Secure Livelihoods Research Consortium

Non-state health services, networked governance and state legitimacy in eastern DRC

Briefing paper 24
December 2016

Key messages:

- The DRC has a long history of state fragility and deficiencies in performing the functions of modern states, including the provision of public health services and social welfare.
- Through networked governance, non-state service providers and the state interact to ensure effective policy-making and enforcement, health-system management and service provision.
- Efforts to respond to population vulnerability should also include state-building engagement, as fragility hampers the success and sustainability of networked health governance and undermines state legitimacy

Credit: SLRC

Introduction

State fragility in the Democratic Republic of Congo (DRC) has impacted the provision of public services, as well as the population's experience and perceptions of the state. For public health and for social welfare more broadly, the contributions of the state are weak and contingent on the involvement of non-state service providers (NSPs).[11] The state and NSPs interact through networked governance,[22] where relevant actors participate through resource interdependency, cooperation, collaboration and even competition to achieve social goals (Klijn, 2004).

The link between legitimacy and state service delivery has been the subject of many previous studies, but there has been little investigation of the link between basic service provision by NSPs and state legitimacy in fragile states. Based on fieldwork in South Kivu (with complementary data collection in Kinshasa) between 2012

1 These non-state actors include international and national non-governmental organisations (INGOs and NGOs), faith-based and community-based organisations, and a range of donor organisations.

2 In the network literature, 'governance refers to the horizontal interactions by which various public and private actors at various levels of government coordinate their interdependencies in order to realize public policies and deliver public services' (Erik-Hans and Koppenjan, 2012: 8).

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Secure Livelihoods Research Consortium
Overseas Development Institute (ODI)
203 Blackfriars Road
London SE1 8NJ
United Kingdom

T +44 (0)20 3817 0031
F +44 (0)20 7922 0399
E slrc@odi.org.uk
www.securelivelihoods.org
@SLRCtweet

ISDR-BUKAVU

and 2015, this study explores how networked governance of the health sector contributes to state-building processes and outcomes in the fragile setting of eastern DRC, including effective public-health governance, the strengthening of system management, and health service provision through state–non-state interactions. We also explore state legitimacy, and how the population's experience and perceptions of the state are shaped by NSP service provision.

Non-state service providers have been actively involved in the delivery of basic public services throughout the history of the DRC (Pearson, 2011; Seay, 2013; Waldman, 2006). Some scholars have argued that inputs from NSPs, supported by international funding, are the reason for the 'current resilient' outlook of the country's health sector (Pearson, 2011: 12; Seay, 2013). Although these inputs have not been homogeneous across provinces or health zones (HZs) within provinces (Pavignani et al., 2013; Pearson, 2011), their aggregate contribution accounts for the persistence of the sector in terms of policy-making and enforcement, health-system management and service delivery.

NSPs can be national or international, and traditional or situational partners. Most international NGOs are situational partners whose emergence was spurred by state fragility and the humanitarian consequences of wars. Such situational partners are mostly engaged in specific projects and interventions focusing on social vulnerability and, through the frequent use of different policies and approaches, have involuntarily contributed to a decentralised and rather fragmented system. Faith-based organisations (FBOs) are classified as national and traditional partners of the state, while international traditional health-policy partners mostly include bilateral and multilateral institutions that have long supported state-building in the DRC. The latter contribute to national policy-making and system strengthening through collaboration with the Ministry of Health (MoH) and, along with FBOs, play a crucial role in the networked governance of the health sector and in public health care delivery.

Networked governance and state legitimacy in the DRC's fragile health sector

The DRC has a long history of state fragility and deficiencies in performing the functions of modern states. NSPs therefore operate like surrogate state service providers, with both the state and NSPs engaged in the process of health care provision through networked governance.

In our examination of state legitimacy, 'a state is more legitimate the more it is treated by its citizens as rightfully holding and exercising political power' (Gilley, 2006). A lack of legitimacy is a major contributor to state fragility, because it undermines state authority (Unsworth, 2010). In most cases, declines in service delivery have been found to reduce the population's support of the state and its leadership (OECD/DAC, 2008). However, little is known about how this works in fragile settings characterised by institutional multiplicity, so the contribution of NSPs to statehood legitimacy was treated as an open question in this study.

Networked governance arenas and their multi-level nature

Health-sector governance in the DRC has a pyramidal structure involving the central (national), intermediate (provincial) and operational (HZ) levels 2012).

> Performance-based financing supports health sector-based state-building, but it cannot repair a collapsed state.

The central level consists of the national MoH, which is expected to play a strategic role, engaging in policy formulation, elaboration of the mechanisms for public-policy implementation, sector funding and high-level interactions with non-state stakeholders (i.e. signing framework agreements or specific agreements). The MoH is responsible for general policy and system regulation, national programmes and tertiary hospitals (Waldman, 2006). Although policy-making is an exclusive function of the MoH (Zinnen, 2012), donors and other development partners inform and support the process through technical and financial assistance.

The intermediate level concerns the management of the provincial health system, providing oversight and technical support to the operational (HZ) level (World Bank, 2005). At this level, state and non-state actors interact to improve governance of the structural system and to manage the provision of health services. Using HZ evidence-based reports, the Comité Provincial de Pilotage Santé defines stakeholder priorities in line with national health policy, harmonises interventions and establishes the model of engagement at the provincial level.

The HZ is the operational unit that integrates primary health care services and the first-referral level. A HZ covers an average population of 110,000, and consist of a central HZ office with a management board (Bureau Central de Zone de Santé), an array of health posts and centres, and a general referral hospital (Carlson et al., 2009). Because of the lack of government financing over the last decades, HZs and their constituent facilities have operated with considerable autonomy, although MoH structures have retained administrative control, particularly over human resources (ibid.). In effect, many facilities have become privatised, relying on patient fees to pay staff and operating costs. In the HZ arena, interactions take place among representatives of the state, non-state actors (where possible) and community-based organizations – especially the community health development committees (Comité de Développement Sanitaires).

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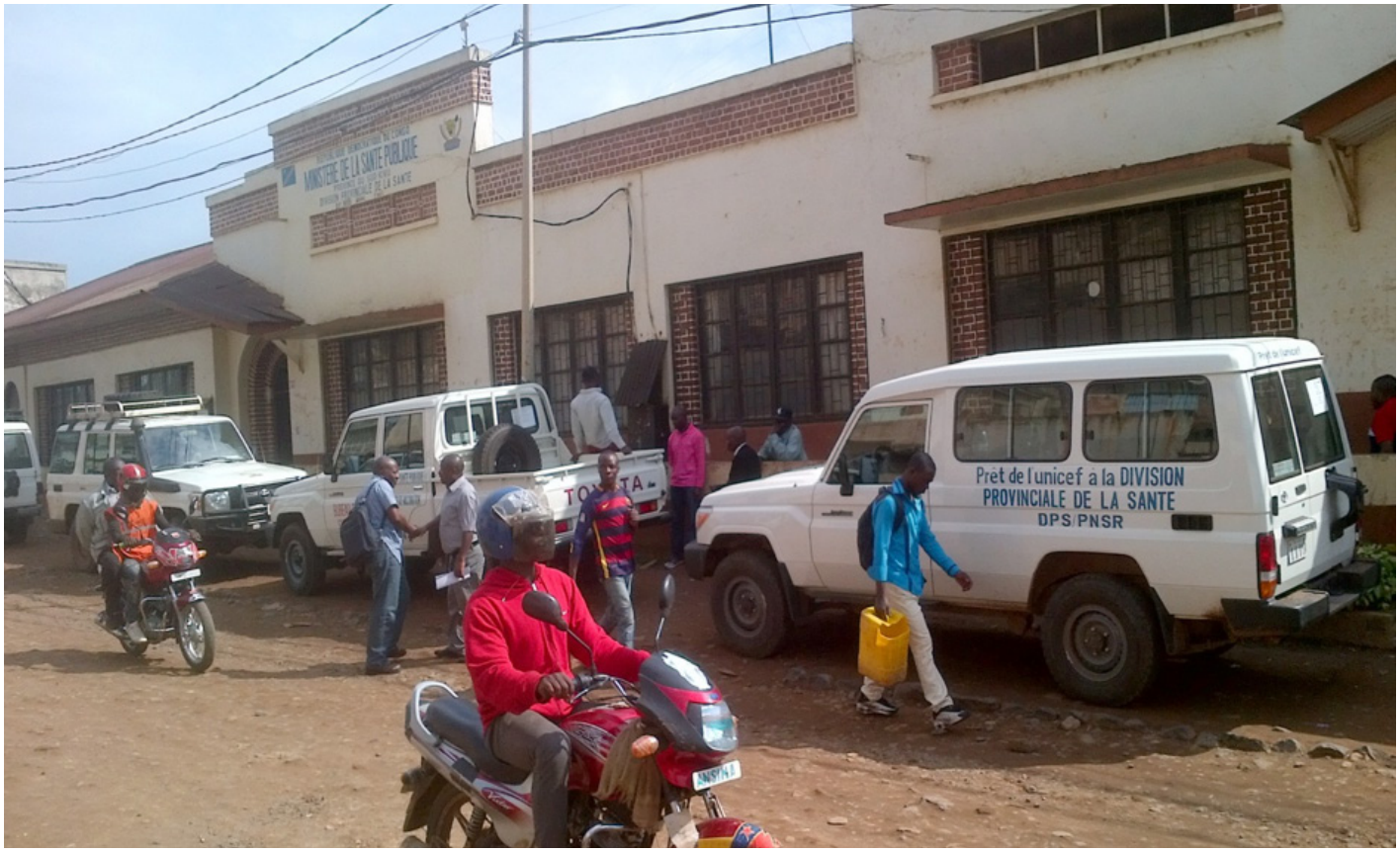

Provincial health department in Bukavu

Research methods

This study began in 2012, with empirical research starting in August 2013. The fieldwork lasted 19 months, ending in April 2015. Most of the research was conducted in the province of South Kivu, with complementary data collection in Kinshasa.

A case study design was used, with two multi-stakeholder governance arrangements serving as the cases. The first case was performance-based financing (PBF) (the transfer of money or material goods from a funder to a contracting recipient, on the condition that the recipient will take a measurable action or achieve a predetermined performance goal), which has played a pivotal role in the process of building the health system in DRC. The second case was a community-based health insurance (CBHI) programme – Mutuelle de Santé (MUS) – and explored MUS outcomes related to equity in access to health services, protection from financial risk and the financing of health services, and was based primarily on observations in a rural area (Katana) and a semi-urban area (Uvira).

Focusing on the multi-level networked governance of the DRC's health sector, this study drew on institutional ethnography, which examines the coordination of work processes, typically by examining various texts and discourses (Smith, 2009). Attention was given to discourses, relationship patterns, writings and multi-stakeholder governance arrangements throughout the study period.

Six types of participants were interviewed: public health officials and state actors from MoH offices at national and provincial levels (approximately 30 participants); representatives of donor organisations, international NGOs and national NGOs (16 organisations including three donor organisations, six international organisations and seven national NGOs); health service providers throughout the province (20 doctors); individuals involved in the management of CBHI/MUS at multiple levels, especially in Katana and Uvira (approximately 68 participants); CBOs (35 people from Comité de Développement de l'Aire de Santé, CODESA); and community members (beneficiaries, clients and citizens), especially in Katana, Bukavu, Uvira and Idjwi (approximately 1,000 participants). For the latter category of respondents, community opinions on health services, the state and NSPs were assessed through interviewees' personal story telling, semi-structured interviews and focus groups. A content analysis of the four main official policy papers[33] was also conducted to assess the baseline situation in the health sector.

3 Including the 'Growth and Poverty Reduction Strategy Paper' (Second Generation, 2011–2015) (International Monetary Fund, 2007; RDC/MINIPLAN, 2011), the 'Health System Strengthening Strategy' (RDC/MINISANTE, 2006), the 'National Health Development Plan (2011–2015)' (RDC/MINISANTE, 2010), and the 'National Health Human Resources Development Plan (2011–2015)' (RDC/MINISANTE, 2011).

Research findings

1) Institutional outlook, functioning and state-building outcomes

Networked health-sector governance and state-building outcomes. Longstanding patterns of interaction exist between state and non-state actors seeking to improve public health in the DRC. In many cases, private actors have stepped in due to the lack of state health care provision. Our findings demonstrate that state–non-state interactions in the DRC's health sector create a burgeoning form of multi-level networked governance, and that these interactions help to explain the persistence of the health sector despite the weakness of the state. It is difficult to assess the real influence of these interactions on state-building in a context of critical fragility, however, where coordination and alignment are problematic. The findings also indicate that several factors – specifically, the fragmented nature of interventions conducted by the majority of international NGOs, imbalanced power relations during negotiations with development partners, and weaknesses in governance –impede the construction of a coherent, resilient and sustainable health system in the DRC. Generally, our findings indicate that networked governance through interactions between the state and non-state providers may contribute to state-building.

State fragility discourse and the challenge of policy coalition-building for interventions programming and stakeholder engagement models. The DRC's health sector governance network lacks a coalition at present, with the government and donors/international NGOs failing to reach a harmonised view of fragility. These key stakeholders have also not reached a common understanding on intervention policy, and there is a clash between opposing institutional logics in the processes of policy-making and intervention programming. Donors rationalise the persistence of emergency-based interventions by emphasising fragile statehood, whereas DRC officials assert political statehood and argue for a paradigm shift towards a higher degree of state control. The lack of consensus around state fragility has influenced perceptions of the state and international NGOs/donors in their engagement with health interventions programming in the DRC. Government officials in the DRC see fragile statehood as a stigmatising concept that contributes to difficulties with international NGOs complying with the Paris Declaration on Aid Effectiveness. Representatives of the state and donor organisations do agree that, because public health-sector funding is lacking, donors' financial contributions ensure the sector's survival, however.

Multi-stakeholder health system arrangements: strengthening networked health governance and community health coverage

PBF for stronger public health governance. In general, we found that PBF positively impacted the process of health system-building in three areas: structural governance from a capacity-building perspective; health service-provision management; and demand-side empowerment for effective accountability. Although much is still lacking, health governance and the provision of services have improved, and patient-centred care and social accountability have strengthened the provider–patient relationship. We also found positive outcomes for incentive-based contracting and output-based financing. However, donors, state officials and other stakeholders doubt the sustainability of these approaches, and PBF faces obstacles associated with state fragility. Ultimately, the research found out that PBF supports health sector-based state-building, but it cannot repair a collapsed state.

CBHI and community-health coverage. The MUS CBHI scheme began operating just after the wars in South Kivu. Our research findings indicate that MUS schemes lead to improvements in access and social protection, but only for a portion of the population. Similar findings for outcomes related to resource mobilisation and the financial sustainability of the health sector point to continued management challenges for MUS schemes, which are compounded by state fragility. To contribute effectively to universal health coverage, the state should reinforce its stewardship presence in strengthening MUS.

Credit: SLRC

PBF experiment in Fomulac Health Zone

2. NSPs and local perceptions of the state

Service provision – especially health care delivery – serves as a public sphere and an arena for interactions and multi-stakeholder processes. Our findings indicate that the population's perceptions of the state reflect a breach of social contract, because the state has failed to live up to their needs and expectations. The presence of NSPs may have negative effects on these perceptions, because NSPs' performance establishes their own benevolent image while solidifying a negative image of the state. However, the state-building legitimacy outcomes are contingent on how the services are delivered by NSPs: when NSPs engage with the state on the ground, people also see the state in action and assign credit to both parties. There is no direct correlation between service provision by NSPs and the positive image of the state, however.

Conclusions

This study explored state-building outcomes resulting from networked health-sector governance in a war-affected context with an empirically weak state. State fragility has a negative impact on networked health governance and donor-supported interventions, therefore the input of NSPs towards public health provision and management of the health system is crucial for the population's welfare. Bids to respond to population vulnerability and humanitarian needs should include state-building engagement, as state fragility hampers the success and undermines the sustainability of any rational intervention carried out by non-state actors.

Written by: Aembe Bwimana

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