

GAVI support for civil society organisations in DR Congo

Background on the Democratic Republic of Congo (DR Congo)

The DR Congo, located in Central Africa, has a population of approximately 63 million inhabitants and a land surface area of 2,345,000 km². In 2006, the Gross National Income per capita was US\$ 120. Rates of access to and utilisation of preventive medical care are low due to over a decade-long war and the poor governance in the three preceding decades. The DR Congo has one of the highest rates for maternal and for infant mortality in the world. Its maternal mortality rate in 2006 was estimated at 1,289 per 100,000 live births, and infant mortality was 115 per 1,000 live births.

From the late 1980s until 1997, in DR Congo – then still called Zaire – the Mobutu government neglected health services.



CSO vehicle stuck in the mud for five hours, Mukanga Road, Haut Lomamien

This situation was exacerbated by war and continuing conflict since 1998. As a result, many areas in DR Congo have virtually no infrastructure, they experience continued unrest, and the majority of the population

About fragile states

The term “fragile states” is used to describe countries that face particularly difficult political, social and economic conditions. They have weak institutions and governance systems and lack effective political processes to influence the state to meet social welfare expectations. Most have had or are experiencing civil conflict, and even when the conflict ends, they face challenges in recovering and strengthening their systems. Most fragile states have growing levels of extreme poverty, contrary to most low-income countries. A global study

conducted in 2007 found that for 19 fragile states, the median basic immunisation coverage rates were roughly half that of the 37 non-fragile developing countries with which they were compared¹.

The role of civil society organisations (CSOs) in fragile states

In fragile states, civil society organisations are often abundant and readily accepted, given the emergency relief and humanitarian nature of their missions during civil war or crisis. In fact, in most cases, CSO services are more firmly established and

institutionalised than government services in post-conflict or otherwise fragile situations. In fragile or weakened states, CSOs are generally perceived by political leaders as allies and play a critical role in planning and service delivery due to low or weak public sector presence throughout the country. CSOs often fill a humanitarian services gap that the government cannot address because of a conflict or political situation; in a post-conflict situation they also play a key part while the new government is establishing its role and presence.

¹ Davidson R. Gwatkin, S. Rustein, et al. (2007). Socioeconomic Differences in Health, Nutrition, and Population. The World Bank, Washington, DC.

lives in extreme poverty. However, the humanitarian aid and missionary presence of CSOs in the country has helped to address some service delivery gaps. Providing any health services in DR Congo is a monumental challenge for the Ministry of Health (MoH).

GAVI HSS and CSO support to DR Congo

The GAVI health system strengthening (HSS) grant² was designed to build up the human resource pool and infrastructure in 65 health districts with weak performance. Together with a civil society organisation

grant, the HSS funds have been efficiently used to fortify cooperation between the health ministry and its CSO partners who are the primary service delivery providers in the country. HSS funds for DR Congo are totaling US\$ 62.1 million from 2007-2009.

US\$ 5.41 million have been approved by GAVI for CSO support from 2007 to 2010. The grant was channelled through an already established network of non-governmental organisations (NGOs) that then issued sub-grants to other NGOs for implementation. This has resulted in significant achievements within the first year of implementation, as seen in DR Congo's 2008 Progress Report (see excerpt in box).

Implementation status of CSO support

The five GAVI-funded CSOs, organised into a consortium with a coordinating unit referred to as the Chief of Party, have been able to achieve the majority of the principal activities planned in the first year, despite the delay in the start of activities:

- Support for local census and microplanning;
- Training of health zone personnel in EPI management and in data quality self-assessment;
- Supply of transport, gas, and kerosene for the cold chain;
- Administration of performance contracts for health zone personnel;
- Identification and training of local CSOs, community mobilisers (*relais communautaires*) and Red Cross volunteers; and
- Supervision and monitoring of activities in the health zones.

Results:

- 80% of planned activities conducted despite a nearly half-year delay in receipt of funds
- New management consortium formed and functional
- Vaccination coverage of 74% for DTP3 and measles and 71% for TT2+ (tetanus toxoid) from the first half of 2007 for the 65 Health Zones increased to 83% for DTP3 (close to the 85% defined in the Comprehensive multi-year plan for immunisation 2005-2009) to 79% for measles and 76% for TT2+ in 2008 despite long strikes and numerous vaccine stock-outs
- Effective implementation of a strategy for reducing drop-outs and the number of unimmunised through the use of community mobilisers and Red Cross volunteers, resulting in 10,613 children recuperated from May to December 2008

Source: excerpted and translated from the DR Congo 2008 Annual Progress Report to GAVI

² For more information, see the Democratic Republic of the Congo's HSS proposal: http://www.gavialliance.org/resources/Congo_Dem_Rep_HSS_Proposal_en.doc

One third of health facilities operated by CSOs

In 2001, the government increased the number of health zones from 306 to 515. These health zones have 425 referral hospitals and over 7,725 sub-district health centres. The new health zones were added primarily to increase geographic coverage of referral services and health system management. Because of the lack of government financing, the health zones and facilities operate with considerable autonomy. Many facilities became de facto privatised, relying on patient fees to pay staff and operating costs. Estimates are that one third of the facilities are operated by CSOs, mainly church groups, that have traditionally co-operated with the public structure. This has facilitated building effective relationships between the ministry and CSOs for financing recurring personnel and operating costs, particularly at the health zone level.

CSOs and their funding for health zones were taken into account for HSS programmes. The proposal development process was unique – jointly led by the Department of Planning (DEP) in the health ministry and three CSOs: the Rural Health Programme of DR Congo (SANRU), Catholic Relief Services (CRS), and Rotary.

The CSO granting process in DR Congo provides many lessons on how funding can effectively flow from central level directly to local level. This has been in large part due to the long tradition of CSO support to the health sector and de facto decentralisation of donor and government money which



Official handing over of supply (motorcycles, computer kits, bikes equipped with antennae)



Transportation of supplies (vaccines and others) in mountainous regions in eastern part of the country (Kivu)

is flowing directly to the health zones. All CSOs already working in 65 health zones across the country were considered for grant funding to further address service delivery gaps. SANRU³, CRS, and Rotary contacted other organisations (e.g. Red Cross, and the National Committee of NGOs) to participate as implementers.

“Because so few of these organisations have been ‘at the table’ with the MOH, the government has a hard time reaching hard-to-reach populations that only gain access to health care via locally-based organisations. For example, displaced Angolans were cited as one group that is neglected but might be reached with support of (other) CSOs that would serve marginalised groups out of concern for human rights or other special interests.”

Yolande Vuo Masembe, RED focal point, WHO

³ The “Sante Rural” project is managed through a partnership of Protestant missionary groups under the umbrella organisations of the ECC (Protestant Churches of Congo) and IMA (Interchurch Medical Assistance).

Partnerships for hard-to-reach areas

Civil society organisations contribute to peripheral service delivery at the provincial, satellite and health zone levels as well as at the central level, for example through support to the Expanded Programme on Immunization (EPI) office. At the provincial and satellite levels, the CSOs primarily focus on immunisation efforts. For example, Rotary and others have assisted with ensuring functioning health offices and infrastructure for provincial and satellite health teams. In terms of broader HSS efforts, CSOs also train community-based health care workers (“relais de santé”) at the zonal level in vaccine protocols and supply chain management, as well as in a wide range of primary health care interventions.

Support to CSOs is catalytic

In countries with weak infrastructure for health, and particularly in areas of low security or where populations are hard to reach, immunisation is a familiar and widely accepted health service. Immunisation services are therefore often used as a springboard or vehicle for building and strengthening primary health care in general. This was the case in Zaire in the early 1980s, when the health zone system of primary health care services was rolled out with CSO involvement – with immunisation as a key starting component. Given the acceptance of the presence of CSOs, even during the political crisis of the early 1990s and the conflict in the last 10 years, they were for the most part seen as vital to implementing the HSS plan, in line with plans for decentralisation.

The role of CSOs in post-conflict situations

One of the main challenges for ministries of health and CSOs is the transition from humanitarian and emergency programming to development and sustainable recovery. This is further complicated by continued unrest in many post-conflict or fragile states, including DR Congo. As fragile states transition to become more solidified and state confidence and capacity are strengthened, CSOs will need to rethink their strategies to ensure alignment with, and support to, state-building.

This new role for CSOs strikes a delicate balance between alignment with government policies and systems and an independent outside “civil society role”, which is essential to promote legitimacy and confidence in the state as well. It is also important to point out that while the government may depend in large part upon the CSOs for outreach and health service delivery, there is still a great deal of work and capacity building to be done to ensure long-term impact and sustainability.



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Training of Red Cross Volunteers and community mobilisers in Tshikaji, during the first year of the project (2008)

Information current as of May 2010