGO/Nonprofit)	Heal Africa
Public Sector	Division Provinciale de la Santé (DPS)
	Kinshasa
Civil Society	Alliance du Secteur Privé de la Santé (ASPS)
Civil Society	Centre de Gestion de Risque et d'Accompagnement Technique des Mutuels de Santé (CGAT)
Civil Society	Association Professionnelle des Coopératives d'Épargne et Crédit (APCEC)
Civil Society	Mouvement Ouvrier Chrétien du Congo (MOCC)
Civil Society	Plateforme des Organisations Promotrices des Mutuelles de Santé du Congo (POMUCO)
Civil Society	Order of Doctors
Civil Society	Societe Congolaise de la Practice de Sages-Femmes (SCOSAF)
Civil Society	Order of Pharmacists
Corporate	Fédération des Entreprises du Congo (FEC)
Corporate	AIB RDC
Corporate	Global Access Health Network (GAHN)
Corporate	iFinance
Corporate	ProCredit Bank
Corporate	Trust Merchant Bank (TMB)
Corporate	Africell
Corporate	Airtel
Corporate	Orange
Corporate	Vodacom
Corporate	WapiMed
Corporate	Essor Equipment
Donor	USAID

(*continues on page 108*)

Donor	Department for International Development
Donor	European Union
Donor	GAVI
Donor	World Bank
Donor	International Finance Corporation (IFC)
Implementing Partner	JSI—Maternal and Child Survival Program
Implementing Partner	UNICEF
Implementing Partner	Engenderhealth
Implementing Partner	FINCA
Implementing Partner	FHI 360
Implementing Partner	MSH
Implementing Partner	World Health Organization (WHO)
Implementing Partner	Abt Associates—Health Financing and Governance (HFG) Project
Implementing Partner	Pathfinder
Implementing Partner	DKT
Implementing Partner	PSI
Implementing Partner	Save the Children
Implementing Partner	Tulane University
Implementing Partner	UNFPA
Private Sector (FBO)	IMA World Health
Private Sector (FBO)	Eglise du Christ au Congo (ECC)
Private Sector (FBO)	BDOM Kinshasa
Private Sector (FBO)	SANRU
Private Sector (FBO)	Armee du Salut
Private Sector (FBO)	Kimbanguist Church
Private Sector (FBO)	Caritas
Private Sector (FBO)	Union des Mutuelles de Santé du Congo (UMUSAC)
Private Sector (FBO)	Centre Bandal
Private Sector (For-Profit—IPPF Affiliate)	Clinique Bongisa Libota
Private Sector (For-Profit)	Clinique de la Nuit
Private Sector (For-Profit)	Clinique IK
Private Sector (For-Profit)	Clinique Marie Yvette
Private Sector (For-Profit)	MissionPharma
Private Sector (For-Profit)	Pharmagros
Private Sector (For-Profit)	Phatkin
Private Sector (NGO/Nonprofit)	Mutuelle de Santé des Enseignants de l'Enseignement Primaire, Secondaire et Professionnel (EPSP)
Private Sector (NGO/Nonprofit)	Solidarco
Private Sector (NGO/Nonprofit)	Fédération des Centrales d'Approvisionnement en Médicaments Essentiels (FEDECAME)
Private Sector (NGO/Nonprofit)	CAMESKIN
Private Sector (NGO/Nonprofit)	Association de Santé Familiale (ASF)
Public Sector	Programme National de Lutte contre les Infections Respiratoires Aiguës (PNIRA)
Public Sector	Coordinator of the Prise en Charge Intégrée des Maladies de l'Enfant (PCIME)
Public Sector	Programme National de Lutte contre les Maladies Diarrhéiques (PNLMD)
Public Sector	Programme Nationale de Nutrition (PRONAUT)

Public Sector	Direction de Partenariat, MSP
Public Sector	Conseiller en Charge du Secteur Privé—MSP
Public Sector	Program Nationale de l'Appui de la Protection Sociale (PNAPS)
Public Sector	Autorité de Régulation et de Contrôle des Assurances (ARCA)
Public Sector	Programme National de Promotion des Mutuelles de Santé (PNPMS)
Public Sector	Direction de la Lutte contre les Maladies—MSP
Public Sector	Programme National de Lutte contre le Paludisme (PNLP)—MSP
Public Sector	Programme National de Santé pour Adolescents (PNSA)—MSP
Public Sector	Programme National de Santé de la Reproduction (PNSR)—MSP
Public Sector	Directeur de Cabinet—MSP
Public Sector	Direction de Développement de Soins de Santé Primaires—MSP
Public Sector	Division de SNIS, Direction de Développement de Soins de Santé Primaires—MSP
Public Sector	Direction d'études et de planification (DEP)
Public Sector	Office Congolais du Contrôle (OCC)
Public Sector	Programme National d'Approvisionnement en Médicament (PNAM)
Public Sector	Direction de la Formation Continue—MSP
Civil Society	Association of Midwives
Civil Society	Order of Nurses
Public Sector	Direction des Services Généraux et des Ressources Humaines—MSP
Public Sector	Direction de l'Enseignement des Sciences de la Santé—MSP
	Lubumbashi
Private Sector (NGO/Nonprofit)	Association de Bien-Être Familial–Naissances Désirées (ABEF-ND)
Private Sector (FBO)	Agence Adventiste d'Aide et Développement (ADRA)
Private Sector (For-Profit)	Centre Médical du Centre-Ville (CMDC)
Private Sector (For-Profit, Enterprise Affiliated)	Centre Médical de la Communauté
Private Sector (For-Profit)	Centre Médical Light
Public Sector	Division Provinciale de la Santé (DPS)
Private Sector (FBO)	Clinique Les Meles
Private Sector (FBO—ABEF Affiliate)	Clinique Masaidijano
Private Sector (For-Profit)	Clinique St. Felly
Private Sector (NGO/Nonprofit)	Clinique Watoto
Implementing Partner	Concern
Implementing Partner	Catholic Relief Services (CRS)
Private Sector (NGO/Nonprofit)	Fondation Vie et Sante, Centre de Chirurgie et Traumatologie (Clinique Del Gado)
Private Sector (FBO)	Centre de Santé de St François d'Assise
Private Sector (FBO—Armée du Salut Associate)	Compassion Clinic
Private Sector (NGO/Nonprofit)	Centre de Santé Kalebuka
Private Sector (NGO—ABEF Clinic)	Centre de Santé de Uzazi Bora
Public Sector	Zone de Santé de Kamalondo
Implementing Partner	Catholic Relief Services (CRS)–ELIKIA Project
Corporate	LISUNGI
Corporate	Standard Bank

(*continues on page 108*)

Implementing Partner	Abt Associates—Health Financing and Governance (HFG) Project
Public Sector	Hôpital Sendwe
Private Sector (NGO/Nonprofit)	Hôpital Barak—NGO Arc en Ciel
Private Sector (NGO/Nonprofit)	Hôpital Radem Hewabora—NGO Radem
Corporate	Investment Durable de Katanga (IDAK)
Implementing Partner	International Rescue Committee
Corporate	Katanga Mining Company
Implementing Partner	MEASURE Evaluation
Public Sector	Chef de Province
Corporate	MMG
Implementing Partner	MSH
Implementing Partner	Pathfinder
Civil Society	Order of Doctors
Civil Society	Order of Pharmacists
Private Sector (For-Profit)	Etisalat Pharmacy
Private Sector (NGO/Nonprofit)	Polyclinique Les Mels
Private Sector (NGO/Nonprofit)	Polyclinique Medicare
Civil Society	Plateforme des Organisations de la Société Civile Intervenant dans le Secteur Minier (POM)
Public Sector	Ministère Provincial
Private Sector (NGO/Nonprofit)	CAMELU
Private Sector (For-Profit)	Unique
Private Sector (NGO/Nonprofit)	Association de Santé Familiale (ASF)
Civil Society	Syndicat National des Médecins du Congo (SYNAMED)
Corporate	Kamoto Mining Company
Matadi	
Public Sector	Division Provinciale de la Santé (DPS)
Civil Society	Order of Doctors
Private Sector (NGO/Nonprofit)	Centrale d'Achats et d'Approvisionnement en Médicaments Essentiels au Bas-Congo Ouest (CAAMEBO)
Private Sector (FBO)	Hôpital Saint Gérard Congrégation des Pères Rédemption
Kolwezi	
Civil Society	Syndicat National des Médecins du Congo (SYNAMED)
Private Sector	Hôpital Général de Mwangeji
Civil Society	Order of Doctors
Private Sector (For-Profit—Corporate)	Hôpital Général de Référence de GECAMINE
Civil Society	Syndicat des Infirmiers et Infirmieres
Civil Society	Order of Pharmacists
Private Sector (FBO)	Polyclinique Adventisse
Private Sector (For-Profit—Corporate)	Centre de Santé de l'Entreprise Minière Komoto Copper Compagny SA
Corporate	Komoto Copper Compagny SA
Private Sector (For-Profit—Corporate)	Centre de Santé de l'Entreprise Minière de la Société Minière de Tenke Fungurume (SMTF)
Corporate	Société Minière de Tenke Fungurume (SMTF)
Private Sector (FBO)	Hôpital Méthodiste Mama Tabitha

Mbuji-Mayi	
Private Sector (For-Profit)	Pharmacy Sapaumed
Private Sector (For-Profit)	Pharma KM
Private Sector (For-Profit)	Milo Pharma
Corporate	Advans Bank
Public Sector	Division Provinciale de la Santé (DPS)
Public Sector	Provincial Ministry of Health
Private Sector (FBO)	Hôpital Christ Roi
Public Sector/Private Sector (FBO)	Hôpital Kansele
Private Sector (FBO)	Hôpital Presbytérien de Dibindi
Private Sector (For-Profit)	Hôpital Valentin Disashi
Private Sector (For-Profit)	Pharmacie Sanctuaire
Private Sector	Université Officielle de Mbuji Mayi (UOM)
Private Sector (For-Profit)	Centre Hospitalier Saint Sauveur
Private Sector (For-Profit)	Centre Hospitalier Pédiatrique de Mbuji Mayi (CHPM)
Private Sector (NGO/Nonprofit)	Centre de Distribution Régionale CADMEKO
Civil Society	Order of Doctors
Implementing Partner	Save the Children
Private Sector (Corporate)	MIBA (Société Minière de Bakwanga)
Public Sector	Office Congolais de Contrôle
Private Sector (FBO)	CSR Bakhita
Implementing Partner	Caritas
Private Sector (For-Profit)	Pharmacy Beldis
Private Sector (For-Profit)	Pharmacy Hewa Nzuri
Civil Society	Order of Pharmacists
Private Sector (For-Profit)	Centre Hospitalier Notre Dame
Other	
Implementing Partner	Training for Health Equity Network (THENet)
Implementing Partner	Bill and Melinda Gates Foundation
Corporate	GSK
Implementing Partner	VillageReach

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