SUPPORTING DEVELOPMENT OF CONGO’s HEALTH SECTOR

by

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Section I:

CONGO’S MILLENNIUM DEVELOPMENT GOALS
MILLENNIUM DEVELOPMENT GOALS
2015 TARGETS

• Under Five mortality rates: < 40 per 1000
• Maternal mortality rates: < 300 per 100,000 live births
• Deliveries adequately assisted: > 85%
• Children 13-24 months completely immunized: > 55%
• New curative visits: > 0.40 per capita, per year
Section II:

CONGO’S PRESENT AND PAST
2007 CONGO’s INDICATORS

- Maternal mortality rate: > 500 per 100,000
- Under Five mortality rate: > 90 per 1000
- Hospital case-fatality rate: > 15 per 100
- Number of premature deaths due to malnutrition and easily controllable infectious diseases: Extremely high
- Accessibility to basic social services (including Water, Sanitation and Education): Unacceptably low
2007 CONGO’s INDICATORS

• Annual cases of malaria: +/- 25 million
• Prevalence of HIV infection: > 4.3% (among pregnant women)
• Prevalence of arterial hypertension: 11% (among individuals 15 years old and +)
• Prevalence of diabetes: > 15.5% per 100 (among individuals 15 years old and +)
• New curative visits: <0.25 (per capita and per year)
• Health expenditure by Government: <10USD (per capita and per year)
Maternal mortality rate, in DR Congo, per 100 000 live births
Under-Five Mortality Rates, per province, EDS 2007
DRC’s Immunization coverage rate among children 13-months, per region, in 2001 (blue) and 2007 (red).
Human Resources for Health

MoH Physicians, per 10 000 population

MoH Nurses, per 10 000 population
Government health expenditure, in % of GDP (in red) and % of total Government expenditure (in blue).
Actual Government health expenditure, in % of allocated budget
Donors’ contribution to health financing, per category
Graphique 5 : Evolution du PIB par habitant de 1958 à 2002 (en dollars)
CONGO’s 3-PHASE EVOLUTION

Phase 1 (1885-1930): First Decline; Phase 2 (1931-1975): Steady Progress; and Phase 3 (1976 to present): Second Decline
Phase One (1885-1934)

First decline due to:

- King Leopold’s abusive regime (Red Rubber following discovery of vulcanization by Dunlop and Firestone)
- Spread of AHT, smallpox and other communicable diseases (following increase in people’s movements)
PHASE 2 (1928-1975)

Steady improvement due to:

- Advocacy by dedicated Champions;
- String of benevolent leaders (from King Albert 1 (bottom right) to Mobutu, the Nationalist);
- Succession of economic booms; and
- Implementation of sound strategies
A sample of Congo’s Champions (up to 1975)

1917: Dr. Lejeune
1923: Dr. Trolli
1926: Prof. Malengreau
1928: Queen Elisabeth
1960: Dr. Pr. d’Arembert
1960: Dr. W.T. Close
1975: Dr M. Ngwete
      Kinkela
Etc.
Phase Three (1976 and after)

Second decline due to:

- Inadequate leadership
- 1973 Oil Shock and other global mishaps;
- Spill-over of Angola’s, Uganda’s and Rwanda’s internal issues;
- International struggle for oil, coltan, and other natural resources;
- Ill conceived transition to democracy; and

Mobutu, the Nationalist, turned into Mobutu, the “M’en-foutiste”
CONGO’s 3-PHASE EVOLUTION

**Phase 1 (1885-1927):** First Decline;  **Phase 2 (1928-1975):** Steady Progress; and  **Phase 3 (1976 to present):** Second Decline
Section III:

A HEALTH AGENDA FOR CONGO
HEALTH SECTOR DEVELOPMENT OBJECTIVE

- To quadruple utilization of good quality health services throughout the DR Congo by 2030
HEALTH SECTOR DEVELOPMENT
PROJECT COMPONENTS

• Providing good quality health services through well functioning health zones as well as secondary and tertiary hospitals;

• Supporting provision and utilization of good quality health services, including through strong advocacy, adequate leadership, and sustainable financing,
HEALTH SECTOR DEVELOPMENT
PROJECT ACTIVITIES

• Goods
  – Construction/renovation of health-related facilities (i.e. HCs; FHs; SHs; and THs)
  – Equipment of health-related facilities (i.e. HCs; FHs; SHs; and THs)
  – Provision of drugs as well as other medical and non medical consumables

• Services
  – Provision of health care services (curative as well as palliative and preventive)
  – Supportive activities (including management, advocacy, and logistic-related services)
HEALTH SECTOR DEVELOPMENT
UNIT COSTS

• **Investment costs:**
  – Health Zone (15 HCs and 1 FRH): .................. US$6,250,000
    • Health center (HC): .................................. US$250,000
    • First Referral Hospital (FRH): ............ US$ 2,500,000
  – Secondary Hospital: ................................. US$7,500,000
  – Tertiary Hospital: ................................. US$12,500,000

• **Recurrent costs:**
  – Overall Health Financing (per capita and per year): US$60
HEALTH SECTOR DEVELOPMENT
TOTAL COSTS

• **Investment costs:**
  – Construction: Tbd
  – Equipment: Tbd
  – Training/Human Resource Development: Tbd

• **Recurrent costs:**
  – Labor: Tbd
  – Consumables: Tbd
  – Maintenance: Tbd
  – Other recurrent costs: Tbd *(To be determined upon negotiations with Financiers)*
HEALTH SECTOR DEVELOPMENT

SOURCES OF FUNDS

Year 2015

- Government
- Out-of-pocket
- Donors

Year 2030

- Donors
- Government
- Insurance
HEALTH SECTOR DEVELOPMENT
RISKS

• Donors’ Fatigue
• Toxic Aid due to:
  – Receivers’ sins
  – Donors’ sins and/or
Donors’ Fatigue

**PRO**

- DR Congo has been a major recipient of development assistance
- Yet, the country’s growth and development has been very poor

**CON**

- The fate of DR Congo is partly in its own hand and partly in the hands of the Global Community.
- Reform is needed both at National and Global levels.
Receivers’ Seven Common Sins

1) Anger (*The Receiver’s hand lies under the Donor’s*)
2) Meek submissiveness
3) Cynicism
4) Dissociation
5) Fake compliance
6) Subtle sabotage
7) Embezzlements
Donors’ Seven Deadly Sins

1) **Impatience** (with institution building)
2) **Pride** (failure to exit)
3) **Ignorance** (failure to evaluate)
4) **Sloth** (pretending participation equals ownership)
5) **Envy** (failure to collaborate)
6) **Greed** (stingy and unreliable financing)
7) **Foolishness** (underfunding of global and regional public goods)
As in the past, success will require coexistence of three conditions, namely:

1. Support from the good leaders,
2. Strong advocacy by dedicated champions, and
3. Continuous availability of Financial and other resources.

... the same way jets require three sets of tires to take off.
HEALTH SECTOR DEVELOPMENT
FEASIBILITY & DESIRABILITY

• Mission not impossible
• A sine qua non condition for national, regional, and global peace
CONGO’s SUCCESS STORIES

• Development of PHC, by FOREAMI, FOMULAC, USAID, etc.
• Public-Private Partnership, by the Vatican, UMHK, FOMECO, etc.
• Control of AHT
• Control of AIDS
• USAID-Funded SANRU Project
• Etc...
Congo’s Health Pyramid

- **Health Zones** (i.e. constellations of Health Centers around one First Referral Hospital)
- **Secondary/Regional Hospitals**
- **Tertiary/National Hospitals**
FBO Co-Managed Health Zones in DR Congo

CATHOLIC

PROTESTANT
ÉVOLUTION DE LA TRYpanosomiase humaine africaine (THA) DE 1926 À 2006 EN RDC
CONTROL OF AIDS

• Significant contribution to the knowledge about HIV

• Effective stabilization of HIV prevalence (under 5 per cent of pregnant women, since 1984)
The Health Zones of the Dem. Rep. of Congo Assisted by SANRU III
(1 decembre 2002)
mortalité néonatale
(age moins de 1 mois)
mortalité infantile
(age moins de 1 an)
mortalité juvénile
(age 1-4 ans)
mortalité infanto-juvénile
(age 0-4 ans)
HEALTH SECTOR DEVELOPMENT BENEFITS

- Greater human capital
- Enhanced productivity
- Higher degree of symbiosis
HEALTH SECTOR DEVELOPMENT BENEFITS

Area: 2,345,000 sq. km (the size of Western Europe or USA East to Mississipi)

Total Population (in millions)
- 1960.............................................14.31
- 2010.............................................64.42

DR Congo’s Strategic Resources (in % of world reserves):
- Cobalt: 10%
- Hydro-electrical potential: 13%
- Tropical forests: 50%
- Coltan: 80%
- Uranium: na
- Etc...
With a prosperous Congo at its heart, Africa could significantly contribute to nurturing global development, rolling back poverty, and securing peace.

“Africa is shaped like a revolver, and Congo holds its bullets.”
In the village,

The Poor Man does not sleep
Because hunger gnaws his stomach,
The Rich Man does not sleep
Because the Poor Man cannot sleep.

(African proverb)