Networked Health Sector Governance and State-building Legitimacy in Conflict-affected Fragile States

The Variable Impact of Non-state Provision of Public Health Services in Eastern Democratic Republic of Congo

Bwimana Aembe

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This thesis is dedicated to the honour of:

The late Caleb Fitimana Rugari,

Rev. Mukuma Aembe Venance and

My wife and children.

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ACRONYMS/ABBREVIATIONS

AAP:	Agence d'achat de performance
AGF:	Agence de gestion financière
BCZS:	Bureau central de zone de Santé
BDOM:	Bureau Diocésain des Œuvres Médicales
CAMS:	Cellule d'Appui aux Mutuelles de Santé
CAPSA:	Centre d'Appui à la Promotion de Santé
CBHI:	Community-based health insurance
CBO:	Community-based organisation
CDF:	Congolese Francs
CELPA:	Communauté des Eglises Libres de Pentecôte en Afrique
CNPSS:	Comité National de Pilotage du Secteur de Santé
CNS:	Comptes Nationaux Santé
CODESA:	Comités de Développement de l'Aire de Santé
COGES:	Comité de gestion
COOPEC:	Coopérative d'Epargne et de Crédit
CPPSS:	Comité Provincial de Pilotage du Secteur Santé
CTFBR:	Cellule technique du financement basé sur les résultats
DFID:	The United Kingdom's Department for International Development
DRC:	Democratic Republic of Congo
ECA:	African Union Economic Commission for Africa
ECC:	Eglise du Christ au Congo
ECC-DOM:	Eglise du Christ au Congo-Département des Œuvres Médicales
EU:	European Union
EU-PS9FED:	9th European Development Fund
FBO:	Faith-based organisation
Fomulac:	Fondation Médicale de l'Université de Louvain en Afrique Central
FY:	Fiscal year
GAVI:	Global Alliance for Vaccines and Immunization
HGR:	Hôpital général de référence
HRM:	Human resources management
HZs:	Health zones
IMF:	International Monetary Fund
INGOs:	International nongovernmental organisations

IRC:	International Rescue Committee
MoH:	Ministry of Health
MONUSCO:	Mission des Nations Unies pour la Stabilization du Congo
MoU:	Memorandum of understanding
MSF:	Médecins Sans Frontières
MUS:	Mutuelle de santé
NHP:	National health policy
NPM:	New public management
NSP:	Non-state service providers
OECD:	Organisation for Economic Co-operation and Development
PBF:	Performance-based financing
PROSANI:	Projet de Santé Intégrée
PSS:	Programme solidarité santé
RDC:	République Démocratique du Congo
RDC/MINIPLAN:	Ministère du Plan de la RDC
RDC/MINISANTE:	Ministère de la Santé de la RDC
SK/MINISANTE:	Ministère de la Santé du Sud Kivu
SLRC:	Secure Livelihoods Research Consortium
UHC:	Universal health coverage
UN:	United Nations
UNICEF:	United Nations Children's Fund
USAID:	United States Agency for International Development
WASH:	Water, sanitation and hygiene
WHO:	World Health Organization

Chapter 1: Introduction to the Thesis

Fragility is a well-known characteristic of the Democratic Republic of Congo (DRC) state, and it has impacted the effectiveness of empirical statehood in terms of public service provision and the population's experiences and perceptions of the state. In the DRC, the provision of basic social services such as health care and education is dependent on the engagement of non-state actors, who have taken on a role as indispensable supporters of the population's social welfare. The engagement of non-state service providers (NSPs) accounts for the survival of the health sector—especially where this concerns public health. For that reason, state and non-state actors engage in interactive relationships around community health needs and public health policy. Non-state actors such as international NGOs (INGOs), other NGOs, faith-based organisations (FBOs), community-based organisations (CBOs) and a range of donor organisations play the role of service providers, filling the vacuum of empirical statelessness in the field of public health services. As active stakeholders engaged in the health sector through interactive collaborations, state and non-state actors develop patterns of interdependent relationships that produce a networked governance management model in the DRC's fragile public health sector.

How this networked health sector governance affects the state-building process is an open question that was problematised in the present research. In the post-conflict era, there is always a tension between state-building and the intermediate provision of services, which may lead to parallel services that could undermine the state in the long term. Conversely, the involvement of the state in these networked forms of service delivery could also have the effect of strengthening the state. Through the prism of networked governance, state actors, along with non-state actors and donors are viewed as developing a kind of agreement on how they will collaborate and what different roles they will play in the effort to effectively provide social services. In the DRC, the provision of health services, as well as the governance of the entire health sector, reflects the interdependent interactions that result in multi-actor and/or networked arrangements. This thesis explores how the health sector networked governance contributes to state-building and the state's popular legitimacy in the fragile state of the DRC. The study's investigation revolves around the state-building outcomes of the networked health sector governance regarding effective public health governance, the strengthening of system management and the actuality of health service provision through state–non-state interactions. The thesis also problematises statehood legitimacy, as well as the population's experiences

and perceptions of the (fragile) state, where the delivery of public health services is mostly mediated by non-state actors.

Statehood Fragility, Health Sector Networked Governance and State Legitimacy (Dilemma) in the DRC

This sub-section explains the theoretical underpinnings of networked governance and its conceptual workings in fragile states. The sub-section brings to light the legitimacy dilemma that occurs in fragile settings, such as African contexts, where the effectiveness of public service delivery is dependent on the involvement of non-state actors and/or multi-actor arrangements.

The Networked Governance and State Legitimacy Dilemma in the DRC's Fragile Health Sector

The DRC is a country with a long history of state fragility, where the empirical attributes of modern states are hardly performed. The persistent failure of statehood has affected the population's welfare, institutional systems and the population's perceptions of the state. However, the social effects of state fragility are mitigated by the active engagement of non-state actors in the sector of basic service delivery. These NSPs operate as surrogate-state service providers. Both the state and the NSPs engage in the process of health care provision under a de facto public management form of networked governance. This networked governance implies a network of relevant actors and/or stakeholders linked through resource interdependency, cooperation, collaboration and even competition for achieving the social goals (Klijn & Koppenjan, 2004). The concept of networks has increasingly been connected to that of governance, to the extent that, instead of policy networks and network management, scholars now mostly speak of governance networks and networked governance (Klijn & Koppenjan, 2012). Within the literature on networks, 'governance refers to the horizontal interactions by which various public and private actors at various levels of government coordinate their interdependencies in order to realise public policies and deliver public services' (Klijn & Koppenjan, 2012: 8).

In the contemporary networked world, solutions to global problems are based on networks and informal relationships instead of hierarchy and authority (Maarten & Hendrik, 2003; Maria, 2011; ODI & FDC, 2003). In this context, strategic alliances across the categories of business, government and civil society are a growing feature of both developed and emerging

economies, because the complexities of sustainable development require the synergistic actions of various actors (ODI & FDC, 2003). Going back to the 1980s, the failure of national and local governments to solve concrete policy problems and exploit new opportunities through hierarchical command and control triggered an increasing use of market regulations in the provision of public goods and services (Sorensen & Torfing, 2007). In developing countries especially, the idea of a Weberian state providing the full array of public services and goods has proved to be simply utopian (Titeca & de Herdt, 2011). Therefore, scholars view the emergence of (networked) governance mechanisms as a neoliberal search for an efficient solution to the challenges of the end of 20th century, as well as a consequence of globalisation, contracting out, hyper-pluralism and devolution (Sörensen & Torfin, 2007). Hence, interestingly, for different reasons, networked governance arrangements have become a new norm in both developed and developing countries.

In the realm of public administration, the governance perspective is regarded as an expression of two leading narratives: the neoliberal narrative, which emphasises market principles inspired by rational choice, and the network narrative, which is associated with institutionalism in political science (Bevir, 2002). Introduced in 1992 by the Wold Bank, the concept of good governance was part of their criteria for lending to developing countries. This concept referred to neoliberal reforms in the public sector, which the Bank believed would lead to great efficiency (Bevir, 2002: 3). An alternative to the neoliberal narrative of governance is the narrative of networks. This narrative was conceived to explain an unintended consequence of neoliberal policies, which allegedly fragmented service delivery and thus weakened central control without establishing proper markets, leading to the creation of networks (Bevir, 2002). In networked governance perspectives, the state acts as one of several organisations that come together in diverse networks to deliver services (Bevir, 2002).

In fragile settings—especially in Africa, where the state is empirically weak—both network logics and institutional hybridity perspectives are concurrently at play. Network logics imply designed patterns of horizontal and interdependent engagement among both public and private actors in the policy process and service provision. Institutional hybridity is the expression of '[real] hybrid public governance' in a context of institutional multiplicity characterised by state fragility, contested statehood, disputed legitimacy of public authority and the subsequent bid for social control. In contrast to network logics, the notion of real hybrid governance conveys the idea that institutional multiplicity and social ingenuity occur in social contexts

characterised by—and coping with—state fragility. The logic of hybrid governance highlights the roles of non-state actors and the defective role played by the state. It emphasises the leading role that the (normal) state should play in the process of public service delivery. Generally, hybrid governance is organised through new organisational arrangements that incorporate local institutions and popular organisations to fill the gaps in state capacity (Meagher, de Herdt & Titeca, 2014). Hybrid governance is also referred to as 'governance without government', a 'twilight institution', 'real governance', and 'hybrid political orders' in which the governance outcomes are the result of a game of complex negotiations between a number of actors, groups and forces (Boege, Brown, Clements & Nolan, 2008; Clements, Boege, Brown, Foley & Nolan, 2007; Hagmann & Péclard, 2010; Meager et al., 2014).

The DRC health sector is a blend and result of both networked governance logics—through longstanding interactions between state and traditional non-state partners—and the hybrid governance model, which has serendipitously emerged as a social response to humanitarian tragedies and state fragility. The DRC health sector functions by relying on formalised arrangements between state and non-state actors. In these arrangements, both state and non-state actors have particular agreed roles, inputs/funding and responsibilities. Their roles and responsibilities are clearly acknowledged in national health policy documents. However, the DRC health sector also reflects hybrid governance in that informal interactions, interpenetrations, mutual exclusion and even contestations between state institutions and non-state interventions are reported at all levels of the sector.

Figure 1: The Blend of Networked and Hybrid Governance in the DRC Health Sector
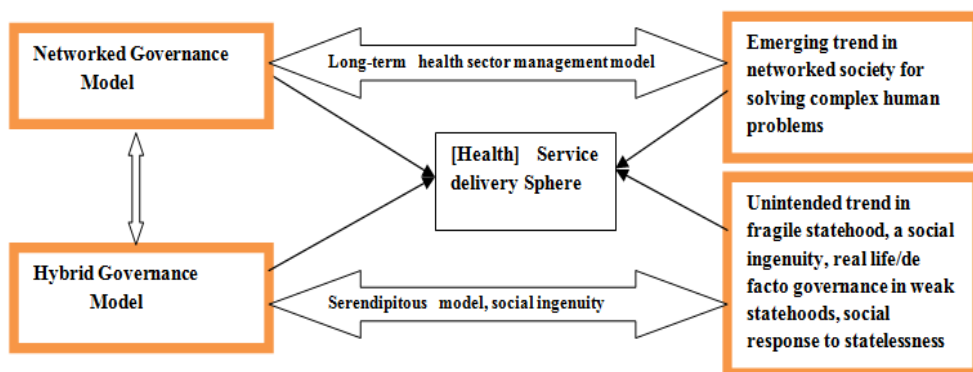
Networks as a form of governance imply patterns of interactions among a range of institutions and structures of authority, as well as collaboration on the allocation of resources and the

coordination and control of joint actions across the network as a whole (Provan & Kenis, 2008). Networks are considered more formal governance regimes when the players develop a culture of mutual cooperation because of their long-term relationship (Kim, 2006). Networked governance refers to public policy making and implementation through a web of relationships between government and non-state stakeholders (Klijn & Skelcher, 2007). This explains why networked governance is described as a form of organisational alliance in which relevant policy actors are linked together as co-producers, who are more likely to identify and share common interests (Kim, 2006). In the DRC health sector, networked governance calls for the engagement of the state and NSPs in policy processes and public health care delivery management.

This study examines the state-building legitimacy outcomes of these interactive collaborations between the state and NSPs in the realm of public health service provision. This thesis adopts the simplest definition of state legitimacy: 'a state is more legitimate the more it is treated by its citizens as rightfully holding and exercising political power' (Gilley, 2006a). Akin to this conceptualisation is the interrelation between perceptions and state legitimacy: State legitimacy is concerned with people's perceptions and beliefs; a political order, institution or actor is legitimate to the extent that people regard it as satisfactory and believe that no available alternative would be vastly superior (Unsworth, 2010). From the perspective of state-building, a lack of legitimacy is among the major contributors to state fragility, because it undermines state authority (Unsworth, 2010). Legitimacy has therefore become a strategic centre of gravity for all state-building interventions (McLoughlin, 2005). Invoking the creation of new governmental institutions and the strengthening of existing ones, state-building has become a crucial issue for the world community today because weak or failed states are regarded as close to the root of many of the world's most serious problems' (Fukuyama, 2004).

This study is cognisant of the policy tension, in terms of achieving state legitimacy, between state-building in fragile states and the necessity of providing emergency public health services in these settings. However, although there may be tensions between the urgent need to provide basic services to the population and the importance of state-building in fragile states (Batley & Mcloughlin, 2010), scholars acknowledge that, in general, service delivery supports the building of effective, legitimate and resilient states (Batley & Mcloughlin, 2010; Klimis, 2007). Networked governance processes in the DRC take place at three structural levels of the

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public health sector governance: national, provincial and operational. Through these three levels, networked governance appears as a de facto institutionalised public model for the management of the DRC health sector. This thesis enquires about this model's properties, how it works in practice and how it evolves (or fails to evolve) into a sustainable health care system. In doing so, the thesis will address the core research problem, which asks how service delivery contributes to state legitimacy where the state is fragile and, like in the DRC, relies mostly on NSPs through networked governance.

Background on Networked Governance in the History of the DRC Health Sector Management

The engagement of private actors in parallel with—and sometimes without—the state in the provision of public services including health care has a long history in the DRC (Pearson, 2011; Seay, 2013; Tshiyoyo, 2011; Waldman, 2006; Weijs, Hilhorst & Ferf, 2012). Throughout its history, the state has relied on NSPs, especially FBOs, private enterprises and international actors, for their voluntary social involvement in responding to the population's expectations and social needs. Scholars widely report the active involvement of non-state stakeholders in the delivery of basic public services throughout the history of the DRC (Pearson, 2011; Seay, 2013; Tshiyoyo, 2011; Vlassenroot & Raeymaekers, 2008; Waldman, 2006; Weijs et al., 2012). Although such interactive arrangements also occur in other spheres, the health sector is among the most commonly mentioned in this literature.

The substantive involvement of NSPs has caused the health sector to be considered the strongest of weak public sectors in the DRC (Pearson, 2011). Existing work indicates that strong inputs from NSPs supported by international funding gives the DRC health sector its 'current resilient' outlook (Pearson, 2011: 12; Seay, 2013). Although NSP inputs into the health sector have not been homogeneous across provinces and health zones (HZs, equivalent to health districts in other countries) within different provinces (Pavignani, Michael, Murru, Beesley & Hill, 2013; Pearson, 2011), their aggregate contribution accounts for the persistence of the sector regarding the processes of policy making and enforcement, health system management and service delivery. This is why, in the DRC health sector's formal nomenclature, NSPs are referred to as partners of the state (RDC/MINISANTE, 2003).

These NSPs may be categorised as national or international actors. They may also be grouped as traditional or situational partners. FBOs are classified as national and traditional partners of the state. International actors recognised as traditional health policy partners include mostly

bi- and multilateral institutions because of their longstanding support of state-building in the DRC. Most of INGOs fall into the situational category of partners, as their emergence was spurred by the situational variables of state fragility and humanitarian consequences of the wars. Traditional international partners, in collaboration with the Ministry of Health (MoH), contribute to the process of national policy making and system strengthening through a horizontal approach. Situational partners mostly take a vertical approach, which aims to respond through un-integrated projects and humanitarian interventions that focus on circumstantial situations of social vulnerability. Humanitarian organisations have involuntarily contributed to a decentralised and rather fragmented system, because they often pursue different policies and stand-alone projects. Traditional partners such as FBOs and international donor organisations play a crucial role in the process of the health sector networked governance and public health care delivery.

FBOs: Partners for system management and service delivery

FBOs are among the national NSPs that have been very influential in basic service provision since the colonial period (Boyle, 1995). The Belgian colonial power in the Congo was structured around 'an alliance of state, church, and large corporations; a trinity which was not [however…] a virtually seamless web' (Boyle, 1995: 451–468). In the contemporary DRC, marked by the aggravation of state fragility, the church is tasked with managing effective service provision structures throughout the country, especially in the education sector and in health care provision (Seay, 2013). Of the 515 HZs in the DRC health system, over 35% are co-managed by FBOs alone. Working with NGOs or CBOs, FBOs support over half of the HZs in the country. As many as 256 HZs were reportedly supported through service delivery contracts with FBOs or NGOs as of 2009 (Global Health Initiative, 2011). In the province of South Kivu, FBOs currently co-manage more than 19 of a total of 34 HZs making up the provincial health system. The Catholic Church is involved in 12 of these HZs, and Protestant co-manages 7.

INGOs/Donors: Critical actors endeavouring to transform 'that country on the map' into a state

Donors account for the public health sector's survival in the DRC. Donor organisations support both the state and national NSPs. External actors play the role either of donors offering financial and technical support or of donors' interface organisations—in the case of some INGOs—through which the funding is channelled. INGOs have also been acting as

frontline providers during humanitarian crises. The involvement of these international actors in the health sector has a long history in the post-colonial Belgian Congo (DRC). They have been very supportive to both the state and non-state providers such as FBOs that are actively involved in the provision and management of public health care. From international organisations, national actors—both state and non-state providers—secure technical assistance for institutional capacity building, as well as financial endowments for implementing health projects and programmes.

Donors' financial support for funding the sector, along with household contributions, account for more than 85% of payments for current health expenses in the DRC. According to a European Union report (*Evaluation de la Coopération de l'Union-Européenne avec la République Démocratique du Congo 2008–2013*), from 2008 to 2012, international aid given to the DRC health sector amounted to 16,550 million USD (ADE, 2014). The European Union (EU) member states, multilateral institutions and the United States are the leading public aid donors for the DRC health sector (ADE, 2014: 19–20) (see Chapter 4). Again, the engagement of these international partners and national NSPs alleviates multiple effects of state fragility on the public health sector.

The Fragile State, Networked Governance and State Legitimacy in the DRC
In the first paragraph of its preamble, the DRC Constitution of February 2006 states, 'Since its accession to independence on 30 June 1960, the DRC has confronted recurrent political crises of which a fundamental cause is, among others, institutional illegitimacy' (RDC/Présidence, 2006 [Translated from French]). Although the Constitution does not specify the nature of this state illegitimacy, the document's contextual background indicates that defective legitimacy stems mostly from unresponsive institutions, undemocratic public governance and corrupt political actors. Emerging as a political settlement outcome reached through the comprehensive Sun City/South Africa peace agreement, which was signed on 17 December 2002, the current Constitution reveals the necessity of establishing the legitimacy of the state and setting up a responsive political system for institutional stability and social peace.

Institutional legitimacy and social stability in the DRC, as in other fragile states, are the social variables that have bearing on the situational context of public governance and institutional performance. Public governance refers to the formal and informal arrangements that determine how public decisions are made and how public actions are carried out, from the

perspective of maintaining a country's constitutional values when facing changing problems and environments (OECD, 2011: 2). This implies that dysfunction in public governance disturbs the state–society relation, the legitimacy of public institutions and, thus, social peace. From such a perspective, the African Union's Economic Commission for Africa (ECA) report maintains that the weakness of the state has played a key role in the genesis of the conflicts in the DRC (ECA, 2015).

Since 2002–2003, the DRC has undertaken a range of measures on public policy in view of reforming the state (Arnould & Vlassenroot, 2016; Shepherd, 2014; Trefon, 2011). However, these institutional reforms have failed to materialise, leading some to view the DRC as an 'unreformable' state (Trefon, 2011: 101), whose failure has gone beyond institutional features to reach a condition of societal fragility. Local authorities show little commitment to strengthening the state's institutions (Martinelli, 2013). Analysts, such as Trefon (2011: 92), view the Congolese people as developing a kind of 'social cannibalism where society is its own self-consuming prey'. For Trefon, 'The Congo is on the move, while we may not know where it is going […], the institutional future of the country is uncertain and there are no convincing prospects for a new deal' (Trefon, 2011: 129).

Nevertheless, networked governance in the DRC health sector through interactions between the state and NSPs has emerged as a means of somehow filling the void of empirical statelessness. The engagement of NSPs alleviates the population's suffering, because the NSPs (reportedly) aim to meet the population's vital needs (Seay, 2013). However, the impact of NSPs' contributions on the state–citizen relationship is a matter of debate. Previous research has posited that fragile states, such as the DRC, are places where competing claims to power and logics of order coexist, overlap and intertwine, concerning especially the logic of the formal state, of the traditional informal societal order, and of globalisation and its associated fragmentation (Boege et al., 2009a in Hoffman & Kirk, 2013).

Interactions between state and non-state actors in the public health field are affected by disputed legitimacy and differing institutional logics, which accounts for the rationalistic gaming and competitions. Scholars argue that different competing legitimacies are at play in situations of legal and institutional pluralism such as post-colonial and post-socialist countries (Sikor & Lund, 2009). Moreover, in societies where various patterns of legitimacy coexist without the state being able to act as an overarching structure, some groups may ignore or

refuse the legitimacy of the state (Bellina, Darbon, Eriksen & Sending, 2009). Consequently, 'informal' and 'non-state' institutions, rules and processes may enjoy considerable legitimacy and are often more trusted, because, over time, these non-state institutions have been able to establish a sense of allegiance, trust and loyalty (Bellina et al., 2009: 20).

The above arguments imply that networked governance, as it plays out in reality in fragile states, may cast questions of legitimacy and ownership into sharper relief. Analysing the DRC context, it is obvious that the aims of non-state social actors may range from responding to the population's basic needs and statehood expectations to competition for social control. In the DRC and other fragile states, the struggle for social control and the bid for stakeholders' legitimacy are not mutually exclusive but rather mutually reinforcing. In most cases, the decline in service delivery causes the state and its leadership to lose the population's support (OECD/DAC, 2008). Nonetheless, whether NSP interventions contribute to state legitimacy in fragile situations characterised by institutional multiplicity is an open question.

Reviewing the Concepts and Prevailing Policy Discourses of the State in Fragile Settings
On multiple fragility indexes, the DRC has always ranked among the most fragile states in the world, indicating that the state relies least on de facto statehood and most on international recognition, known as de jure statehood. This is obvious in indexes such as the *Country Indicators for Foreign Policy Report* (2014), which focuses on authority, legitimacy and capacity (Carment, Langlois-Bertrandt & Samy, 2014), and the *Brookings Institution's Index on State Weakness in the Developing World* (2008), which relies on four domains of public management: economic welfare provision; political institutions' effectiveness and the legitimacy of the system of governance; security (physical security of the territory and the people); and social welfare (to what extent the state meets the basic human needs) (Rice & Patrick, 2008). In all of these indexes, the DRC is counted among the most fragile states.

Conceptual Conundrums of Defining Statehood in Fragile African Settings
There is no standard or universally accepted definition of the state (Shaapera, 2012). As a politically social organisation, the state's architectural arrangements appear complex, with multiplex functions and manifestations. The state also has variegated claims (Midgal, 1988), even if it is deemed fragile and collapsing. This goes along with the argument that '*sovereignty* is [still] alive and kicking' (ISS, 2010), even in a contested and weak state such

as the DRC, where the political elite flag up political sovereignty to ward off any external encroachment (see Chapter 3).

Different from European (nation-)states, which emerged from internal struggles and historical empires, where juridical attributes were contingent on the empirical actuality of statehood, the paradox of African states, which mostly emerged from colonisation, is that juridical statehood (i.e. international recognition) preceded empirical state-ness. This situation is thought to have predisposed those countries to empirical fragility (Jackson & Rosberg, 1986). According to the modern 'European model, statehood is determined by territorial power, sovereignty is a manifestation of that power, and international recognition is an effect and not the foundation of statehood' (Jackson & Rosberg, 1986: 3). In the case of Europe, for instance, it is argued that credibility and competition—often under conditions of war—was the historical context for the formation and development of states (Jackson & Rosberg, 1986). For this reason, scholars think that African states exist primarily by means of international legitimacy; their sovereignty derives far more from right than from fact (Jackson & Rosberg, 1986: 2).

In any case, however, the state is regarded through different definitional prisms (Clarke, 1991; Jessop, 1982). The ideal-type for the modern state was provided by Max Weber. Weber's definition conceptualises the state as an organisation, composed of numerous agencies led and coordinated by the state's leadership (executive), that has the ability and authority to make and implement the binding rules for all of the people, as well as the parameters of rulemaking for other social organisations in a given territory, using legitimate force if necessary to have its way (Migdal, 1988). In light of this definition, the state contains four main elements:

i)   a differentiated set of institutions and personnel;
ii)   centrality in the sense that political relations radiate outwards from the centre;
iii)   coverage of a territorially demarcated area; and
iv)   a monopoly on authoritative binding rule-making, backed-up by a monopoly on the means of physical violence (Mann, 2003).

Based on Midgal's (1988) adaptation of the ideal-type definition, this thesis adopts a simple variant of the definitions of the state, according to which the state is a political organisation that is the basis of the government in a given territory. This definition resonates with the

research participants' understanding. Their referent for the state often pointed to public institutions, official practices, public actors and/or political elites.

Ideal-typical notions of statehood constitute the analytical lenses through which scholars interpret state politics around the world (Hagmann & Péclard, 2010). For some analysts, many of the states that were created in the decolonisation process did not qualify for statehood by the criteria of international law in use in the 1930s—especially, the existence of effective government, with centralised administrative and legislative organs (Milliken & Krause, 2002). This 'pseudo-statehood' was arguably converted in some cases—especially in Asia—into 'real' statehood; however, in many other instances—especially in Africa—post-colonial state-building resulted in the formation of 'quasi-states' (Milliken & Krause, 2002). In these African states, public governance takes the form of hybrid governance/political orders.

Regarding state formation, hybrid governance orders as a new practical model posit the blend of traditional and modern norms and practices (Clement et al., 2007). Scholars view the negotiation of statehood dynamics and, at least partly, undetermined processes of state (de-)construction as the defining features of African state-building (Hagmann & Péclard, 2010). For instance, Lund (2006) asserts that, in Africa, there is no shortage of institutions attempting to exercise public authority in the sense that there are multiple layers and branches of government institutions that are present and active to various degrees; however, there are also so-called traditional institutions vying for public authority, often bolstered by government recognition (Lund, 2006).

Viewed from this angle, the governance/political hybrid orders and institutional multiplicity that characterise many African states seem to be not only the defining features of their state weakness, but also a mark of their specificity, which accounts for the persistence of these fragile states. This is why some scholars argue that the Weberian ideal-type of the state as a goal-oriented, centralising and unitary actor that is distinct from society should now be replaced by a practical view that pays attention to the different alliances and connections with non-state actors, who play an important role in the formation of public authority (Titeca & de Herdt, 2011). In Weber's ideal-type of the state, service delivery is both the domain and the responsibility of the state. The provision of social services is thus viewed, especially in functionalist theories of statehood, not only as one of the functions of states (John, 2011), but also—taking a transactional outlook—as linked to statehood legitimacy. In contrast, in a

globalised world, the provision of public goods takes the form of a responsibility that is shared among various social stakeholders. From this perspective, the issue of interactive networking is not necessarily related only to state fragility.

The International Policy Response to State Fragility

The threats caused by fragile states to international security have prompted multiple policies and strategies from different donor governments and international organisations (Carment, Samy & Prest, 2008; IDC, 2012; Sepputat & Engeberg-Pedersen, 2008). Most donors have converged around the OECD-DAC perspective, which defines state fragility in terms of the capacity and/or willingness of state structures to deliver key services needed for poverty reduction, development, security and the protection of human rights for their population (FASID, 2009; Hilker, 2012).

The international reaction to 9/11, at first focusing on Afghanistan, reinforced the underlying perception that poorly governed states constitute weaknesses in the fabric of international society, and that the developed world has a considerable self-interest in strengthening their governance capacities (Wesley, 2008). This threat of fragile statehood problematised the classical Westphalian political notion of state sovereignty and facilitated external interventions. State fragility also prompted a contentious debate on aid effectiveness in fragile states in the first decade of the 2000s (Hayman, 2012; Naudé, 2012; OECD/DAC, 2008; OPM/IDL, 2008; Wood, Kabell, Muwanga & Sagasti, 2008). However, the lack of common understanding and the diverging perceptions that characterise state fragility discourse to date affect donors' engagement in the so-called fragile states. As a discourse, state fragility influences policy coalition-building and donor interventions programming in the DRC health sector.

Public Health Systems in Fragile States

A health system consists of all of the organisations, institutions, resources and people whose primary purpose is to improve health (Van Olmen et al., 2010; World Health Organization, 2000, 2010a). The health system delivers preventive, promotive, curative and rehabilitative interventions through a combination of public health actions and the pyramid of health care facilities that deliver personal health care—provided by both state and non-state actors (World Health Organization, 2010a).

The Health System and its Operational Functioning in a Working State

In light of the above definition and mostly building on health system functions, also called health system building blocks, it appears that the role of the state is vital for achieving the public health system's expected outcomes. In the 2000 World Health Report, the World Health Organization (WHO) provides a practical health system framework that describes the functions/building blocks and overall goals/outcomes of any public health system (See Figure 2) (World Health Organization, 2000).

Figure 2: Health System Building Blocks (Functions) and Outcomes

SYSTEM BUILDING BLOCKS

OVERALL GOALS / OUTCOMES

SERVICE DELIVERY

HEALTH WORKFORCE

HEALTH INFORMATION SYSTEMS

ACCESS TO ESSENTIAL MEDICINES

FINANCING

LEADERSHIP / GOVERNANCE

ACCESS COVERAGE

QUALITY SAFETY

IMPROVED HEALTH (LEVEL AND EQUITY)

RESPONSIVENESS

SOCIAL AND FINANCIAL RISK PROTECTION

IMPROVED EFFICIENCY

THE SIX BUILDING BLOCKS OF A HEALTH SYSTEM: AIMS AND DESIRABLE ATTRIBUTES

Source: World Health Organization (2000)

This WHO enumeration of the building blocks has been adopted widely and now provides a common terminology for discussing key health system functions (Health-Systems-20/20, 2012). The six building blocks contribute to strengthening health systems in different ways (World Health Organization, 2010a):

- o Some cross-cutting components, such as *leadership/governance* and *health information systems,* provide the basis for the overall policy and regulation of all of the other health system building blocks.
- o Key input components to the health system include, specifically, *financing* and the *health workforce*.

o A third group, comprising *medical products and technologies* and *service delivery*, reflects the immediate outputs of the health system in terms of the availability and distribution of care.

For their effective performance, the health system building blocks require streamlined interactions among each other and the involved stakeholders (see Figure 3) (Health-Systems-20/20, 2012).

Figure 3: Health System Building Blocks Interactions
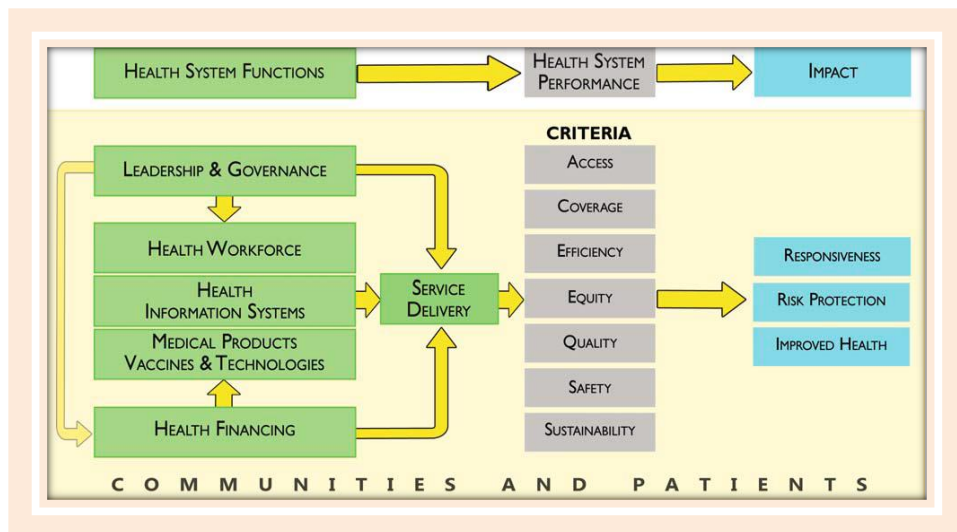
According to public health experts, the actions of the health system should be responsive and financially fair, while treating people with respect (World Health Organization, 2010a). Consequently, to function, the health system needs staff, funds, information, supplies, transport, communications and overall guidance and direction (World Health Organization, 2010b). The functions and expected outcomes of health systems thus suppose working states, which assure the operational functioning of the system. The Director-General of the WHO at the time, Dr. Gro Harlem Brundtland, argued, 'Ultimate responsibility for the performance of a country's health system lies with government; the careful and responsible management of the wellbeing of the population—stewardship—is the very essence of good government; health of people is always a national priority' (World Health Organization, 2000).

Public Health Systems in Fragile Environments

In fragile settings, states suffer from the incapacity to assure the public stewardship role. In these environments, NSPs assume the flagship role of public service delivery and may cooperate or even operate in parallel with state institutions (Batley & Mcloughlin, 2010; Bold, Collier & Zeitlin, 2009). The so-called fragile or, especially, conflict-affected states suffer deficits in governance that hinder development, and, as the conditions are too unstable for long-term planning and investment, society focuses on short-term coping strategies to secure the population's basic needs (Massing & Jonas, 2008). These states are characterised by weak policy, institutions and governance (Haar & Rubenstein, 2012b).

Table 1: Health System Deficiencies in Fragile States

Health System Area	Deficiencies
Infrastructure	Facilities are insufficient; there are problems related to human resources for health, equipment and supplies, and drugs.
Health delivery system	There is a lack of coordination or oversight; services are accessible primarily to urban populations.
Equity in the provision of health services	There is great inequity, especially for secondary and curative services.
Health service providers	For the most part, health services are provided by non-state providers, with no policy direction or monitoring by the government.
System for establishing policy	The health system is like a ship without a rudder, with no direction or course to follow.
Implementation of policies	The health system and government are in disarray; the policies that exist are not followed because there is no oversight of the health sector or of the implementation of policies.
Information system	The health system operates without adequate information.
Management system	Few functional management systems are in place; there is no basis for developing budgets, tracking expenditures, assessing current workloads, tracking the availability of human resources or carrying out disease surveillance.
Management capacity	There is a shortage of managers skilled in managing the health system, health facilities and human resources for health.

Source: Newbrander (2006)

Newbrander (2006) has summarised the deficiencies from which health systems suffer in fragile states (see Table 1). In the baseline situation analysis that was conducted as part of the present study (see Chapter 4) using the DRC's country policy documents, it was obvious that the deficiencies in the DRC health system encompassed all of the indications of fragility displayed in Table 1. Previous research by a group of MoH staff members and Congolese health advisors working in other agencies (known as the internal diaspora) analysed the problems found within the health sector as a whole (Carlson, Maw & Mafuta, 2009: 18). According to their main findings, the DRC health sector is mostly plagued by the following problems:

The under-financing of the health sector due to the de facto disengagement of the state, the limited contributions of the international community and the impoverishment of the population. This has resulted in (i) the collapse of the structures providing health care; (ii) the commercialisation of the health sector, with many perverse effects; (iii) major barriers hindering access for a very large part of the population; and (iv) the negative effects of the current financing of a commercialised system.

The problem of human resources, namely an over-supply of ill-trained and underpaid personnel, constrained to seek the advantages available through externally financed vertical programmes, to the detriment of the work to be carried out within the HZs, or to exploit their customers through a supply of care of sometimes dubious quality.

The organisation of the HZs has become fragmented and no longer has any clear frame of reference.

The lack of leadership of the MoH: The marginalisation of the MoH in budget terms has resulted in (i) the loss of its power to make decisions independently; (ii) the manifest difficulties in coordinating the funding agencies and their sometimes misplaced initiatives; (iii) a lack of control and authority over the financing of the sector; and (iv) a failure (until recently) to maintain the planning framework of HZs in the face of a multitude of external initiatives that, though uncoordinated, enjoy the benefit of outside financial support that bears no comparison with that of the HZs.

Although the health system in the DRC shows many signs of fragility, the engagement of NSPs has cushioned the social impact of the weakness of the state at the community health level (Seay, 2013). Without taking the place of formal statehood, these NSPs fill the social vacuum created by weak statehood in the sector of community health welfare.

Research Question

The networked governance of the fragile DRC health sector engages the state and NSPs through interactive processes of system governance and health service provision management. This interactive engagement of the state and NSPs motivated the fundamental question of this study:

> How does the networked governance of health services, involving state and non-state actors through multi-stakeholder processes, affect state-building processes and legitimacy in the fragile setting of eastern DRC?

This question allowed space for examining the functioning of networked governance processes in the DRC's fragile health sector, focusing especially on its outcomes concerning i) state capacity in terms of the effective delivery of services and social protection in conflict-affected situations and ii) state legitimacy regarding the population's experiences, perceptions and expectations of the state and governance in conflict-affected situations.

The fundamental question was broken down into five sub-questions:

1. How does the health system governance, characterised by multi-stakeholders' engagement, function, and how has this de facto (real) networked governance been relevant for the working of the state in the fragile context of the DRC? (Chapter 2)

2. How do key stakeholders intervening in the health sector—especially state and donor organisations—use the discourse on state-fragility in their interactions, and how does this impact interventions programming and policy coalition-building in the fragile state of the DRC? (Chapter 3)

3. What are the outcomes of strengthening the health system governance by means of networked governance through multi-stakeholder process initiatives, such as the

introduction and implementation of performance-based financing (PBF) in the health sector in the context of state-building in the fragile state of the DRC? (Chapter 4)

4. How do non-state actor-inspired arrangements such as community-based insurance schemes affect networked governance and the achievement of universal primary health care coverage in war-torn communities experiencing excessive financial hardship and state fragility in South Kivu? (Chapter 5)

5. How do health services provided by non-state actors in the DRC affect popular perceptions of the state in the context of limited statehood? (Chapter 6)

The DRC Health Sector Networked Governance as an Arena Featured in Actor-oriented Interactions

The functioning of the DRC health sector has bearing on social arenas. Intervention outcomes in social arenas result from actor-oriented negotiations (Hilhorst & Jansen, 2010). Interactive processes concerning policy making, policy implementation and intervention programming turn the health sector into a social field, where stakeholders' levels of capital and position determine their influence (Fligstein & McAdam, 2012).

Based on institutional ethnography, this research explored the real networked governance of the DRC health sector through its three structural governance levels. Institutional ethnography builds on the examination of work processes and studies how they are coordinated, typically through analysing texts and discourses of various sorts (Smith, 2009). Work activities are taken as the fundamental grounding of social life, and an institutional ethnography generally takes some particular experience (and associated work processes) as a 'point of entry' (Smith, 2009: 32). From the perspective of institutional ethnography, this study focused on observing and decrypting the practices and enabling factors of the multilevel networked governance of the DRC health sector. Practices as discourses and patterns of relationships were given close attention throughout the fieldwork.

Architectural Design of the DRC Health Sector Networked Governance

The DRC health sector governance has a pyramidal outlook, revolving around three levels that constitute its structural architecture: the central, intermediate (provincial) and operational (HZ) levels (Bukonda, Chand, Disashi, Lumbala & Mbiye, 2012). The national MoH is the

central level, expected to play a strategic role in policy formulation, elaboration of the mechanisms for public policy implementation, funding of the sector and high-level interactions with non-state stakeholders. The MoH primarily defines standards and policy, but it also has considerable administrative authority in terms of oversight and management of personnel issues (World Bank, 2005: 58). The design, coordination and organisation of health policy are handled at this level. 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 is in charge of provincial health system management, as well as the accompaniment and oversight of the operational (HZ) level. The intermediate level organises and provides technical support to the HZs (World Bank, 2005). The intermediate level has considerable administrative power over the HZs: Health workers, for instance, are supposed to be appointed by the state, even when an HZ is managed by a non-state agent. At this structural arena, state and non-state actors (such as FBOs, CBOs, I/NGOs and donor organisations) interact to improve the structural system governance and the management of the provision of health services.

The HZ is the operational unit that integrates primary health care services and the first-referral level. An HZ covers an average population of 110,000 and consists of a central HZ office, an array of health posts and centres that provide the population with the Minimum Package of Activities defined by the MoH, and a general referral hospital offering a complementary package of activities (Carlson et al., 2009; Waldman, 2006; World Bank, 2005). Each health centre serves an average of 5,000–10,000 people. In 2001, the government increased the number of HZs from 306 to 515, the strategy being to increase the geographical coverage of referral services, as each HZ was to have a referral hospital (Carlson et al., 2009: 15–18). Due to the lack of government financing over the last decade, HZs and facilities have been operating with considerable autonomy, although the MoH structures have retained administrative control, particularly over human resources (Carlson et al., 2009: 15–18).

At every level of the DRC health sector networked governance, there are corresponding key actors, modes of interaction, and both operational and structural challenges. However, there are conjunctures that amplify interactions among various stakeholders on the basis of their respective portfolios and intervention goals. During vaccination campaigns, epidemiological

outburst management, humanitarian disasters and crises, networked governance intensifies because these require collective actions.

The Health Sector Functioning as a Public Policy Arena for Actor-oriented Interactions

Networked governance arrangements in the DRC health sector share the characteristics of a social arena. A social arena is a metaphor to describe symbolic locations of political actions that influence collective decisions or policies (Kitschelt, 1980 in Renn, 1993). As symbolic locations, social arenas are neither geographical entities nor organisational systems; rather, they describe the political actions of all of the social actors involved in a specific issue (Renn, 1993). The arena concept attempts to explain the process of policy formulation and enforcement in a specific policy field (Renn, 1993).

The arena idea is founded in the actor-oriented approach, which posits that actors do not display the same, predictable behaviour in every situation; rather, their practices are driven by different motives, and decisions are taken in response to actors' interpretation of the needs of the situation and in interactions with others (Hilhorst & Jansen, 2010). In other words, as Long (2001: 13) elaborated, 'social actors must not be depicted as simply disembodied social categories […], or passive recipients of interventions, but as active participants who process information and strategies in their dealings with various local actors as well as with outside institutions and personnel'.

The arena perspective is an apt entry point for analysing the policy domain of the health sector. It is related to the broader theory of social fields. The social field theory explains the regularities in individual actions using position vis-à-vis others (Martin, 2003), referring to situations where organised groups of actors gather and frame their actions vis-à-vis one another (Fligstein, 2001). Fields are related to the concept of local social orders, which can be labelled as 'fields' (Bourdieu, 1977; Bourdieu & Wacquant, 1992 in Fligstein, 2001), 'organizational fields', 'sectors' or 'games' (Axelrod, 1984 in Fligstein, 2001; DiMaggio & Powell, 1983; Meyer & Scott, 1983).

The essence of fields as arenas of social action is that there is always something at stake (Fligstein & McAdam, 2012). Figure 4 presents the arena metaphor visually to better convey the description of networked governance in the DRC public health policy space.

Figure 4: Graphical Representation of the Arena Metaphor Adjusted for the DRC Health Sector
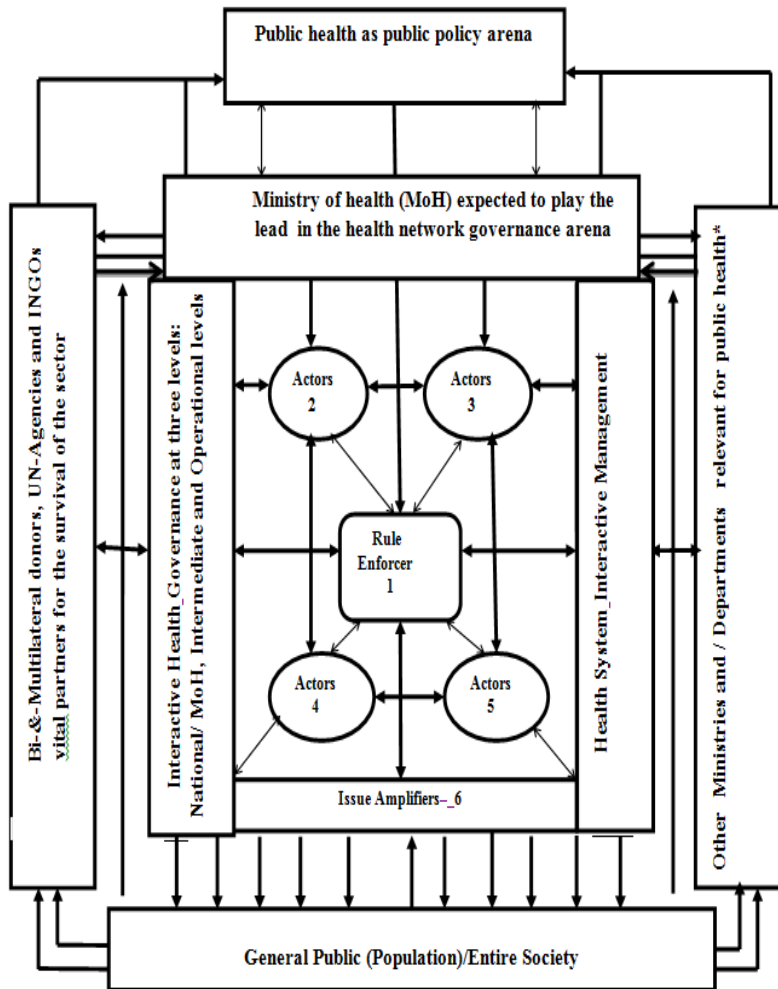
Source: Adapted from Renn (1993)
Arrows: Arrows show communication flow and the direction of social mobilisation.

Actors/stakeholders in the stages of the DRC health sector networked governance arena:

***Rule Enforcer 1*:** State/MoH institutions, which are administratively at the centre of stakeholder interactions, as the state, in spite of its weakness, still provides the legal framework for the rest of the actors; ***Actors 2*:** Public managers and providers; ***Actors 3*:** National non-state service providers (NSPs); ***Actors 4*:** International NSPs; ***Actors 5*:** Community-based organisations, civil society structures and others; ***Issue Amplifiers 6*:** Civil society, NGOs, epistemic community (i.e. public health experts, public health training organisations), researchers, services providers and civil society activists.

*The MoH is the lead ministry for public health welfare, but the social determinants of public health go beyond the purview of the health sector. This is why there are other ministries (e.g. the Ministry of Finance, the Ministry of Budget and the Ministry of Education), state agencies, private organisations, provider associations and other entities, whose inputs are essential in the sector of public health (Islam, 2007).

The arrows of communication flows in Figure 4 indicate the multiplex nature of stakeholders' interactions. The centre stage of the arena is occupied by principal actors, that is, those groups in society that seek to influence policies (Renn, 1993). In the case of the DRC health sector, the present study identified the following groups as key actors:

1. The state is still considered the law-making and policy-enforcing actor, despite its fragility.
2. Donors/INGOs provide financing and technical assistance.
3. National NSPs are vital for health services management.
4. Members of the population are clients, beneficiaries and citizens, but also the reservoir of popular legitimacy.

The DRC national health policy is a result of the interactions of the state, national NSPs and donor organisations. The formal rules in the DRC health sector are embodied by the national policy and international standard instruments for donor engagement in fragile states. The government institutions along all the three stages of the health sector networked governance play the role of rule-enforcing actor.

The arena metaphor sheds light on the role that should be played by the rule-enforcement agency (the state), which is in many arenas the ultimate decision maker. The rule enforcer ensures that the actors abide by the formal rules and often coordinates the process of interaction and negotiation (Renn, 1993). In fragile states, where there is no de facto ultimate public authority in the realm of service provision, as in the DRC health sector, both the coordination of actors and the harmonisation of their interventions pose a difficult problem (see Chapter 2).

Among the actors in the arena metaphor is the category of 'issue amplifiers'. Issue amplifiers are the professional 'theatre critics' who observe the actions on stage, communicate with the principal actors, interpret their findings and report them to audience (Renn, 1993). During the field research, I/NGOs, civil society activists and service providers reflected the role of issue amplifiers, as they freely expressed their views on the state of the health sector.

The audience consists of other social groups who may be enticed to enter the arena and individuals who process the information and may feel motivated to show their support or displeasure with one or several actors or with the arena as a whole (Renn, 1993). For eastern DRC, CBOs, *Comité de Développement de l'Aire Sanitaire* (CODESA), FBOs and community members are the most active actors in the category of the audience, which voices criticisms of the functioning of the sector.

Research Methods

This research is part of the Secure Livelihoods Research Consortium, at the centre of which are three core themes: i) state legitimacy's connection to the experiences, perceptions and expectations of the state and of local governance in conflict-affected situations; ii) state capacity in terms of building effective state institutions that deliver services and social protection in conflict-affected situations and iii) livelihood trajectories and economic activities in conflict-affected situations (Levine, 2014).[1]

This PhD project began in 2012, with the empirical research being conducted from August 2013 to April 2015.

Case Selection

The province of South Kivu was the main geographical unit of the research. Complementary research was conducted in Kinshasa.

South Kivu as the geographical scope of the research

South Kivu is one of the DRC's eastern provinces and one of 26 provinces that currently make up the DRC. According to the current constitution, the provincial administration is decentralised (Mushi, 2012). However, enforcing the decentralisation has been among the weakest spots of the DRC's statehood.

Political patronage institutionalised as the mode of public governance strips provincial deputies of their legal rights, as they are more accountable to the central government in Kinshasa than to their local constituencies. Figure 5 depicts the DRC's current administrative structure, with 26 decentralised provinces.

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[1] *For more information about the Secure Livelihoods Research Consortium (SLRC), please see www.securelivelihoods.org*

Figure 5: Administrative Map of Decentralised Provinces of the DRC

Source: www.radiookapi.net
Note: The red arrow indicates the flight from the South Kivu province (Bukavu) to Kinshasa (the capital city)—about 2000 km in a direct line.

The South Kivu province is one of the provinces of eastern DRC that have been sorely affected by wars and social turbulence over the two last decades (1996–2016). Like other eastern provinces in the country, South Kivu displays a mix of acute vulnerability stemming from humanitarian crises and chronic vulnerability and crises resulting from persistent statelessness (Bailey, 2011). What marks the difference between the eastern and the western provinces in the DRC is the persistence of war-related humanitarian crises and the violent contestation of the state through countless armed groups in the East.

Research Design, Data Collection Tools and Epistemological Positioning

Research design and data collection tools

This research was an ethnographic study in the sense that it entailed extensive fieldwork (Hancock, Ockleford & Windridge, 1998). Consequently, the primary data collection process used qualitative tools, such as participant observation, semi-structured interviews,

unstructured interviews, experience-based storytelling and focus groups. Moreover, secondary data analyses were conducted through the review of scholarly literature and the critical content analysis of donors' country policies and government documents. During individual and paired (or triad) interviews (in-depth interviews carried out with two, and in some cases three, people at the same time), as well as during focus group discussions (involving approximately 4–10 participants brought together as a group), both verbal and paralinguistic elements of communication (non-verbal communication such as laughter, smiling or a certain look) (Ritchie & Lewis, 2004), were carefully considered.

Data Collection Process and Typology of Research Participants

The research in South Kivu

The research in South Kivu was conducted mostly in three sites: Bukavu town, Katana and Uvira. The Idjwi HZ was also visited twice for the purpose of supplementing the collected data on performance-based financing (see Chapter 4) and community-based health insurance (CBHI, see Chapter 5). In Bukavu, the research was conducted primarily with the Provincial Department of Health, representatives of donor organisations' provincial offices, representatives of national NSP organisations (such as FBOs), INGOs, public health experts and key informants with provincial profiles.

Research visit to Kinshasa (January–February 2014)

In Kinshasa, in-depth discussions and semi-structured interviews were conducted with high-level officials from the MoH, as well as with representatives of some NSPs, such as the representatives of the United Kingdom Department for International Development (DFID), Caritas Congo's Kinshasa office, the national office of Cordaid (a Dutch NGO) and the national office of *Eglise du Christ au Congo*. The research in Kinshasa facilitated the understanding of how multilevel networked health governance is empirically conducted at the national level.

Typology of research participants

Six types of participants were interviewed:

Public health officials and state actors. I interviewed public health officials and state actors from the MoH offices at the national and provincial levels. At the national MoH, interviews were conducted at the Department of Study and Planning (*Direction d'Études et de Plannification*), which is the backbone of the national public health policy; the

Department/Direction of Primary Health Care; the Department/Direction of Partnership; the *Cellule Technique du Financement Basé sur les Résultats* and the *Projet d'Appui au Renforcement du System de Santé*. In Bukavu, interviews were conducted with Provincial MoH workers and officials from the Provincial Health Inspectorate, including those employed by the Health Inspectorate, the Partnership Office, the Primary Healthcare and Data Analysis Office, the Study and Planning Office, the Office of Legislation and Management of Health Structures, and the Human Resource Management and Administration Office.

Donor organisations, INGOs and NGOs. This category of interviewees included workers at I/NGOs and donor organisations that are among the most active entities in supporting the health sector: three donor organisations—DFID, the Belgian international NGO *Louvain Coopération au Développement* and *Coopération Suisse*; six international organisations— Cordaid, Malteser International, the International Rescue Committee, the *Projet de Santé Intégrée* (PROSANI), *Médecins Sans Frontières/Hollande* (MSF/Hollande) and MSF/Spain; two UN agencies—the WHO and UNICEF; and seven national NGOs—*Agence d'Achat des Performance* (AAP), Caritas Congo in both Bukavu and Kinshasa, *Bureau Diocésain des Oeuvres Médicales* (BDOM), the Health Department of *Eglise du Christ au Congo* (ECC, in both Bukavu and Kinshasa), the Civil Society Office in Bukavu, the *Reseau d'Innovation Organisationnelle* and the *Centre d'Appui à la Santé*. Among the INGOs, Cordaid and its staff members were of great importance for my personal understanding of how performance-based financing (PBF) functions; how it enforces its contextual theory of change which is state-building oriented; and the nature and quality of the coalition that the state, donors, I/NGOs and providers have been building around PBF ideals (see Chapter 4).

Health service providers. Interviews were conducted with health service providers, including the teams of the two HZ management boards (HZ Central Offices) in the Katana and Uvira HZs, their respective general referral hospitals, and the nursing committees for 15 health centres in Katana HZ and for 10 health centres in Uvira HZ. Katana is a rural and Catholic Church (co-) managed HZ; Uvira is a state-led HZ located in a semi-urban setting. In Katana, the informants included some of the members of HZ management boards at Fomulac Referral Hospital and Birava Hospital, as well as the board of health centre committees in 15 of the 17 health centres in the HZ. For Uvira, in addition to the HZ management board, 10 of the 22 health centres in the HZ were visited. Eight medical doctors at Fomulac, Birava, Idjwi and

Uvira hospitals, as well as six health supervisors in the Katana and Idjwi HZs and two administrators in Katana HZ were interviewed.

Additionally, I interviewed 20 medical doctors from different health facilities across the province, 38 nurses at the 15 visited health centres in Katana HZ and 22 Nurses at the 10 health centres visited in Uvira. Interviews were also conducted with members of the *Comité de Développement de l'Aire de Santé* (CODESA): 35 in Katana and 12 in Uvira. In Idjwi, the research was limited to the HZ board and the *Mutuelles de Santé* (MUS) offices.

The structural branches of CBHI/MUS. MUS scheme management structures were visited at different levels. At the provincial level, I interviewed three main provincial organisational actors, including the BDOM, *Cellule d'Appui aux Mutuelles de Santé* (CAMS) and the *Programme Solidarité-Santé* (PSS). These structures play a strategic role in the organisational management of MUS at the provincial level (see Chapter 4). The management board of four MUS schemes were interviewed in Bukavu town (MUS d'Ibanda), Katana, Uvira and Idjwi. However, the bulk of this part of the research was conducted in Katana and Uvira, which were selected for a comparative case study of CBHI/MUS (see Chapter 4).

Community members. Community members were interviewed as beneficiaries, clients and citizens, whose opinions reflect the level of mutual trust and stakeholder legitimacy. Around 1,000 community members were interviewed in different settings, mostly Katana HZ, Bukavu, Uvira and Idjwi. The methods of data collection used were direct and indirect observations, open (unstructured) interviews, semi-structured interviews and focus groups. Additionally, the research encouraged personal storytelling regarding the population's experiences, expectations and perceptions of the state and of NSPs. Community members were met at any occasion and in any setting, according to opportunity: at health facilities, MUS offices, marketplaces, schools, in the villages and after church services. Generally, individual community members were interviewed about their experiences and perceptions of health services, the state and NSPs.

Data Processing and Analytical Tools

Critical thematic analysis was used for data processing and distribution in line with the organisation of the PhD thesis. Thematic analysis seeks to unearth the salient themes in a text, and thematic networks aim to facilitate the structuring and depiction of these themes (Attride-

Stirling, 2001). To this effect, NVivo software was of great use for thematic data coding and analysis. The empirical data were transcribed and then initially coded according to the research questions. NVivo was used to conduct a thematic analysis, grouping relevant evidence on related thematic concepts.

Research Uptake

The dissemination of the mid-term and final research findings was another important component of this study. Research uptake aimed at sharing the research findings with the project participants and with other project relevant stakeholders to assure the transparency of the data collection process, the reliability of the findings and the social impact of the study regarding public policy making and behavioural change.

In this line, the research findings were presented at a number of conferences such as 'The World Conference on Humanitarian Studies' in Addis Ababa (5–8 March 2016), 'The Development Studies Conference' at Oxford University (12–14 September 2016), the 'Bukavu Conference on Transition and Local Development in Eastern DRC' (8–10 December 2016) and '*l'ISDR/Bukavu et la Transformation Locale en RDC, Leçons et Prochaines Étapes*' in Kinshasa (15–17 February 2016).

Additionally, in Bukavu, as well as in Kinshasa, the research findings were presented in interviews with newspapers such as *Le Souverain* in Bukavu, and *Le Potentiel* in Kinshasa. They also were presented on radio programmes such as 'Radio Mama' in Bukavu (December 2016) and on *La Radio Television Nationale du Congo* (RTNC, National Congolese Radio Television) (February 2017). To enable research uptake, a research brief was drafted, summarising the main findings of the research in English and in French, and a YouTube film was produced about the research to reach out to a broader audience.

Research Process Challenges

The main challenges confronting the research included the following:
Accessing some potentially important participants—state officials and INGOs. It was not easy to obtain access to key informants from high-level state institutions and INGOs. For most INGOs, it was necessary to work through a brokering agent as a gatekeeper.

Availability, poor reliability and contradictions in state-related information from the state agencies. Obtaining reliable information in or about the DRC was difficult. For instance, the national health accounts from the DRC's MoH for 2011, 2012 and 2013 contradicted themselves, although they were all from the same MoH (Manzambi Kuwekita et al., 2015; RDC-MINISANTE/PNCNS, 2013; RDC/MINISANTE, 2015). For example, according to these national health accounts of demographic statistics, the DRC's aggregate population was 75,259,000 in 2011 and 77,817,000 in 2012. In 2013, the reported population plummeted to 67,510,000. This trend defies rationality.

Researcher Reflexivity/Personal Positioning and the Practicality of Ethical Considerations

Reflexivity means thinking critically about what you are doing and why, confronting and often challenging your own assumptions, and recognising the extent to which your thoughts, actions and decisions shape how you research and what you see (Mason, 2002). Positioning myself as researcher and citizen was both a requirement according to research principles and a challenge, because, as a member of the DRC polity, I am also affected by structural fragility. Keeping the principles of research ethics in mind helped me to distinguish the social phenomena under study from my own opinions. Throughout the research process, I was firmly grounded in the literature, and I continued reading literature throughout the fieldwork to ensure that my enquiry was informed by academic insights. It also helped to be part of a large research consortium that was working in different countries; I could always use this to gain perspective and to reflect on my country of study. Moreover, the time I spent away from the DRC in Wageningen enabled me to gain distance, and I actively sought critical reflection from my supervisors.

Generally, the research process required both astuteness and human sensitivity. Astuteness was required because, in a fragile state, the issue of state legitimacy being akin to public management and the population's acceptance of state practices aroused the political sensibilities of regime elites. Interactions with local community members, who have been victims of wars, social vulnerability and state fragility, as well as being the subjects of many previous studies, required empathy, sympathy and, especially, a sense of respect without condescension.

The research also faced a number of limitations, including personal health concerns and contextual constraints. I began the field research in August 2013, just two months after undergoing surgery in the Netherlands. It was medically unadvised to use some means of

transportation commonly used in the DRC, such as motorbikes. Moreover, I was unable to study many of the HZs, as the security situation was volatile, especially in many rural areas.

Structure and Synthesis of the Thesis

The organisation of this thesis is depicted in the Figure 6. The structural arrangement of the chapters reflects a pattern of strands woven around three main themes: the architectural outlook of the health sector networked governance and models of international engagement in the DRC health sector, a review of two multi-stakeholder arrangements fostering networked governance, and NSP interventions and perceptions of the state.

Figure 6: Overview of the Thesis
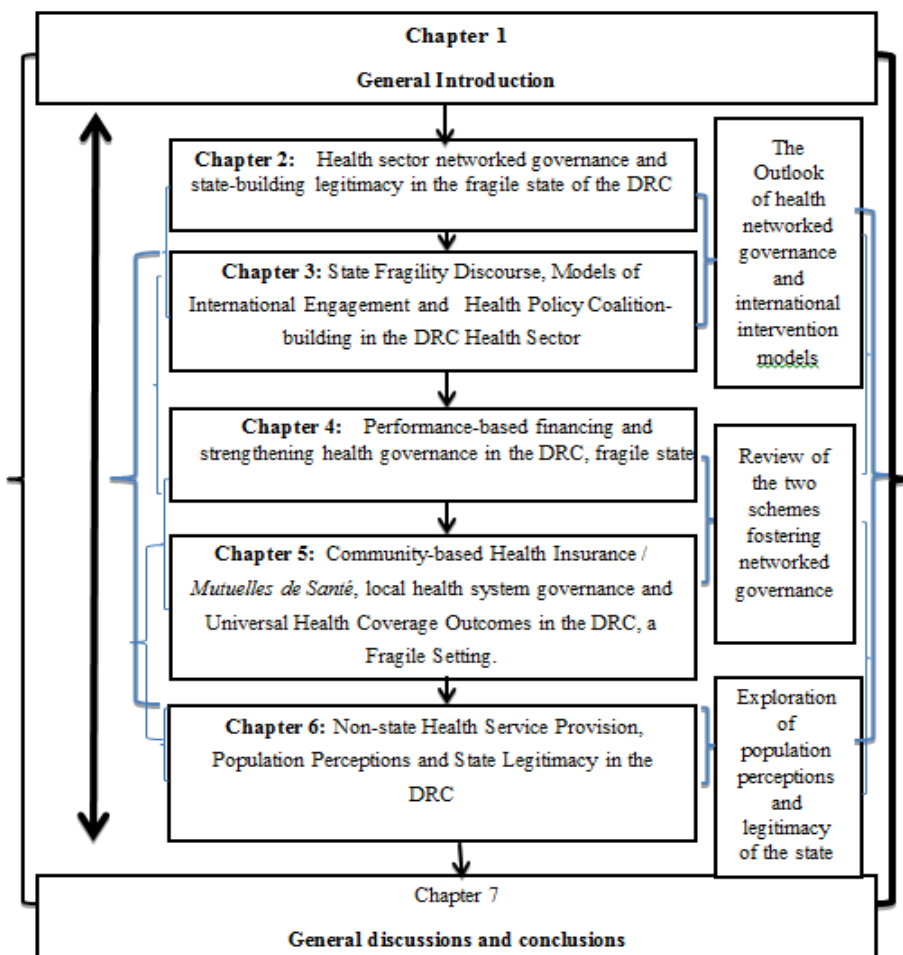
Chapter 2 examines how multiple stakeholders work to manage the health system and how the resulting networked governance has been relevant for the state-building process. The findings demonstrate that state/non-state interactions in the DRC health sector create a form of networked governance and that these interactions play a role in explaining the persistence of the health sector, despite the weakness of the state. However, it is difficult to assess the real influence of these interactions on the state-building process in a context of critical fragility, where coordination and alignment of the actions have been problematic.

The third chapter studies how the discourse on state fragility affects the attitudes of INGOs and donors towards programming health interventions in the DRC, as well as how these influence building a policy coalition. The research explored the impact of this interactive discourse on the processes of establishing health-related policy. Donors have rationalised the persistence of emergency-based interventions by emphasising fragile statehood, whereas state officials have preferred to assert political statehood and argue for a paradigm shift towards a higher degree of state control.

The fourth chapter explores the outcomes of performance-based financing for rebuilding the health system in the DRC. Based on long-term qualitative field research, the study examined the effectiveness of performance-based financing in three areas of health system governance: structural governance from a capacity-building perspective, health service provision management and demand-side empowerment for effective social accountability. In general, the study found that performance-based financing has positively impacted the process of health system-building in these three areas, but much work is still needed.

Chapter 5 explores the outcomes of community-based health insurance/*Mutuelles de Santé* in South Kivu. Based primarily on case studies in a rural area (Katana) and in a semi-urban area (Uvira), the study examined MUS outcomes in terms of equity in access to health services, protection from the financial risk of disease and the financing of health services. The findings indicate that MUS schemes reinforce the networked governance but also lead to improvements in access and social protection 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 facing MUS schemes that are compounded by contextual fragility.

Chapter 6 explores the population's perceptions of the state through the provision of public health services by NSPs in the DRC. Katana HZ was the analytical research unit for this chapter. The research found that the population's perceptions of the state convey symptoms of frustration. This is because the state has failed to live up to the population's needs and expectations. Furthermore, although their work is beneficial in terms of service provision, NSPs may have counterintuitive effects on the population's perceptions of the state, as NSPs' contributions may crystallise their benevolent image while calcifying the negative image of the state. However, whenever NSPs engage with the state on the ground (e.g. during vaccination of under-five campaigns), people also see the state, because state officials are mobilised and deploy with the international organisations.

The seventh chapter provides the general conclusion for the thesis. This chapter includes major discussions and concluding remarks drawn on the basis of the key findings and the driving concepts for this research, which were developed in the general introduction and the subsequent chapters. The overall finding of this thesis is that networked governance through interactions of the state and NSPs may contribute to state-building in a fragile state. Through networked governance, NSP arrangements fill the vacuum of statelessness created by entrenched state fragility, especially in the domain of health service delivery. Nonetheless, this study's findings indicate that there is no direct interrelation between services being delivered by NSPs and state legitimacy in the DRC. State-building legitimacy outcomes of the engagement of NSPs are contingent on how the services are provided.

Chapter 2: Health Sector Governance Network and State-building in the Fragile Democratic Republic of Congo

South Kivu Department of Health, fieldwork photo

During an interview with the provincial Minister of Public Health/South Kivu, field photo

This chapter has been submitted to a journal as:

Aembe, Bwimana. (Forthcoming). Health sector governance network and state-building in South Kivu, Democratic Republic of Congo.

During one of the health sector stakeholder meetings at the provincial department of public health, field photo

 Kalundu/ Uvira HZ, state-led health centre newly built with the support of the *Cooperation Suisse*, fieldwork photo

Abstract

Longstanding patterns of interaction exist between state and non-state actors seeking to improve public health in the Democratic Republic of Congo (DRC). The DRC is a weak state, and, in many cases non-state actors have stepped in to fill the void created by the lack of state health care provision. Throughout the DRC's state-building trajectory, state- partners have interacted in multiple arenas to rebuild the health sector. However, the role of these interactions in creating a governance network in the health sector has been underexplored. Using data from 18 months of qualitative field research, this study aims to explore the governance network in the DRC's health sector, examining how multiple stakeholders work to manage the health system and how the resulting governance network has been relevant for the state-building process. The fieldwork was carried out primarily in the eastern province of South Kivu, DRC, from September 2013 to April 2015, with additional national-level data collected in Kinshasa. The findings demonstrate that state/non-state interactions in the DRC's health sector create a burgeoning form of networked governance and that these interactions play a role in explaining the persistence of the health sector despite the weakness of the state. However, it is difficult to assess the real influence of these interactions on the state-building process in a context of critical fragility, where coordination and alignment of actors and policies have been 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.

Introduction

Both state and non-state actors are involved in the operation of the health system in the Democratic Republic of Congo (DRC). These actors fulfil multiple, and sometimes overlapping, roles. State and non-state actors share the common interest of providing health services, but their institutional interests vary. Though independent, these actors interact in a variety of ways to solve public health problems in the DRC. Through longstanding patterns of interactions regarding public health policy processes, state and non-state actors have developed a de facto networked health sector governance that accounts for the survival of the health system in the fragile DRC context. The contribution of non-state actors ranges from policy formulation support through institutional capacity building and sectorial funding to health service delivery management, amongst other things. However, little is known about the exact nature of these interactions or the resulting impact on the overall health system and on state-building more broadly.

Understanding the interactions that take place between the multiple actors involved in the DRC's health system, as well as their concrete consequences, is of both practical and theoretical relevance. In practical terms, it is useful to have a clear overview of the different

types of service providers making up the health system and to understand cooperation among these different actors. In addition, analysing different service providers' profiles along with the nature of stakeholder interactions and the health system-building effects of their engagements provides practical insights on the operational functioning and contextual challenges of the DRC health sector governance network. It is also of practical relevance for policy makers, both in the DRC and more broadly, to see how such cooperation may contribute to the state-building process. This investigation also contributes empirical insights to the evolving literature on network governance in the health sector in cases where the state is empirically weak.

State-building, state legitimacy and the provision of services in fragile states

The rise and character of the contemporary state-building agenda have bearing on the post-Cold War world (Hehir & Robinson, 2007). Commonly understood as the creation of new governmental institutions and the strengthening of existing ones, state-building is a crucial issue for the world community today, because, since 9/11, weak states have been regarded as close to the root of the world's most serious problems (Fukuyama, 2004). State-building consists of 'purposeful actions to develop the capacity, institutions and legitimacy of the state in relation to an effective political process' (Bruce & Chandran, 2008: 14). State-building thus includes strengthening three dimensions of statehood: state authority, state capacity and state legitimacy (Grävingholt, Ziaja & Kreibaum, 2012; World Bank, 2012).

However, in fragile and/or conflict-affected states, there is policy tension between prioritising state-building and the urgent provision of basic services to the population (Batley and Mcloughlin, 2010). In fragile states, the inputs of non-state actors enhance the capacity of state authority structures and contribute to improving service delivery (Krasner & Risse, 2014). State-building and service provision are linked, as service delivery supports the building of state effectiveness, legitimacy and resilience (Batley & Mcloughlin, 2010). In the

same vein, authors have identified the delivery of social services as a dimension of state-building from the public health perspective (Witter et al., 2015).

However, little is known about *how* service delivery contributes to state-building where the state is fragile and—as in DRC—mostly reliant on non-state providers through the governance network. The present chapter focuses on state-building processes and outcomes within DRC's health sector, exploring how the governance network in this sector contributes to building state capacity and effectiveness through the delivery of social services.

Governance Networks

Governance involves state–society problem solving in public arenas (Brinkerhoff & Bossert, 2013). Within 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 realise public policies and deliver public services' (Klijn & Koppenjan, 2012: 8). In contrast, the institutionalist perspective sees governance as concerning the rules that distribute authority, roles and responsibilities among societal actors (Brinkerhoff & Bossert, 2013).

Governance can be carried out both with and through networks, which are sets of generally stable, non-hierarchical and interdependent resource-sharing relationships among actors with a common interest (Rhodes, 2007). The concept of governance networks is useful for analysing the interactions among health service providers in DRC. Although constitutionally owned by the state, the DRC health sector is in effect a common-pool resource that is owned by everyone in community, where all of the key stakeholders are potential governance practitioners (Abimbola et al., 2014).

In the contemporary networked world, solutions to global problems are increasingly based on networks and informal relationships instead of hierarchy and authority (Maarten & Hendrik, 2003; Maria, 2011; ODI & FDC, 2003). The idea of governance networks represents a new paradigm in service provision and policy making that has increasingly gained popularity amongst scholars. Arguably in developing countries especially, the idea of a Weberian state providing the full array of public goods and services has proved to be simply utopian (Titeca & de Herdt, 2011). This brings to light the necessity of networks for public service delivery in these countries.

In addition to determining how policy is set up, actors in a governance network also contribute some of their own assets to make the policy operational (Torfing, 2005). Although governance networks necessarily relate to the networks of actors engaged in public governance (Torfing, 2005), there is no agreement on the specific definition (Dedeurwaerdere, 2005; Esty, 2006; Torfing & Sørensen, 2014). Here, we adopt the 'governance school' definition, which 'conceives policy networks as a specific form of governance, as a mechanism to mobilise political resources in situations where these resources are widely dispersed between public and private actors' (Carlson, Maw & Mafuta, 2009).

Highly relevant for the case of the health system in the DRC, governance networks may play an important role when governments fail: When non-state actors step in to compensate for the state's failure, they may also contribute to the state's capacity development and help to improve state policies (Börzel, 2011). In contexts such as the DRC, where the state has retreated from its basic social functions, empirical solutions through which public services continue to be provided have been negotiated in response to the state's incapacity (Titeca & de Herdt, 2011). However, in weak settings where the state is unable both to implement its public policy and to coordinate non-state actors' interventions, the governance networks may face critical problems in terms of the effectiveness, accountability and legitimacy, and critics caution that governance networks should not be seen as 'cure-alls' in fragile contexts (Börzel, 2011; Torfing & Sørensen, 2014).

Weak states have difficulty taking up a regulatory role, ensuring harmonisation and integration of non-state interventions and coordinating stakeholders taking over state functions such as basic service delivery (Provan & Milward, 2001). Relatedly, the ideal role

of the state in governance networks is unclear; such networks may advance partnerships, or they may strengthen the role of the state, eventually making the state the central actor in the networks (Stel et al., 2012).

To this point, there has been little research or evidence on how the interdependent stakeholders in the DRC's health sector interact, or on how these stakeholders contribute to health care delivery and to state-building. The present study aims to explore governance networks in the DRC's heath sector, examining how multiple stakeholders work to manage the health system. Therefore, the following question guides this chapter:

> How does the health system governance characterised by multi-stakeholders' engagement function, and how has this de facto networked governance been relevant for the state formation process in the fragile context of the DRC?

Thus, the study also aims to investigate the implications of these governance networks for the health system and the state formation process in the fragile context of the DRC. Our findings map the actors involved, as well as the nature of stakeholder interactions and their methods of working, and demonstrate how governance networks work in practice in a context of fragility.

History and Context: Public Governance and the Health System in the DRC
The health system in the DRC has been progressively made and remade, and understanding the current system requires an overview of its trajectory of institutionalisation, as well as the public policy-making process and patterns of inter-organisational interactions.

Evolution and Institutionalisation of Public Health in the DRC
Tracing the development of the public health sector alongside the DRC's state-building history reveals how historical factors and political context influenced the design and management of the sector. The health sector has been the state's flagship division for public policy making since the colonial era. However, although the governor general under the Colonial Ministry played a pivotal role in public policy during the colonial period, including staffing and financing the health sector, private actors and churches were also deeply involved with public health management (Lyons, 1994). Following the disturbing persistence of sleeping sickness in the Belgian Congo in the early 1900s, the state increased its provision of medical services, ultimately resulting in a public health policy (RDC/MINISANTE, 2006). In

1908, a new colonial charter provided for the health of the Congolese population. This departed from earlier legislation, which was primarily concerned with the health of European residents in the Congo (Lyons, 1994). Next, in 1922, a Colonial Hygiene Service was established. After World War II, the Belgian Congo was divided into districts, with each district functioning as an operational unit with a medical centre and lower-level satellite health centres and dispensaries (RDC/MINSANTE, 2010).

When the DRC became independent in 1960, it inherited a health system that relied on hospitals and clinics backed up by mobile teams for controlling major endemic diseases (RDC/MINISANTE, 2006). In the first decade following independence, the national health sector hardly existed, and non-state actors, especially churches, took charge of most health services (Lyons, 1994: 377). There was, however, an awareness of the need to reorganise the health system, as was underscored in the Manifesto on Health and Well-being, which was published in 1968 (RDC/MINISANTE, 2012b). To put these ideas into practice, the National Council for Health and Well-being was set up in 1973. The Council was to be responsible for designing, directing and monitoring the national health policy (RDC/MINISANTE, 2012b). In addition to major political developments, the 1970s were marked by experiments with community medicine carried out in selected locations throughout the DRC. In the course of those new initiatives, churches and donor organisations—designated as traditional partners in the DRC national health policy (NHP)—played a momentous role, mostly in terms of policy formulation, system management and the funding of the sector. These experiments gave rise to the health zones (HZs), the first decentralised health facilities in the DRC (DRC/MINISANTE, 2006).

In terms of primary health care principles, Zaïre was considered a forerunner on the African continent in the 1980s and even 1990s, with a public health care charter in place that set out a health policy based on health districts (Delamalle, 2004). In 1975, the first national conference on community medicine adopted the principles of integrated care and proposed the creation of geographically defined HZs and the decentralised management of health care services. The 1978 Alma Ata Declaration on Primary Health Care took up the concept of health districts, and the DRC was seen as a showcase example for other countries. International donor support contributed to the development of the health sector in the DRC (Delamalle, 2004). In 1984, the DRC completed its health policy and strategy, giving concrete expression to its accession to the Charter for Health Development in Africa

(RDC/MINISANTE, 2006). At the completion of the restructuring of the health sector in 1985, the country was to be subdivided into 306 HZs (World Bank, 2005). This increased to 515 in 2001 (Waldman, 2006).

The public mismanagement that characterised Mobutu's regime undermined international cooperation with the DRC's traditional partners. Because of declines in donors' trust, their enthusiasm for the extension of coverage through operational HZs waned from 1987 to 1991. A shift of political regime at the national level offered an opportunity to reconsider all aspects of national governance; the collapse of Mobutu's dictatorship was regarded by many as an opportunity for resuming development cooperation. Since the 1990s, several meetings that were important for the health sector were organised in the DRC, including the States-General on Health (1999), the *Santé Rurale* (SANRU) symposium (2003) and the Round Table on Health (2004). The need for a revised NHP proved to be imperative. The government understood, at least formally, that setting up an NHP was essential for achieving sustainable socioeconomic development.

The NHP was introduced in 1984 and revised in 2001 following the health sector states-general recommendations in 1999. The revision of the NHP also followed the DRC's subscription to a number of international declarations, such as the Alma Ata Declaration on Primary Health Care (1978), the African Charter for Health Development (1980) and the Bamako Initiative of 1987. The NHP aims to promote the health of the population by providing a package of high quality, globally integrated health care and continuously calling for community participation through HZ management structures (RDC/MINISANTE, 2012b).

In 2006, along with development partners, the DRC government adopted the first version of a Health System Strengthening Strategy manual. This manual was revised in 2010. The objective of the Health System Strengthening Strategy was 'to impose better controls, licensing and regulation in the private sector' (Carlson et al., 2009). An evaluation of the strategy identified three key roles for the government to improve the accountability of health partners: 'a normative role, a regulatory role and a coordinator role' (Carlson et al., 2009: 18–19). The strategy was operationalised through a five-year implementation plan called *Plan National de Développement Sanitaire 2011–2015* (PNDS). Together, the strategy document and the national plan constituted a turning point in the process of reforming public health with respect to health care delivery, system design and management in the DRC.

Health Care Delivery, System Design and Management in the DRC

Following the Alma Ata Conference, the DRC further developed its hierarchical structure of health care provision, with the system being organised at three levels: central, intermediate (provincial) and operational (HZ) (Bukonda, Chand, Disashi, Lumbala & Mbiye, 2012). At the central level, the Ministry of Health (MoH) is responsible for general sector policy and system regulation, national programmes and tertiary hospitals (Waldman, 2006). The design and organisation of health policy are handled at this level. 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 has considerable administrative power over the HZs. Health workers, for instance, are supposed to be appointed by the state, even when an HZ is managed by a non-state agent.

In light of ongoing public management reform in the DRC, the health system is moving in the direction of financial decentralisation, making the provinces directly responsible for health services. Pursuant to this process, the health sector will fall under provincial jurisdiction. This policy might undermine the principle of equity and promote uneven development—something that is already decried across and within provinces when the government fails to enforce equity principles. Officially, according to Article 181 of the Constitution, a national pooled fund should ensure that economically less powerful provinces have comparable sums of funding available.

The delivery of public health at operational level happens through the HZ, which is a de-centralised entity in charge of planning, implementation, monitoring and evaluation of primary health care strategy in accordance with the NHP. HZs have considerable autonomy but must be accountable to the MoH. Each HZ is subdivided into sub-health areas (*aires de santé*), which offer a minimum level of health care services. In each HZ, more advanced care is provided in a general referral hospital (Waldman, 2006). Referral hospitals are not necessarily state-led; they may also be led by non-state actors.

Methods

This chapter examines the current state of the health sector in the DRC. In particular, we explore interactions between relevant state and non-state actors operating at each level of the

health system in the DRC and also investigate the effects of these interactions for the maintenance of the health system and the development of the state.

This study is based on 19 months of qualitative data collection at the national, provincial and operational levels. Policy-making interactions concern the management of the health sector throughout the country, but operational interactions are particularly obvious in eastern DRC, where ongoing conflicts have led to a particularly high level of international engagement in health care delivery. For that reason, the main focus of this study was on the eastern province of South Kivu.

National-level data were collected in Kinshasa, provincial-level data in South Kivu and operational-level data in two HZs in South Kivu—namely, Katana and Uvira HZs. In both HZs, interactions between the state and non-state actors are very intensive, although Katana is a Catholic Church co-managed HZ, whereas Uvira is a state-led HZ. Grounded in a thorough review of existing literature, the study drew upon multiple methods of data collection, including unstructured interviews, semi-structured interviews, focus groups and both direct and indirect observation.

Interview and focus groups participants included key informants from the state, as well as representatives of international and local NGOs, health care providers and beneficiaries. Respondents from all quarters acknowledged the relevance of state and non-state actors' interactions to ensure the functioning of the health sector in the DRC.

Non-state actors participating in interviews and/or focus groups included representatives of the World Health Organization (WHO), UNICEF, the Dutch NGO Cordaid (in Bukavu and Kinshasa), *Médecins Sans Frontiers* (MSF) Hollande and France, Malteser, the Belgium NGO *Louvain Coopération au Développement*, the UK's Department for International Development (DFID, in Kinshasa), the International Rescue Committee (IRC), *Projet de Santé Integrée* (PROSANI), *Coopération Suisse*, Caritas Congo (Bukavu and Kinshasa*), Eglise du Christ au Congo* (ECC Bukavu and Kinshasa) and the Civil Society Office in Bukavu. Public officials participating in the study were mostly from the MoH in Bukavu and Kinshasa, the Provincial Inspectorate/Department of Health and local health system management boards that supervise 10 HZs. Data were collected through interviews and focus groups with over 500 beneficiaries in Bukavu, Katana, Uvira and Idjwi. NVivo qualitative

data analysis software was used for data management and analysis. The study faced challenges in gaining access to updated data from DRC government records on health and interactions with non-state actors.

Results and Discussion

The DRC Health System as a Governance Network

Understanding the governance network operating within the DRC's health system necessitated an in-depth analysis of the system's architectural set-up and operational functioning.

Governance network or embodiment of institutional fragility?

In the DRC health system, non-state actors participate not only in service provision but also in organisational management and the government's sectoral policy making, which takes place at national level. In the province of South Kivu, for example, 13 of the 34 HZs are managed or co-managed by the Catholic Church, and seven are managed or co-managed by the Protestant Church Counsel (*Eglise du Christ au Congo*, ECC). In many remote areas where the state is virtually absent, churches or international or national NGOs are the only health service providers.

In the management of the DRC health system, multiple scholars have argued that non-state actors play the role of surrogate state-like service providers (Bailey, 2011; Devisch, 1998; RDC/MINISANTE, 2012b). Scholars have recognised that the provision of statehood outputs by a multitude of actors—including non-state actors—is a reality in many post-conflict and low-income countries (Zürcher, 2007). The involvement of non-state actors in the DRC health sector, specifically, has been widely acknowledged in previous work, (Bailey, 2011; Devisch, 1998; Waldman, 2006), but this research gives more insight on institutional patterns of stakeholders' interactions and state-building outcomes of networked governance in the health sector.

Since the 1990s, the broader literature on governance within and beyond the state has focused on non-hierarchical modes of coordination and the role of non-state actors in setting up and carrying out public policy (Börzel & Risse, 2010). Following Kilduff and Tsai (2003), Provan and Kenis (2008) argued that interactions among multiple actors in the network may be

characterised as either goal-oriented or serendipitous. Goal-oriented networks have become extremely important as formal mechanisms for achieving multi-organisational outcomes, where collective action is often required for problem solving. Serendipitous interactions develop more opportunistically, often within goal-oriented networks.

In the DRC health sector, we found that stakeholders' interactions are both goal-oriented and unanticipated. They can be seen as goal-oriented because the national health policy recognises the state's long-term partnership with non-state actors (RDC/MINISANTE, 2003). These interactions can also be seen as part of a serendipitous governance network because these interactions have often developed opportunistically; this can be seen especially in the increased engagement of NGOs in the 1990s in response to the fragility of the state, recurring wars and the resulting social vulnerability, which was compounded by longstanding humanitarian conundrums, especially in the eastern regions. Due to their large number and the heterogeneity of their operational agendas (ECA, 2015: 101), serendipitous actors have posed a challenge of coordination for the DRC.

In line with these two types of interactions, DRC public health policy recognises two categories of non-state partners: traditional partners, such as churches, and situational partners, which refers to international NGOs operating in the sphere of humanitarian emergencies and a few in health system development. The traditional partners have a long record of involvement, and some state functions have been formally delegated to them. The situational partnerships, in contrast, are characterised more by dynamic than static processes, and interactions between actors are not imposed through authority structures or legal contracts (Jones, Hesterly & Borgatti, 1997). These different histories and characteristics of partnerships may have implications on policy-making processes and on the effectiveness of multi-actor health provision.

The role of the state in the health sector governance network

Exploring the DRC's health system through the lens of governance networks implies considering the system to be the product of an interactive process in which the locus, rules of the game and levels of interaction may have multiple forms (Stoker, 1998). Within the DRC health sector, interactive relations between state and non-state actors take place at numerous

levels. These relations take shape in various ways and are not necessarily imposed through top-down policy making.

Previous work has distinguished three basic forms of governance networks: participant-governed, lead organisation-governed and network-administrative organisation (Provan & Kenis, 2008). Within these networks, decision-making is carried out jointly (participant-governed network), by one of the actors involved (lead organisation-governed network) or by a separate administrative entity set up by the partners for this specific purpose (network-administrative organisation) (Provan & Kenis, 2008).

Our analyses indicated that health system management in the DRC is characterised by a blend of participant-governed and lead organisation-governed networks. It embodies participant-governed networks because its functioning depends on the involvement of all committed partners, who interact in a decentralised system, in different arenas and on a relatively equal basis to achieve health outcomes. It also has characteristics of a lead organisation-governed network, as all major network-level activities and key decisions are supposed to be coordinated through and by the MoH. From the DRC's NHP perspective and its Health System Strengthening Strategy manual, it appears that a lead organisation-governed network, with the MoH as the lead actor, is both a state policy and an aspiration.

Unfortunately, the reality often shows the absence of state leadership in the realm of public health service provision. This research found out that the implementation of policy plans and health sector networked governance strategies is undermined by the state's weakness, which is embodied in multifaceted ways. The *Evaluation de la Coopération de l'Union-Europeénne avec la République Démocratique du Congo 2008–2013* report describes state weakness in the DRC in terms of institutional fragility, poor public governance, shortages of budgetary resources, weak compliance with the principles of the state of law and the reticence to engage meaningfully in political sector reform (ADE, 2014).

Nevertheless, an empirical example from our fieldwork illustrates how, in areas where the state has little effective involvement, it takes up (or is attributed) its regulatory role, even if only in a formal way: During a meeting in March 2015 at the Provincial Department of Health, two international NGOs presented the findings of an original survey on sexual and reproductive health. At the end of the meeting, the international NGO representatives

requested the endorsement of the Ministry for the validation of findings before further dissemination and publication. The request was accepted. This example shows that, although the state's existence and value is sometimes disputed (what/who and for whom it is), its nominal shadow is ubiquitous in internal multi-stakeholder interactions.

Regarding health system management, most informants recognised some progress in terms of policy making, especially with the Health System Strengthening Strategy as a reform framework. However, they also complained about the government's lack of capacity and its unwillingness to implement rational policies. From in-depth interviews held with public health officials and civil servants, it was clear that the state is aware of its duties, and even of the relevance of the provision of public services, especially those related to public health. During a meeting at the Provincial MoH, a research participant acknowledged the importance of the role the state plays in public health for the state's survival:

> Health is the pillar of state-building for the reason that it ensures the welfare of the citizenry. Service delivery lies in the realm of state sovereignty, for otherwise the latter will lose its authority. People accept state authority because of the services they receive.[2]

Correspondingly, satisfactory service delivery performance has been identified in past work as one dimension through which a state fulfils the population's needs and expectations (Fritz & Menocal, 2007). Indeed, in the present study, we found that public administration regarding health policy implementation was one major point of reference for people's overall perceptions of the state.

However, despite evidence of the state taking up some roles in health sector management, ordinary people involved in this study largely perceived the state as absent in the health sector. This was illustrated by statements made during a focus group discussion with 20 community members from Lwiro, South Kivu Province. These participants were asked about their views of the state's role in the health sector. A young man stood up and said, 'With regard to the state, I have a feeling of profound and mortal regret ['*hasira ya kufa*' in Swahili]. I feel driven to war against the so-called state, but, alas, as I have no means to face the state by war, then I can but pray.' A more senior man, of whom one would culturally

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[2] Interview, Bukavu, 10/10/2013

expect a more nuanced view, added, 'There is no state. It is completely absent. Be it in the health sector or in public administration, there is no state at all'.[3]

Perceptions of the absence of the state in the health sector appear to have contributed to views regarding the state that are negative overall. However, despite the perception of ordinary people that the state plays no role in the health system, close observation as part of this research revealed that there is in fact a shadow of the state taking up some roles in this system. This initial involvement might be seen as the early stages of a fuller participation of the state in the health sector governance network in the DRC.

State-building outcomes of Multilevel State and Non-state Interactions in the Health Sector

The DRC health sector has a pyramidal outlook reflecting theoretical principles of primary health care that are an integral part of the health system (Perrin, 1995). This pyramidal outlook consists of three arenas: national, intermediate and operational.Interactive engagement of non-state actors at different levels of the health system contributes to improving institutional capacity. In addition to their funding role, non-state actors engage with state institutions for health system management and institutional development. For this reason, DFID's health officer in Kinshasa noted that donors are committed to strengthening state institutions, noting that, 'with this goal, the DRC MoH and its international partners have set up a Management Support Unit [*Cellule d'Appui et de Gestion*] and a Finance Agency [*Agence de Gestion Fiduciaire*] for management capacity strengthening'.[4] Both agencies are multi-actor mechanisms for donor interventions coordination at national level (ADE, 2014: 99).

Based on observations of the DRC health sector, this research realised that the involvement of non-state actors at the central, intermediate and operational levels indicates the presence of a governance network because of the patterns of multi-level interdependencies and collaboration between the state and its non-state partners. The involvement of non-state actors at each of these levels indicates the presence of a governance network (see Figure 7).

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[3] Focus group, Lwiro, 27/04/2014
[4] Interview, Kinshasa, 24/01/014

Figure 7: Multilevel Health Sector Networked Governance Arenas for Stakeholder Interactions

Multi - level health networked governance	Main activities and actors' expected roles	Corresponding actors/stakeholders	Modes of interactions	Main challenges
Level III : *National / Macro-Level*	Policy making, regulation mechanisms, sector funding, interactions with high level stakeholders (Donors/ INGOs), signing of Framework Agreement & MoU.	MoH (& other relevant ministries), Bi- & multi-lateral donors, UN-Agencies, INGOs, National representatives of some FBOs.	Central level networked governance based on interdependency among key stakeholders; MoH playing the lead organisation.	Trust between the state and donors / INGO; Institutional fragility and endemic corruption; Power imbalance; Building policy coalition, etc.
Level II : *Intermediate / Meso -level*	Health sector management/ Policy enforcement, Meso-level stakeholder interactions; signing of meso-level/ specific agreements and MoU with NSPs, support to operational level.	The Governor, provincial MoH (other relevant ministries & public agencies), donor organisations, I/NGOs, UN-Agency representatives, FBOs and relevant CBOs.	Intermediate network level based on resource interdependency and signed agreements	Trust, institutional fragility, failure of policy coalition building, failure to coordinate some external stakeholders, overlapping institutions/offices and centres of decision making; failed decentralization, etc.
Level I : *Operational / Micro-level*	Health Service production and delivery, Micro-level stakeholder interactions, health scheme experiments, Community health and primary health care principles implementation, Operational Agreements etc.	Health Zone (HZ) Management Board, Referral Hospital Directorates, Health Centres, I/NGOs, donor interfaces, local chieftaincies, FBOs, CBOs, Comités de Développement de l'Aire de santé (CODESA).	Local level networked governance: both autonomous operationally and dependent administratively regarding resources and policy, parallel institutions, *the breeding ground for real networked governance*	Weak enforcement of national health policy, weak human resources management (HRM), unattended social health determinants, societal fragility, political influence, etc.

General public/ population (beneficiaries and clients) nesting the health system and playing the role of the reservoir for stakeholders' legitimacy

The DRC health system is deconcentrated at provincial level through the HZ management offices (*Bureau Central de Zone de Santé*) representing the MoH and decentralised at operational level by means of the HZs' operational autonomy. The governance network including the state and its development partners is multilevel in terms of interaction arenas but also multidimensional in terms of the nature and content of interventions.

Interactions among state and non-state actors in the health system reflect the architectural design of this system (RDC/MINISANTE, 2012b). Networked governance operates in various arenas of the health sector, with either traditional non-state partners (faith-based organisations and community-based organisations) or development NGOs (RDC/MINISANTE, 2003). Impaired by advanced state disruption, these interactions take different forms, as the embodiment of integrative network governance for sector strengthening, as the reflection of an aggregative body with disparate interests or even as quintessential manifestations of statelessness and chaos. On this point, in an individual interview, a top official from the national partnership department in the MoH noted, 'Donors come with their own agenda according to their respective interests, and as a consequence there is always a priority-setting problem between the state and donors'.[5]

With integrative actors such as faith-based/community-based organisations and traditional bilateral and multilateral cooperation partners, it is possible to build up a 'policy community'. However, with some other actors—mainly humanitarian international NGOs and private for-profit organisations—our findings indicate that interactions are generally difficult, because these actors pursue their respective agendas based on a short-term emergency logic or a for-profit approach. This results in policy selectiveness and vertical interventions, which contrast sharply with the integrated approach. In individual interviews, state officials in Kinshasa and Bukavu denounced non-state actors for operating through vertical programmes, bypassing the state as though the state should align with their programmes.

Nonetheless, for many interviewed representatives from the state civil service, churches and frontline providers, interactive governance including state/non-state partnership accounts for the persistence of the health sector in the DRC. Even the most critical of the high profile state officials in Kinshasa acknowledged the vital role of this kind of partnership for the survival of the sector: 'There is a contribution from the partners, as you know the state budget does not include health services; state budget provision is limited to only institutional support (administration) and salary, but the partners fill the gap for health interventions'.[6]

Our findings demonstrate that partnership with non-state actors was often regarded by state actors as the only way they could live up to the population's expectations. In one of the focus

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[5] Interview, Kinshasa,17/01/2014
[6] Interview, Kinshasa/MoH, 24/01/2014

group sessions with state officials at the Provincial Inspectorate of Health, a participant posed a rhetorical question: 'What would have come of the public health sector without the involvement of non-state actors?[7] This opinion, which our results indicate is widely shared by Congolese actors of all outlooks, points to the relevance of non-state actors for the DRC health sector.

Inputs from donors in terms of technical and financial support coupled with non-state national actors' commitment fills the vacuum created by the empirical ineffectiveness of state institutions across many dimensions and many geographical areas in the DRC. During an interview, the administrator of a health clinic in South Kivu praised the work of donors:

> International and local NGOs have been working and reaching out where the state is absent. *Aide Médicale Internationale* [AMI], the International Rescue Committee [IRC] and Malteser, for example, have a deeper understanding of the population's situation in Fizi-Itombwe, Mwenga and Shabunda than any state agency. These international NGOs have a better understanding of the health territory than the governor and even the Provincial Health Department. The latter discover through and refer to international and local NGOs' demographic health records to get an image of what the situation looks like.[8]

Overall, our findings indicate that state and non-state health service providers shared a general acknowledgement of international and local NGO inputs in public health governance even at grassroots level.

The Operational Functioning of 'Partnerships' between State and Non-state Actors

The DRC's public health policy identifies several types of counterparts, officially called partners: the state, private non-profit organisations, private for-profit organisations, the population and external funders (RDC/MINISANTE, 2003). The government recognises a dichotomous typology of non-state partners, consisting of external and internal actors. External partners provide the sector with financial and technical support, whereas internal partners contribute to the sector with their expertise and act as service providers. In cases of humanitarian emergencies, some external actors, such as MSF, also provide health care services on the ground. The government signs different kinds of agreements, contracts and memoranda of understanding based on typologies of interventions, as well as the scope and

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[7] Interview, Bukavu, 17/11/2013
[8] Interview, Bukavu, 09/03/2015

nature of activities. These include bilateral and multilateral agreements, frameworks and specific agreements, and protocols with a wide spectrum of actors. With internal partners such as churches, framework agreements are signed with regard to health care provision and the co-management of public structures in critical situations.

Among external partners, different types of engagement can be distinguished. In operational partnerships, international NGOs or donor organisations engage at the grassroots level by providing or supporting health services (e.g. *Coopération Suisse*, USAID, IRC, Cordaid and *Louvain Coopération*). In bilateral cooperation, external partners engage with the state at central level (e.g. Belgian Cooperation, French Cooperation, Canadian Cooperation and the United States/USAID). In multilateral cooperation, external partners interact with both the state and their internal partners (e.g. World Bank, Development African Bank (DAB), IMF, EU/ECHO, Global Alliance for Vaccine and Immunization (GAVI), UNICEF, United Nations Population Fund and WHO). Some external partners act at the interface between international institutions and national partners (e.g. USAID, UNICEF, Cordaid, USAID and IRC). Development partners are supposed to be accountable to the state not only in terms of administrative or political accountability but also through 'peer accountability' in networks, involving mutual monitoring of performance (Goodin, 2003).

The full implementation of the Paris Principles on Aid Effectiveness (OPM/IDL, 2008), such as alignment and coordination, has been a contentious issue between the state and its partners. The majority of international NGOs focus on vertical programmes, whereas the state wants to transition to system-building, also called horizontal or integrated interventions under the government's leadership. Unilateral intervention schemes by international NGOs were denounced by many state officials as feeding into the weakness of the sector. In speaking about the real world of international NGOs and their everyday interactions with the state, one top state official in the sector voiced a complaint: 'They take advantage of the weakness of the state to implement their personal agenda'.[9] This official, along with many others, expressed frustration and a feeling of impotence (see Chapter 3).

Representatives of international NGOs interviewed in Kinshasa and Bukavu expressed the view that mistrust between the state and external actors results from allegations of corruption. To provide key interventions at the HZ level, funding agencies have preferred channelling

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[9] Interview, Kinshasa/MoH, 17/02/2014

resources through international and local NGOs and faith-based organisational partners. In the present study, opinions converged concerning the impact of donors in health care. They are necessary for funding, but opinions on their impact on strengthening the health system differed. As for the implementation of the Paris principles, a number of informants, including state actors, acknowledged that some efforts are being made but that much is left to be done.

Cognisant of the challenges presented by the increase in the number of uncoordinated actors and partners in the health sector, its own weakness and the imperative need to assure external partners, the DRC aligned itself with new mechanisms developed at international level, such as the Paris Declaration and the Accra Action Programme (Zinnen, 2012). During the High Level Forum on Aid Effectiveness in Kinshasa (2009), the government and its partners reaffirmed their mutual commitment to stimulating the development sector. In 2010, the government also subscribed to the International Health Partnership and related initiatives to operationalise the Paris Declaration commitments in the health sectors of developing countries. Despite the adoption of the Health System Strengthening Strategy, donor interventions have been mostly vertical, hardly aligned, scarcely harmonised and uncoordinated. Participants in the present study also reported the lack of state leadership and the absence of a shared vision about the health system as causes of the weakening of the system.

To restore the state leadership and stakeholders' alignment, the MoH set up a consultation framework consistent with both strategic and operational needs. This framework (*Comité National de Pilotage Santé*, CNP-SS), chaired by the MoH, is composed of key stakeholders engaged in the health sector. The CNP-SS is duplicated at provincial level (*Comité Provincial de Pilotage Santé*, CPPS) under the leadership of the governor and is represented at operational level by the HZ coordination offices (*Bureaux Centraux de Zones de Santé*). Though much is still needed in terms of the MoH's leadership and institution building, the CNP-SS provides a venue for consultations and intervention coordination.

Though faced with the challenges of endemic weak governance and their own factional agendas, donors have shown a certain degree of determination to accompany the DRC along the way to recovery through initiatives such as the following (Zinnen, 2012):

- The Inter-donors Consultation Framework (*Groupe Inter-Bailleurs Santé*) with the purpose of supporting the MoH in the coordination, harmonisation and alignment of partners, as well as public health policy implementation;
- Humanitarian cluster groups, a formal and continual framework for consultation and dialogue between the government and donor organisations;
- The Management Platform for Aid and Investment and the Support and Management Unit, a mechanism to ensure that management principles of the sector are respected as much as possible.

Although the effectiveness of these structures has been questioned in terms of procedures and actual engagement, the existence of these initiatives nonetheless indicates efforts to work towards a system of networked governance-based interactions between the government and its partners.

Arenas of Interaction and Methods of Engagement in the Health System
The pyramidal configuration of the DRC health system's multilevel governance requires an analysis of actors' different methods of engagement in the health system that considers the three levels at which interaction takes place.

Macro-level networked governance
At the central level, the health system is an arena of top-level interactions for horizontal discourse among stakeholders for the purpose of creating a policy community. These interactions take the form of negotiations, which lead to collaboration and cooperation around frameworks and specific agreements. The MoH makes up this central level of the health system and has a standard-setting and regulatory responsibility at this level. This central level is an arena where multilateral and bilateral contracts and framework agreements are negotiated and signed. Although the state has remained defective in its stewardship responsibility as public caretaker of population welfare, the MoH conceives, formulates and frames the national health policy.

The macro level is the recommended entry point for international engagement, but the MoH has deconcentrated and decentralised structures at provincial and HZ levels that are entitled to handle relevant issues at their respective levels according to partners' specific portfolios. However, for partners whose interventions require framework agreements such as multilateral

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or bilateral contracts, the current configuration implies direct involvement with the national MoH. At this level, negotiations usually result in signed contracts and conventions, frameworks and specific agreements of national scope. The national health policy, but also both the Paris Declaration and the International Health Partnership are reference frameworks for the signing of bilateral and multilateral agreements. In interviews, state officials noted that negotiation is not always smooth between the stakeholders. Power dynamics often determine the outcome of negotiations.

Most of the complaints from state actors recorded in the present study were located at the macro level and related to imbalanced power relationships during negotiations. In the negotiation process, donors enjoy both expert legitimacy and financial leverage for policy making and enforcement; the government, although it is weak, brandishes its juridical sovereignty. What gives donors the upper hand is not only the weakness of the state, but also financial resources that influence national politics and claims of expert knowledge that are, from a Foucauldian perspective, mobilised as a controlling power (Rawlinson, 1987) to shape others' mind-frames and worldviews. Agreement frameworks nevertheless include some non-negotiable matters related to sovereignty and the NHP.

Intermediate arena of interactive governance

The intermediate level is the location for managing national policy at provincial level, regulating health care provision processes and accommodating population expectations on the basis of evidence-based planning conducted at the operational level. The intermediate level is normally responsible for technical support and NHP implementation supervision at operational level (Zinnen, 2012). In the new configuration established in the 2006 Constitution, the Provincial Ministry assumes a political role, and the Provincial Department plays a technical role for the Provincial MoH. This new configuration splits the Provincial Department of Health into the 'Provincial Health Division', which functions as the corresponding MoH at provincial level, and the Provincial Health Inspectorate as a technical branch of the national MoH. Roles and functions of these three organs are still overlapping, and much work is still needed to streamline their collaborations.

To successfully fulfil its public mission, the state's health department engages with development partners to support state interventions. This accounts for the signing of different

deeds of collaboration at this intermediate level of the multilevel governance network. At the intermediate level, protocols and addendums may be signed, depending on the projects. The intermediate level witnesses the signing of memoranda of understanding and conventions related to packages of activities for programmes with framework agreements already signed at the central level.

Depending on the type of interventions being carried out, external interveners can be classified as either developmental, working to provide institution-building support, or humanitarian, with emergency-based interventions. We found that, of over 150 international NGOs engaged in the health sector in South Kivu in 2014, only about four engaged in sector-strengthening and took a developmental approach. Those organisations that have shifted to development are the Internal Rescue Committee/*Projet de Santé Intégré* (IRC/PROSANI), Malteser/*Projet d'Appui au Système de Santé* (PASS), the Belgium NGO *Louvain Coopération au Développément* and the Dutch NGO Cordaid. These international NGOs provide comprehensive support to the government for system strengthening, though not throughout the entire province. They also offer integrated support to the HZs covered by their respective interventions. However, these NGOs differ in terms of interventions as well as methods of engagement (inputs-based funding for *Louvain Coopération au Développément*, outputs-based funding for Cordaid, or a blend of both as seen in IRC/PROSANI).

At the provincial level, we can also witness sub-arenas of interactions where stakeholders play interactive games, including the Cluster Santé Thematic Group among non-state actors and the Provincial Health Steering Committee (*Comité Provincial de Pilotage Santé*, CPPS). Both venues duplicate and reflect the workings of the two frameworks at central level. The CPPS as an inclusive framework is typical of networked governance, where stakeholders directly interact, negotiate and use their respective capital leverage through trade-offs to get their payoffs. The CPPS includes ad hoc thematic commissions designed for orienting non-state interventions. However, the effectiveness of these commissions, as is the case for the entire governance process, is still undermined by the consequences of state fragility. In principle, however, when a partner wishes to engage in any subfield, the CPPS is supposed to refer them to the relevant commissions.

Hence, networked governance is found at the intermediate level, in that consultation is theoretically the agenda of the day through the CPPS, where it is possible to adopt concerted

decision-making and planning, conduct discussions and secure experience sharing. This process did not exist until recently, and its implementation is still lagging behind, because policy alignment has been a significant problem in interactions between the government and external partners. Some HZs, especially around Bukavu, are reportedly saturated with local and international NGOs. In sharp contrast, several HZ directors from remote zones, which are also the most war-affected areas, said that their HZs suffered from either the absence or the insufficient presence of these organisations.

Operational arena of interactions

The NHP is operationalised in the HZ, which is the arena where interactions between state representatives, service providers, local and international NGO interfaces, local faith-based organisation representatives and community leaders may take place. The HZ Central Office is the official venue for operational planning, monitoring, evaluation and activity reporting for primary health care. HZ business meetings develop an operational anatomy of the needs of the population that is then submitted to the intermediate level—or, for the luckier HZs, to local or international NGO partners. Prevailing opinion is that, without partners, work conditions are difficult to manage. One of the faith-based organisation health structure managers interviewed in Bukavu, who had experience in health service provision in village zones, made the following argument about the input of donors and local and international NGOs: 'In any way it is hard to work without partners, especially in villages like Kaziba […] where the HZ might even close its doors because the Norwegian government that used to support the CELPA[10] health department stopped'.[11]

As is the case for other levels, non-state actors such as churches and local and international NGOs bargain with one another, striking trade-offs based on their respective expectations and power positions. During the fieldwork, informants reported rivalry and even competition between state and non-state actors—especially churches—in some HZs regarding personnel staffing. Informants described instances where churches or INGOs imposed their individual preferences regarding personnel appointments. There were also reports that the HZ has sometimes been the ground for 'turf wars', especially between Catholic and Protestant churches tacitly competing for factional influence. The Catholic Church is strongly rooted in the northern part of South Kivu, especially in Bukavu and surrounding territories, while

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[10] *Communauté des Eglises Libres de Pentecôte en Afrique*
[11] Interview, Bukavu, 16/3/015

Protestant churches are more present in the very remote HZs. However, it is not only churches that engage in competition; considerable horizontal competition was also reported among local and international NGOs with overlapping programmes, especially in areas where their presence was reported as saturated—mostly in the northern part of the province. This is to say that the HZ is not only an arena of interactions but also an open ground for factional influences and competing struggles between state and non-state actors—especially churches—regarding staffing, among local and international NGOs or their interfaces and sometimes between these NGOs and the HZ Central Office.

At the operational level, there can be conventions/protocols with the HZ management office along with NGOs providing health care to the population. Some agreements and memoranda of understanding can be signed at this level, depending on the partner's agenda, flexibility and contextual needs. With the ongoing decentralisation process, this division of power should emerge more clearly in the future. As was the case for the central and intermediate levels, problems of rational management of both financial and human resources, politicisation of the sector and societal divisions continue to be noted.

Conclusion

This chapter has shown how health sector management in the DRC is the embodiment of a burgeoning governance network in which a wide range of different stakeholders interact to solve public and community health-related issues. Four principle themes emerged from our analysis of newly collected qualitative data.

First, the DRC health sector is clearly an arena of networked governance. Although people expressed the opinion that the state was largely absent from health care (and other spheres of life), close observation revealed that the state is in fact taking up some roles in relevant health system interactions and increasingly aims to take the lead. The health sector governance network is not yet fully developed in the DRC, as actors' coordination and the harmonisation of their interventions still pose problems, but there are clear examples of state and non-state service providers negotiating, cooperating and even competing through different sets of institutions, arenas, games and processes.

Second, interactions between state and non-state actors through this governance network contribute to explaining the persistence of the health sector in a setting characterised by state weakness regarding the empirical performance of its functions. Longstanding patterns of negotiation-based interactions between state and non-state actors in the health sector are enacted at the three levels of the health system (national, provincial and operational). The concrete value of state/non-state interactions and partnerships for the maintenance and development of the health sector was acknowledged by a wide range of actors participating in this study.

Third, during interactions, power relations are skewed in donors' favour because of their dominance in terms of resources, a situation that causes the state to be dependent in managing the health sector. It is clear that non-state interventions fill the void where the state exists in name only, and non-state actors have undoubtedly contributed to meeting population needs. However, the role of non-state actors in the DRC's health sector also has a darker side. Paradoxically, through long-term humanitarian interventions, short-term funding, competition and weak coordination, the interventions of non-state actors have had a detrimental effect, as the state is not able to enforce its stewardship role as public caretaker of population welfare. In addition to being hampered by its weaknesses in terms of a lack of capacity for governance and allegations of management misconduct, the DRC state has also faced the challenge of interacting with partners with fragmented and horizontally competing agendas. Consequently, building a policy community has been difficult, and the governance network does not function optimally in the DRC's health sector.

Fourth, though it remains weak, the shadow of statehood authority has been present in the arena of stakeholders' interactions, and the state plays a determining role in providing a regulatory framework and hence in managing the formal room for manoeuvre available to non-state actors. However, the state is still far from becoming stronger through this process, as its lack of functional effectiveness persists.

Ultimately, although the health sector governance network in the DRC cannot fully address state weaknesses, networked governance facilitates the management of population needs regarding health welfare when the state is weak. However, strengthening the role of the state in networked governance emerged as a requisite for balancing power relations among key stakeholders to reinforce its stewardship role, which is crucial for the coordination and

harmonisation necessary for state-building. Therefore, the issue of networked governance effectiveness raises normative concerns about the nature, model and priorities of engagement for policy community interventions in empirically weak states. These emerging concerns will be further explored in the next chapters of this thesis.

Chapter 3: State Fragility Discourse, Models of International Engagement and Health Policy Coalition-building in the DRC Health Sector

Focus group with women in Nuru village (Katana), fieldwork photo

During an interview with the national head of Partnership Direction within the MOH (Kinshasa), field photo

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A pharmacy of one of the health centres wich the author visited in Katana HZ, field photo

Focus group with community-based health committee in Tchiranga village (Katana), fieldwork photo

Abstract

This chapter examines how the discourse on state fragility affects the attitudes of international NGOs and donors towards health interventions in the Democratic Republic of Congo (DRC), as well as the state's engagement with them in the processes of establishing health-related policy. Based on an analysis of policy documents and interviews with key stakeholders at the policy-making, system management and operational levels, we found that fragile statehood has been understood and used differently by donors and state actors. It has become a contentious concept, hampering the construction of a policy coalition for health sector interventions. Donors have rationalised the persistence of emergency-based interventions by emphasising fragile statehood, whereas state officials have preferred to assert political statehood and argue for a paradigm shift towards a higher degree of state control. The lack of consensus on state fragility has influenced mutual perceptions of the state and INGOs/donors. Government officials saw the concept as stigmatising and contributing to difficulties in implementing the Paris Declaration on Aid Effectiveness. For international agencies, the fragility of DRC institutions cannot be ignored when following the Paris Declaration. Nevertheless, representatives of the state and donor organisations agreed that donors' financial contributions ensure the survival of the public health sector. Building a policy coalition based on harmonised views of fragility is necessary for effective engagement and the sustainability of interventions in this sector, but given the current political situation in the DRC, this is not likely to happen anytime soon.

Introduction

State fragility has been a contentious concept in interactions between the state and donors/ international nongovernmental organisations (INGOs) regarding health interventions in the DRC. We explore the consequences of this discourse on fragility for the health sector, especially in terms of how health policy is determined and enacted at various levels. In our investigation, what mattered was not so much the substantive content of state fragility, but rather the interactive processes around this discourse among stakeholders in the health sector. Specifically, we investigated how this discourse influences the interactions between the state, donor governments and INGOs, and how it determines preferences for different modes of intervention.

Our findings indicate that service provision—health care delivery in particular—has become an arena where state fragility is used in diverging discourses regarding health policy and operational intervention models by state officials, donors and INGOs. Empirical research on the ground showed how frontline providers are affected by the reality of state fragility. However, this analysis revealed that the notion of fragile statehood in the DRC is not only fed by such micro-level empirical experience of frontline INGOs at the strategic/operational programming level, but also by a prevailing image of fragility among donors. An analysis of donors' policy documents revealed how donors incorporate notions of state fragility in all

their dealings with the state. This raises the question of whether such notions may hamper an evolution out of state fragility.

The Emergence of State Fragility as a Discourse Shaping International Policy

Broadly, a discourse refers to how one discusses ideas and seeks to communicate them to others. Discourse goes beyond ideas or 'text' (what is said) to include context (where, when, how and why it was said), and it refers to both structure (what is said, or where and how) and agency (who said what to whom) (Schmidt, 2008). In social interactions, discourse plays a role in the expression of content, social relations and personal attitudes (Brown & Yule, 1983). As it relates to the processes of policy making and enforcement, Schmidt (2008) has suggested two basic forms of discourse: coordinative discourse, which takes place among policy actors, and communicative discourse, which is between political actors and the public (Schmidt, 2008). In social and policy realms, the term discourse can have different applications to refer to generalised ideas, beliefs and assertions (Humphreys, 2009). Discourse may also reflect ideologies understood as fundamental beliefs of a group and its members (Van Dijk, 2000), as well as an ideological tool that is both descriptive (providing an account, of society and politics) and prescriptive (providing a normative programme for how society and politics should be organised) (Humphreys, 2009).

The emergence of 'state fragility' as a discourse can be traced back to the end of Cold War (Hehir & Robinson, 2007), but there is still no agreed conceptualisation of this fragility. The threats to international security caused by fragile states have prompted scholars to construct a wide array of definitions of and criteria for state fragility, and sharp differences are also seen in the various policies and strategies of different donor governments and international organisations (Carment, Samy & Prest, 2008; IDC, 2012; Stepputat & Engberg-Pedersen, 2008). In most cases, however, the conceptualisation of fragile states revolves mostly around the lack of capacity and willingness to perform key government functions for the benefit of all citizens (OECD, 2008, 2014).

Popularised by the World Bank and the international development community in the early 1990s, fragility was originally used to describe countries that proved ineffective in implementing structural adjustment reforms (Carment et al., 2008). The subsequent search for how to characterise and possibly restore 'failing', 'failed' or 'weak' states has provided the impetus for the evolution of the concept of state fragility (Osaghae, 2007). Regarded as the sum

of the pathologies of problematic states, the concept of fragility suggests deviation from the dominant and supposedly universal Western paradigm of statehood (Osaghae, 2007). The practical consequences of state fragility gained global attention after the attacks on September 11, 2001. The international reaction to these attacks, focusing initially on Afghanistan, reinforced the underlying perception that poorly governed states constitute weaknesses in the fabric of international society, and that the developed world has a considerable self-interest in strengthening their capacities for governance (Wesley, 2008). Hence, the idea of the 'failed' or 'fragile' state shifted the focus of security thinking from an emphasis on the concentration of state power to concern about zones of state powerlessness, where transnational threats can incubate and spread while exploiting the interdependence of a globalised world to attack developed societies (Wesley, 2008).

In the 2000s, a contentious debate began on the effectiveness of aid in fragile states, and a series of high-level global conferences focused on making aid in these contexts more effective. Some scholars have characterised international development in the 2000s by the aid effectiveness agenda (Hayman, 2012). This agenda went beyond aid conditionality and structural adjustment to emphasise country-led development, partnership and context-specific interventions through a number of milestone high-level meetings, including the Monterrey Consensus on Financing for Development (2002), the Rome Declaration on Harmonisation (2003); the Joint Marrakech Memorandum (2004), the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008) which sought to strengthen and deepen the implementation of the Paris Declaration (Hayman, 2012; Naudé, 2012; OECD, 2008; OPM/IDL, 2008). To sustain the momentum, the Busan New Deal for Engagement in Fragile States was adopted in 2011 with the aim of achieving peace-building and state-building in fragile states through international partnership.

Fragile statehood—as empirical reality and discourse—has influenced international engagement in politically weak settings. However, some, especially those in the Global South, have regarded the state fragility discourse, since its inception, not only as playing a representative role but also as an ideological vehicle for the advancement of Western interests and statehood philosophy under the guise of peace-building, humanitarian intervention, the responsibility to protect, development cooperation and state- or nation-building.

State Fragility: Discourses without a Policy Coalition

The DRC is a notoriously fragile state, as indicated by commonly used indexes on state fragility, such as the Country Indicators for Foreign Policy (2014), which focuses on authority, legitimacy and capacity (Carment, Langlois-Bertrandt & Samy, 2014), and the Brookings Institution's Index of State Weakness in the Developing World (2008), which relies on four domains of public management—economic welfare provision, political institutions effectiveness and legitimacy of the system of governance, physical security and social welfare (Rice & Patrick, 2008).

The DRC has become the embodiment of predatory statehood (Englebert, 2003; Trefon, 2011) and enduring social conflicts. It has weak institutional capacity and is dependent on natural resources for domestic revenues. It is among the world's most aid-dependent states (OECD, 2014). As a low-income and fragile country, its fiscal space for public service provision is limited and unstable. Defined as the availability of room in the budget, fiscal space allows a government to provide resources for a desired purpose without threatening the sustainability of a government's financial position (Heller, 2005). Poor performance in public finance management also makes it difficult to achieve fiscal sustainability (IMF, 2014), which is understood as the capacity of a government to finance its desired expenditure programmes, to service any debt obligations and to ensure its solvency (Heller 2005: 1). The DRC actually displays limited statehood, as the central state authorities are too weak to exercise domestic sovereignty, but it continues to carry out some empirical functions of statehood.

When public sector mismanagement reached its apex during the later stages of Mobutu's reign in 1990s, donors stopped cooperating with the government. This disruption of international cooperation compounded the plight of the population, and public institutions and social services deteriorated rapidly. Since international cooperation resumed in 2001, the DRC has received international multisector assistance, particularity to its health sector but also for security through the *Mission des Nations Unies pour la Stabilization du Congo* (MONUSCO). Although this assistance has not provided a 'magic bullet' for public sector resilience and capacity-building, it has brought new momentum to donors' engagement in the public sector and in state-building. The inputs from donors have dramatically increased health sector activity, and there has been a strong commitment to improvements in the eastern provinces, which were deeply afflicted by armed conflicts. Still, with lingering wars in eastern DRC and the lack of state capacity for social and developmental performance, community

health care continues to face serious challenges, and donor interventions remain essential to save lives and improve community health status.

However, the government and donors have not yet harmonised their perceptions of fragility or reached a common understanding on intervention policy and models of engagement. These divergences lead to dissent about the policies and operational interventions. In terms of collective action framing, without a shared vision on problem diagnosis, solution prognosis and action rationale, the prospects of success are limited (Benford & Snow, 2000). Policy dissent due to clashing understandings of state fragility results in confrontations among the main stakeholders. The discrepancy regarding the state fragility discourse in intervention policy processes concerns the models of engagement rather than the mere meaning of state fragility. This study examined how the state fragility discourse affects the attitudes of INGOs and donors towards state engagement in interventions in the health sector. It specifically asked the following question:

How do key stakeholders—especially the state, donors and INGOs—intervening in the health sector use the discourse on state fragility, and how does this impact intervention programming and policy coalition-building in the DRC?

The present chapter used critical discourse analysis to answer the research question. Critical discourse analysis 'studies the way social power abuse, dominance, and inequality are enacted, reproduced, and resisted by text and talk in a socio-political context' (Van Dijk, 2001: 1). Our study dissected the determinants of the use or avoidance of the state fragility discourse by different actors and examined its impact on the implementation of aid effectiveness principles. The principles of the Paris Declaration of 2005 set out an overall framework of agreement and structure of mutual accountability between aid-receiving countries and their development partners to give substance to the consensus model of 'country-led' development (Wood, Kabell, Mwanga & Sagasi, 2008). Our research revealed that the dissent found in interactive discourse in the health sector regarding state fragility simultaneously has a positive effect on improving community health while undermining the state-building process. Not only does it actually give donors leeway to limit their compliance with the Paris Declaration; it is also an implicit stigma, placing state actors in the politically defensive posture of asserting statehood. Previous research has demonstrated that the dilemma resulting from the obligation to comply with aid effectiveness principles and the need for

practically dealing with contextual challenges in fragile states pushes donor organisations developing shadow alignment (Brinkerhoff & Bossert, 2008). This means that donors may look for openings to introduce elements of good health governance, to the extent possible, as they provide the resources for service delivery in anticipation of creating the architecture for a revived national health system that both fits the country context and reflects the principles of good governance (Brinkerhoff & Bossert, 2008: 19).

Methods

This chapter is part of a larger project examining the state-building aspects of health service provision by multiple stakeholders in the fragile state of the DRC. Fieldwork was conducted in South Kivu and Kinshasa from August 2013 to March 2015.

Research Participants

Three categories of respondents participated in the study: 1) state officials from the Ministry of Health (MoH) from both the Provincial Department in Bukavu and the national level in Kinshasa; 2) representatives of the main health sector-supporting INGOs; and 3) frontline providers, faith-based organisation (FBOs) representatives and community-based organisation (CBOs) members. Specifically, we interviewed 22 state officials from the MoH and its related services, 23 health zone (HZ) physicians and administrative managers in the South Kivu health system, 10 representatives of FBOs (the *Bureau Diocésain des Oeuvres Médicales*— the health department of the Catholic Church—and the *Coordination Médicale of Eglise du Christ au Congo*) and 2 CBOs, especially the Civil Society Provincial Office and *Centre d'Appui à la Promotion de Santé* (CAPSA). International organisations represented in the study included the WHO, UNICEF, *Medécins Sans Frontières* (MSF)-Holland and Spain, Malteser*, Louvain Coopération au Développement*, Cordaid, International Rescue Committee (IRC), *Projet de Santé Intégrée*/PROSANI and donor government organisations, such as *Coopération Suisse* and DFID.

Methods of Data Collection

Open and semi-structured interviews and focus groups were conducted. One-on-one interviews were used with representatives from INGOs, UN agencies (especially UNICEF and the WHO) and donor organisations, as well as with state officials. Focus groups were conducted with frontline providers at health facilities in the Katana HZ and at the Provincial Department of Health in Bukavu.

Policy records and documents were also reviewed using thematic critical analysis. Donors' country policy papers were useful for understanding how the state fragility discourse regarding the DRC spreads in the donor community, allowing us to gain insight into donors' perceptions of fragile statehood and the theoretical background of frontline donor organisations' intervention models. Hence, we analysed country policy documents produced by USAID, the European Union (EU), the World Bank, DFID and *Coopération Belge au Développement.* These documents were chosen because they represent the views of the most influential donors, which contribute substantial funding to the health sector and strongly influence the debates on health intervention models.

Research Constraints

The data collection for this study was hindered by the limited willingness of state officials to provide information, mostly evaluation reports on state-managed projects/programmes that would indicate funding embezzlement and corruption. It was also difficult to elicit responses from participants regarding the link between corruption and state fragility, although corruption and exploitation have been notorious throughout much of Congolese history (Trefon, 2011). Moreover, most respondents felt uncomfortable discussing both opportunities that could arise for corruption if the state were to receive more funding and problems of dependency if current funding arrangements were to continue.

Findings

State Fragility as a Coordinative Discourse in Donors' Programming and Policy Documents

Our review of donor documents helped to contextualise statements on state fragility that were repeatedly made by donor organisations on the ground. Table 2 presents an overview of the donor documents consulted.

Table 2: Donor Documents Examined

No.	Partner	Partners' Country Documents	Year
1	USAID	*Country Development Cooperation Strategy: DRC 2015-2019*	2014
2	DFID	*Operational Plan 2011-2015*	2013
3	Belgium	*La Coopération Belge au Développement et les États fragiles*	2014
4	EU	*Évaluation de la Coopération de l'Union-Européenne avec la République Démocratique du Congo 2008-2013. Rapport Final, Volume I.*	2014
5	World Bank	*Country Assistance Strategy for the Democratic Republic of Congo for the Period FY 2013-2016*	2013

Although it is defined differently depending on the donor's focus, fragility is represented as the most dominant feature of the country. The documents reveal how the image of fragility during strategic country policy formulation determines donors' operational planning.

Weak political, administrative and economic governance, along with entrenched corruption, appear as the crosscutting aspects of state weakness and the principal challenges to state-building. According to USAID, the DRC's poor performance is well known to be the result of abysmal governance (USAID, 2014). The DRC is portrayed either as an 'invisible state'—not only a failed state, but also a *non-state*—because of its lack of sovereignty outside its urban centres, or as 'government by substitution', with multilateral and bilateral actors taking on increasing levels of responsibility for governance (USAID, 2014). USAID maintains that the extreme weakness of institutions contributes to fragility and ultimately leads to poor social wellbeing and extreme poverty (USAID, 2014). Based on this view, USAID adopted an 'institutional value chain approach' by investing in support and capacity-building to targeted national institutions that will, in turn, stimulate an enabling environment to facilitate stronger governance and service delivery at the local level (USAID, 2014: 3).

In the EU's *Evaluation de la Coopération de l'Union-Europeénne avec la République Démocratique du Congo 2008–2013* (ADE, 2014), the DRC is depicted as a post-conflict country characterised by entrenched weak performance of public services. The document recognises some progress in terms of reform but also stresses that the conduct of public actions is still characterised by structural weakness and institutional malfunctioning, undermining the sustainability of EU interventions. This weakness relates to institutional fragility, poor public governance, shortages of budgetary resources, weak compliance with the principles of the state of law and the reticence to engage meaningfully in political sector reform (ADE, 2014). This prevailing weakness explains why the EU is still reluctant to transfer the full management of its donated resources to the government.

In *La Coopération Belge au Développement et les Etats Fragiles* (Laer & Matthysen, 2014), the DRC is presented as 'the prototypical fragile state'. According to the Belgian Development Cooperation Law of March 2013, fragility is a situation in which the government and state institutions lack the capacity and/or the political will to ensure security and protect their citizens, effectively manage public affairs and fight poverty (Laer & Matthysen, 2014). A multidimensional concept, fragility refers to defects in public governance and unresponsive institutions resulting in both critical social vulnerability and a

weak state–society relationship. Political and economic fragility in governance results in defective institutions characterised by weakness, corruption, unresponsiveness and the lack of accountability and voice for the Congolese, so the DRC can be said to embody all of the characteristics of a fragile state (Laer & Matthysen, 2014).

Building its interventions on the principles of transparency and accountability according to 'value for money and chain values', DFID describes the DRC as 'one of the world's most difficult environments in which to deliver effective aid' (DFID, 2011). For DFID, strengthening Congolese institutions' ability to respond transparently to citizens' needs is critical for establishing legitimacy and furthering stability, which, in turn, attracts the investment needed by the country for growth (USAID, 2014). Unresponsiveness of state institutions is thus considered to de-legitimise public institutions and negatively affect the effectiveness of donors' aid interventions (DFID, 2011).

In the *World Bank Country Assistance Strategy for the Democratic Republic of Congo for the Period FY 2013*–2016 (World Bank, 2013), the DRC is described as a country with crumbling institutions that are dysfunctional and not held accountable. The public state is designated as being in an 'advanced state of degradation' (World Bank, 2013). The DRC is also 'a destabilizing factor for its nine neighbouring countries' (World Bank, 2013).

Taken together, the review of the selected donor policy documents revealed that state fragility, as both a perceived characteristic and a discourse, is ever-present in donors' strategic policies and their operational planning for the DRC. For these donors, any intervention must address the humanitarian conundrum faced by the Congolese population while considering the transition from a humanitarian model to a development model. Currently, the donors remain reluctant to allocate aid directly through government agencies, because there is no guarantee of its effective management. Paradoxically, the state is both the problem and part of the solution.

State Fragility as a Diverging Discourse for Donor–State Intervention Models and Policy Coalition-building

Our investigation of the diverging discourses on state fragility centred on three main points: 1) INGOs' engagement models in the health sector, which provided insights on their prevailing interventions; 2) INGOs' fragility discourse-based interventions versus the political assertiveness of state officials regarding statehood and 3) deficient public financing of the

health sector, which constitutes a modus vivendi for the Congolese state and donor organisations on state fragility.

The Inputs of INGOs and Donors in Health Services Have Followed Either a Vertical or a Horizontal Model

Horizontal or integrated services are delivered through publicly financed health systems and are commonly known as comprehensive primary care. Vertical/stand-alone delivery of health services implies a selective targeting of specific interventions (Msuya, 2004). Donors' interventions in the health sector may be classified as either emergency-based humanitarian or development-based. Initial humanitarian interventions are often donor- and crisis-driven (Dijkzeul & Wakenge, 2010).

Although most INGO interventions in South Kivu have followed the vertical and emergency-based humanitarian models, the government wishes to move into a sector-wide system-building (or development) model. Many officials at the MoH indicated a preference for building integrated health systems. The respondents praised INGOs and donor organisations engaging in health system-building through development interventions. *Coopération Suisse* and USAID were among the donor organisations that respondents often mentioned, and INGOs such as Cordaid, the IRC, Malteser, PROSANI and *Louvain Coopération au Développement* were repeatedly cited as laudable examples. According to representatives of the Provincial MoH, these organisations engage with an integrated vision and give comprehensive support in terms of brick-and-mortar projects to develop health infrastructure, improve the drug supply and build administrative and institutional capacity.

This preference for system-building can be explained by the fact that, in the vertical model and especially the emergency model, the state is ostensibly side-lined and unable to coordinate, monitor or evaluate non-state actors' interventions. During the interviews with public health officials, they indicated that they wanted more control over the funding from donors. However, donor organisations prefer that contextual considerations determine their intervention into particular HZs.

To contextualise recovery processes in the health sector, DRC policy classifies HZs into five categories:

- o   in emergency (where there is ongoing war/conflict or natural catastrophes);
- o   in transition (where there is potential for early recovery);

- o in development (where the security situation has stabilised and social and economic activities increase);
- o functioning (where the quality conditions for providing minimum and complementary health package are available); or
- o performance (when a HZ reliably performs a certain number of results in line with the health system objectives and the population's expectations) (RDC/MINISANTE, 2012b).

Currently, HZs comprise a blend of the four first categories, with variations between the eastern and western provinces and between the rural and urban zones. Even in the east, the situation is not homogeneous across HZs. In areas where international engagement is low, the system mostly depends on user fees. In South Kivu, many rural HZs could be classified as emergency zones, a blend of emergency and transition, or, to some extent, zones in development. Only a few HZs have shifted into the category of functioning HZ. Respondents from state institutions reported that enduring humanitarian interventions have contributed to the fragmentation of the health system, and the government's desire for horizontal engagement was insistently mentioned. Regarding health system-building, the national public policy focus is on sustaining sector governance, system management effectiveness and the enhancement of service delivery quality and performance. Humanitarian interventions have prevailed in the eastern part of the country as a response to emergencies related to war and state fragility.

Some organisations, such as Malteser and to a certain extent the IRC, have been applying hybrid models that combine emergency-based interventions with system-building. The hybridity model depends not only on the donors organisations' or INGOs' portfolio, but also the prevailing health situation in intervention areas. For example, Malteser provided multisector support including health, nutrition, food security, and water, sanitation and hygiene (WASH) support. All of these contributions influence public health. How an INGO perceives state fragility and the resulting population vulnerability lie at the centre of the choice of their intervention preferences.

Fragility Discourse-based Interventions Versus Assertions of Political Statehood

Whereas donors and INGOs develop a discourse on fragility to justify vertical and emergency-based intervention models, state officials/institutions assert statehood and political sovereignty. As a result, building a policy coalition fails as the fragility discourse of INGOs

and donors is fed by both donor country policy and practical experience, so that they resort to a technocratic intervention model. State institutions are mostly motivated by considerations of political statehood and sovereignty (and a less openly advocated desire for financial control).

INGOs' fragility discourse and the need for humanitarian interventions
Humanitarian agencies use their perception of state-fragility to justify emergency-based interventions regardless of the government`s insistence on a paradigm shift in intervention models. For INGOs, fragility leads to the persistence of humanitarian interventions and to the channelling of donors' inputs through non-state actors. A representative of MSF-Spain discussed his experience in Shabunda in the following way:

> Emergency cases are still observed in many locations of South Kivu regardless of the apparent security. Political stabilisation is not yet guaranteed nor is the state response to the vulnerability of the war-affected population regarding their security and social wellbeing. This is why, for MSF, it is better not to discard the humanitarian intervention model. The current risk of rapid deterioration of the humanitarian context, as was the case in Shabunda in 2009, 2010 and 2012, resulting in an influx of internally displaced persons and consequently poor public health care, encourages the position of MSF. MSF cannot disengage unless there is improvement in the security situation.[12]

Likewise, for other INGOs, humanitarian interventions are a necessity because of the current state of fragility. Representatives of these INGOs expressed the necessity of being realistic regarding the current context. They maintained that the 'humanitarian approach facilitates the improvement of population access and service quality'. When asked about the system-weakening effects of humanitarian interventions that bypass the state, an MSF-Spain representative said that 'the persistence of conflicts is actually the reason why MSF is still present in certain areas such as Baraka even beyond the timeframe for relief interventions; there is a shrinking of state inputs into the health sector'.[13] This statement from an advocate of the vertical, humanitarian model that has outlasted its initial short timeframe implies a broad understanding of both peace and state fragility. This perspective goes beyond a minimalistic conception of peace as limited to the cessation of hostilities and of state authority as only the presence of either an army or other state agents. However state actors often defined social

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[12] Interview, Bukavu, 29/11/2013
[13] Interview, Bukavu, 29/11/2013

peace and population security as just a temporary cessation of hostilities or the absence of violent conflicts among armed factions.

All representatives of INGOs and UN agencies expressed similar views regarding problems with state authority. For example, the provincial UNICEF representative was very critical of the corruption plaguing the health system. For him, corruption is a central factor that has eroded the trust between donors and national actors. A provincial representative of PROSANI conveyed the same opinion: 'The DRC health system is rife with so many problems revolving mostly around the system governance with all its attendant conundrums'.[14] Therefore, for the sake of community health improvement, donors prefer to engage with non-state actors and/or directly with beneficiaries, as state agencies give no guarantee of good management of public development aid.

In most cases, representatives of INGOs also referred to failures of territorial control and the persistence of armed groups, which reflect both contested authority and disputed statehood. They also pointed to failing institutions that are unable to deliver on development outputs; the lack of ability to mobilise funding to finance the public sector; the lack of capacity to meet population needs and expectations for social development, human security and protection; and unlawful attitudes in public space and sectors. These respondents also pointed to the *clientelistic* politicisation of the public sector and the mostly endemic corruption that have been a characteristic feature of INGOs' image of the DRC.[15] Some INGO representatives expressed their disappointment about the peculiar DRC context, where they are expected to provide services beyond the purview of their mission. INGO representatives complained that donors and/or INGOs are expected to do everything, including 'building a bridge, providing energy and paying national security personnel'.

The persistence of vulnerability further explains the INGO perspective. An IRC provincial health officer noted that 'regarding the health sector, we are moving to system-building, but the problem is that the population's vulnerability has not changed'.[16] The case of Itombwe HZ, where the IRC was implementing full-fledged emergency interventions, is a telling example. Preparing its withdrawal, the IRC halved its interventions beginning in 2013. This hampered the functioning of Itombwe referral hospital considerably, because the state did not take over the INGO interventions. According to an Itombwe HZ administrator, the revenue of

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[14] Interview , Bukavu, 17/10/2013
[15] Compiled from multiple interviews
[16] Interview, Bukavu, 24/10/2013

'the hospital plummeted since the decrease of the IRC humanitarian interventions. Health workers, especially doctors and nurses, have been leaving the hospital'.[17]

Assertions of political statehood and the avoidance of the state fragility discourse among state actors

Interactions with state officials revealed how the discourse of state fragility is a politically disturbing construct for governing elites striving for political survival. A state official argued:

> It is good that the partners accompany the state in the health sector, but some go beyond what they are expected to do. Donors should now let the state walk alone, because, even for a child, after a certain time, one lets them walk alone by their own right. In case the partners wish to accompany the state, that is not bad, but to keep considering the state as incapable and fragile—to the extent of deciding on its behalf and in its stead—is inconceivable.[18]

This statement reveals a dilemma faced by the governing elite: In the face of conspicuous evidence of fragility, donors' humanitarian support is necessary, but representatives of the state also have the obligation to convince the society of their capability to make the state work without donors' guidance. Many such statements were expressed by state officials.

Likewise, a public official at the MoH in Kinshasa asserted that 'INGOs/donors capitalise on the fragility of the state to do whatever they want'.[19] These and similar declarations show the attempts of the state to politically assert its sovereign statehood. These assertions aim to justify a political stance that the state should now be in charge of decisions about the intervention model. As a political rationale, public official respondents emphasised the state presence in a context of disputed legitimacy, especially concerning public service provision.

On multiple occasions, we observed discomfort at the mention of the state's empirical performance and popular perceptions. For some state officials, 'donors/INGOs overshadow the visibility of the state'. For others, bad governance, corruption and clientelism in the health sector may justify donors' stance: According to one very critical state official at the MoH, 'There is a facade of improvement, but the health sector management situation is very bad. But that cannot be talked about by the MoH'. Like other institutional failings, bad governance revolves around rampant corruption. This corruption deeply worries donors and INGOs.

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[17] Interview, Bukavu, 20/03/2015
[18] Interview, Kinshasa, 14/02/2014
[19] Interview, Kinshasa, 16/02/2014

Among the state actors, two categories emerged regarding perceptions of fragility and its corresponding discursive positioning. First, political activists asserted statehood. For this group, the fragility discourse appeared threatening to political legitimacy. Second, public health sector officials, system managers and frontline providers were very critical of the state's lack of capabilities, though they also wished to shift to system-building. Among state actors, the aspiration to bring the state leadership back through system-building was fervently pursued, although the conditions necessary for better functioning were widely recognised as unfulfilled.

In contrast to the state officials, the population and many local providers desired state provision of services and wellbeing, but they also welcomed the presence of humanitarian INGOs to improve social welfare. For the state, only a paradigm shift to system-building could ensure that the principles related to state ownership and partners' alignment in the Paris Declaration would be enforced. The state officials' use of the fragility discourse was paradoxical. Regarding the alignment of non-state actors, no compromises were made: Fragility as a concept was omitted, and the necessity of donors' alignment with state policy was emphasised. 'The state is overcoming its fragility and thus taking up its leadership role', remarked a state representative in Bukavu. However, when accounting for a problem or sector management dysfunction, state officials immediately evoked fragility. The state was then implied to refer to an impersonal [reified] entity that was to blame. According to a high-level official at the Provincial MoH, 'It is better to understand the context, as the DRC is still a fragile state that is emerging from a tough situation'.[20]

Five reasons may account for the state officials' stances:

o First, it is not that the state fails to see its own fragility and the vulnerability of its war-affected population. Rather, long-lasting vertical interventions are the essence of its fragility and signifiers of its absence in service provision.

o Second, for state officials, the humanitarian paradigm creates a fragmented distribution (geographically and concerning services) of health care, which conflicts with the administrative standardisation advocated by system-building.

o Third, relief intervention impairs the sustainability of health system financing by abolishing the user-fee system and preventing the state from managing health-related financing.

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[20] Interview, Bukavu, 20/03/2015

- o Fourth, the priority for the state was not only alignment of the donors, but also the recognition of its central role within donors' interventions.
- o Fifth, the desire to control donors' funding for the health system was an underlying reason for state actors to advocate the paradigm shift from humanitarian and vertical models to system-building, where the state is in the driver's seat for the health sector funding management.

Discursive Reference to State Fragility and Stakeholders' Mutual Perceptions

The impact of the state fragility discourse on state officials and its discursive power were clear in critical statements made by knowledgeable informants supporting the state position. A public health official stated that 'INGOs represent donors and sometimes they trade on the fragility of the state and deploy in the sector of service provision with their own terms of reference; this is why there have sometimes been policy clashes between the government and INGOs'. This official recognised that non-state actors vary: 'Respectful INGOs align with state policy by integrating national health policy; others do whatever they like and the state, being weak, stands idly by'.[21]

Many state officials made similar declarations decrying how the state fragility discourse empowers INGOs while disempowering state institutions. Other state officials noted that the fragility discourse makes it difficult to compel donors to comply with national policy. Two themes emerged regarding state fragility and stakeholders' mutual perceptions. First, there is a feeling of frustration about the state's impotence vis-á-vis the resource-based power of the INGOs, which enjoy legitimacy based on both service provision and expertise. Second, there was a consciousness of the negative impact of the state fragility discourse. The prevailing image of state fragility and its discursive referent makes it difficult for the state to assert itself.

Of course, INGOs and donors also have their own perspectives. While consenting to the Paris Declaration, they feel that it is important not to overlook the DRC context. One DFID representative was quite clear about her organisation's image of the country: 'First of all, the state needs to build trust at all levels. The money we do have is from the donor country taxpayers'.[22] Statements like this show how donors are frustrated with the pervasive corruption that permeates state institutions. The same donor representative elaborated that her organisation aims to build the institutional capacity of government structures and that it is

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[21] Interview, Kinshasa,15/02/2014
[22] Interview, Kinshasa, 20/02/2014

currently difficult to channel the money directly through them. For this reason, the money is given primarily to international and national NGOs, who then provide the needed inputs, while the government presently receives 7% of their financial contribution. Echoing this position, a UN agency representative argued:

> In theory, the DRC health system is operational, but there is a huge disarticulation between what is prescriptively said and what is done; all of the theoretical instruments and norms are there, but their application is what poses problems. […] Everyone does what is contrary to the norms.[23]

Some Congolese would consider the above declarations to be too strong, as they present the whole of Congolese society as unlawful. However, some state officials used even stronger words to express their frustrations about the poor performance of statehood.

Deficient Public Financing of the Health Sector as Common Ground for the State and Donors

Some aspects of fragility (e.g. public health governance and policy enforcement) spur more debate among stakeholders than do others. In particular, there is a mutual recognition among both the state and donors regarding the weakness of health sector financing. All of the participants in this study referred to the state's incapacity to mobilise, rationally allocate and effectively disburse public resources to finance the health sector.

In terms of health sector financing, the inputs of donors and households constitute the main pillars for the functioning of the sector. The government itself recognises the importance of both sources for health sector functioning in a three-pronged approach to financing the health sector that draws upon state budgeting, external contributions and community/user fees. Community/user fees comprise 70% of the sector administration and current costs (RDC/MINISANTE, 2010b).

Health sector spending comprises two complementary and inseparable types of outlays: current and capital costs. Whereas current expenditures focus on the population's immediate needs and thus provide for pathology control through both curative and preventive measures, capital costs concern health system development and resource management planning (RDC/MINISANTE, 2015). Figure 8 summarises the aggregate expenses provided by the national MoH regarding current health costs for the 2013 financial year.

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[23] Interview, Kinshasa, 20/02/2014

Figure 8: Current Health Expenses for 2013 by Funding Source
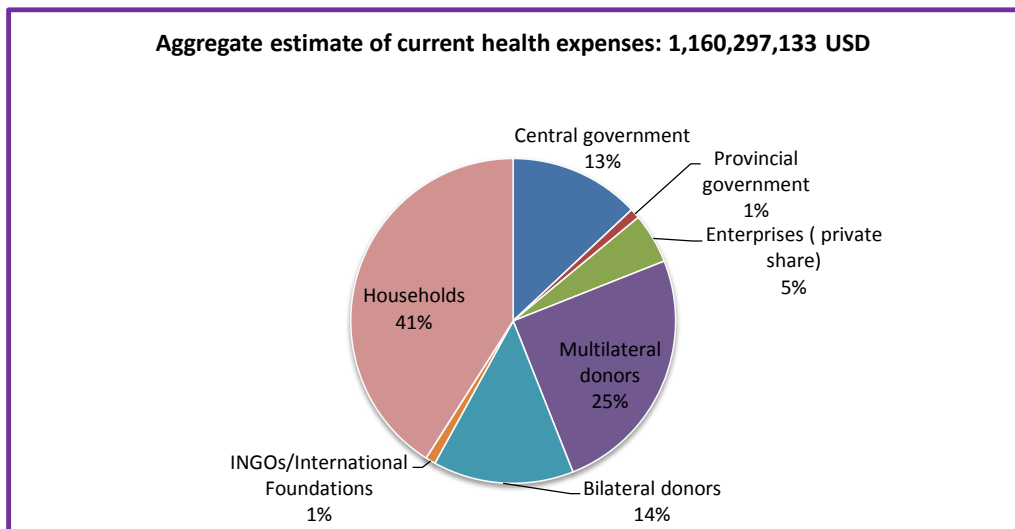
Source: *The National Health Accounts* (RDC/MINISANTE, 2015)

Figure 8 shows that international donors, including both multilateral and bilateral partners along with INGOs and international foundations contributed a total of 40% of health expenses for 2013. Congolese households paid 41% of these costs, whereas the government (both central and provincial) covered only 14%. National enterprises contributed 5%, and the financial contribution of national NGOs was null.

However, obtaining accurate data on health funding in the DRC has been a serious problem for researchers and policy makers. For instance, the national health accounts for 2008–2011 are contradicted by those for 2008–2013 (Manzambi Kuwekita et al., 2015; RDC-MINISANTE/PNCNS, 2013; RDC/MINISANTE, 2015), although both accounts were generated by the MoH. These inconsistencies are seen especially in financial records and population estimates (Dijkzeul & Lynch, 2006).

According to the National Health Information System, in 2012, aggregated national health expenditures amounted to 1,036,777,486.99 USD and current health expenses were 984,687,529.96 USD, for a population of 77,817,000 in the DRC (Matangelo, 2014). Although the figures suggest an improvement in health spending over time, the DRC is still far from achieving sustainable health system financing from domestic revenues.

All respondents—state officials, donors/INGOs and providers—recognised the small share of the government in the funding of the health sector, as well as the inadequacy of the whole public package allocated to the health sector from different financing sources. In this respect, the *Evaluation de la Coopération de l'Union-Europeénne avec la RDC 2008–2013* (ADE, 2014) maintains that, in 2012, only 25% of the estimated public health need was met with the available resources. External support/aid from multilateral and bilateral cooperation is integrated into the general government expenditure on health, thus increasing the figures attributed to the government contribution. The rate of disbursement for government funding and the level of its execution have also been very erratic, so that it is challenging to distinguish precisely the nominal contribution from the true inputs. A Provincial MoH representative in South Kivu recognised that the functioning of the health sector depends mostly on donors' inputs and the population contribution. In his view, donors contribute approximately 60%, the population 30% and the government about 20%.

Analysis

Divergent discourses on state fragility account for the failure to build a policy coalition in the health sector. For donor organisations and INGOs, persistent state fragility determines the ongoing emergency humanitarian approach and vertical intervention models. However, irrespective of the current humanitarian situation, the state aspires to a shift to the system-building approach (i.e. the horizontal model). However, most INGOs engaged in the health sector—especially in eastern DRC—think the state`s fragility necessitates maintaining approaches that respond pragmatically to both humanitarian emergencies and state fragility. Therefore, the fragility discourse becomes contentious not because of its conceptual ambiguity but because of the existence of diverging perspectives and expectations.

Shifting the health sector intervention model to a development approach will not result in system strengthening without a comprehensive fragility assessment and a working state. As the context is far from being stable, a realistic stance that takes into account perceptions of fragility will respond better to the population's humanitarian needs regardless of political positioning on the choice of an intervention model. Still, longstanding vertical interventions and the humanitarian engagement approach constitute risk factors for a dysfunctional state, creating challenges for state actors for whom fragility discourse dovetails with the conditionality of aid.

Despite the lack of the capacity and/or willingness to achieve empirical sovereignty, state officials wished to assert political statehood. In the Weberian ideal type of a state, state actors rely on statehood to hierarchically coordinate the provision of common goods (Börzel, Hönke & Thauer, 2012). However, in terms of health sector financing, the state cannot claim empirical sovereignty. State and donor organisations agree on the weakness of the state and the need for support for the survival of the sector. Hence, the state officials asserting empirical statehood are actually playing a political game, aiming for political legitimacy and greater financial control.

Nonetheless, holding an a priori image of fragility characterised by corruption, incapacity and a weak society may be a double-edged sword for donor organisations. This is because state fragility can make it difficult for recipient states to achieve the alignment of donors and mutual accountability between the state and donors. Additionally, the conviction of state fragility may also affect donor organisations' behaviours on the ground. Some may be prejudiced. Others, as critical remarks in the present study indicate, may develop condescending attitudes that do not serve the population, as not all involved actors are actually corrupt.

Conclusions

This chapter has explored the impact of the state fragility discourse in the interactive process of state, INGO and donor engagement in the health sector in light of the Paris Declaration on Aid Effectiveness. Although the state fragility discourse has gained currency and shaped international policy in weak states, there is as yet no universally agreed conceptualisation of state fragility. In the DRC health sector, state fragility is a discourse without a policy coalition, because the government and donors/INGOs have not harmonised their perceptions of fragility. Concomitantly, they have not yet reached a common understanding on intervention policy. To understand the extent to which the state fragility discourse influences key stakeholders' intervention programming and policy coalition-building in the health sector, the present chapter adopted a critical discourse analysis approach. Our findings demonstrated that state fragility, as both a discursive referent and an ideological rationality, impacts donors' coordinative discourse on intervention programmes in the health sector. The concept of state fragility also affects compliance with the Paris Declaration on donors' alignment and recipient countries' ownership. This divergence in discursive references to state fragility has not, however, overshadowed the recognition from the state of the importance of financial contributions by INGOs and donors to the survival of the health sector.

The inputs of INGOs and donors into health services have followed both vertical and horizontal modes. Most INGOs follow the vertical, humanitarian intervention model. However, state representatives were emphatic in expressing their aspiration to horizontal engagement for health system-building. Discursive references to state fragility revealed a sore issue among INGOs, donors and the state concerning health sector transition intervention models. While donors rationalised their emergency-based interventions and channelling of funding through INGOs by complaining about state fragility, state officials asserted political statehood and an earnest desire for a paradigm shift.

State fragility is thus not a neutral concept in a context of contested statehood and politically disputed legitimacy. Discursive references to state fragility empower donors and INGOs, but disempower the state. Government officials saw the concept as stigmatising, making it difficult for the state to assert its policy perspective, especially regarding partners' compliance with the Paris Declaration. For INGOs, donors and UN agencies, it is necessary to take contextual fragility constraints into account when interpreting the Paris Declaration.

Financing the public health sector nevertheless constitutes a common ground on state fragility discourse for the state and donors. Both groups of actors recognise the state's weakness in terms of resource mobilisation, allocation and disbursement. Without the inputs of donors and households, the health sector might not survive. However, the choice of intervention model, informed by the state's stance on fragility discourse, has been a point of contention in the process of policy coalition-building. Considering the current situation, building a policy coalition based on harmonised views is necessary for effective engagement and intervention sustainability in the health sector. This coalition-building should promote more than the implementation of the Paris Declaration on alignment, also facilitating the accountability and social responsibility of all stakeholders. However, ultimately this requires agreement and commitment among all stakeholders on fighting corruption, which is not likely to happen anytime soon.

Chapter 4: Performance-based Financing and Strengthening Health Governance in the in the Fragile State of the Democratic Republic of Congo

Fomulac Hospital/Katana health zone performance-based financing experiment, fieldwork photo

During a paired interview with executive staffs of performance-based financing cell of the national MOH / Kinshasa, field photo

This chapter has been submitted to a journal under the title of 'Performance-based financing and strengthening public health governance in a fragile state: the DRC story', authored by Aembe Bwimana and Dennis Dijkzeul.

Just after a focus group session conducted with the nurses of Izimero health Centre /Katana, field photo

The author with his two research assistants during the fieldwork in Katana on a rainy day, fieldwork photo

Katana Health Zone Central Office performance-based financing experiment, fieldwork photo

Abstract

This chapter explores the outcomes of performance-based financing (PBF) for strengthening the health system in the context of state-building in the Democratic Republic of Congo. PBF is the transfer of money or any 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. Our analysis focused on health system governance because of its pivotal role in the process of building the health system. Based on long-term qualitative field research, we examined the effectiveness of PBF in three areas of health system governance: structural governance from a capacity-building perspective, health service provision management and demand-side empowerment for effective accountability. In general, the study found that PBF has positively impacted the process of health system-building in these three areas. Although much is still lacking, health governance and the provision of services improved, while patient-centred care and social accountability strengthened the provider–patient relationship. We found positive outcomes for incentive-based contracting and output-based financing. However, donors, state officials and other stakeholders doubted their sustainability. In addition to structural threats related to state fragility and uncertain sustainability, transforming transactional motivation into transformational change is a challenge. Ultimately, PBF supports health sector-based state-building, but it cannot repair a collapsed state.

Introduction

Health service effectiveness and accountability constitute major challenges in fragile environments such as the Democratic Republic of Congo (DRC) and trigger various innovations and policy experiments. One of these is performance-based financing (PBF). PBF is the transfer of money or material goods from a funder or other supporter to a recipient, conditional on the recipient taking a measurable action or achieving a predetermined performance target (AIDSTAR-Two-Project, 2011). In the health sector, PBF is understood as fee-for-service payments conditional on quality of care and a health system approach to achieve results defined in quantity and quality of service outputs (NSHIP, 2013). Health care providers are paid 'for delivering specific services following explicit protocols with a system of inspection and auditing to assure compliance and to raise quality' (Musgrove, 2010).

Performance-based payments are also provided for the teams carrying out these inspections to motivate them to be thorough and accurate (Musgrove, 2010: 4). Contracting for performance and motivating providers constitute the core characteristics of the PBF approach. Inspired by a Rwandan PBF experiment, Cordaid, a Dutch NGO, introduced PBF in the South Kivu province (eastern DRC) in 2005 (Mayaka Manitu, 2015). A DRC government policy document regards PBF as a mechanism for public sector reform, in particular for health financing (MINISANTE/CTFBR, 2012), and as a model promoting the adoption of a holistic perspective for strengthening the health system.

The Emergence of Performance-based Financing in International Development

PBF emerged during the economic slowdown of the 1980s, the 'lost development decade', which facilitated the introduction of the New Public Management (NPM) reforms in the 1980s–1990s (Torfing & Triantafillou, 2013). NPM focused on contracting for financing public service outputs, improving service standards while strengthening accountability based on customer needs, managing by results, decentralising authority and implementing participatory management (Rhodes, 1996).

PBF is regarded as a useful approach to financing health services that can work in both more stable environments and fragile states (Fritsche, Soeters & Meessen, 2014). Compared with traditional bureaucratic approaches, PBF has achieved encouraging, but certainly not homogenous, results across countries (Soeters, 2012). The heterogeneous results across different countries indicate that contextual variables play an important role in explaining PBF success. Understanding what causes the observed differences is therefore crucial.

The present study's relevance lies in its exploratory enquiry of actual PBF outcomes for strengthening the health system governance and state-building in a context of pervasive fragility. It provides empirical evidence on the health sector-building outcomes in a context of a fragile health system and multi-actor networked governance. Networked governance implies a network of relevant actors and/or stakeholders linked through resource interdependency, cooperation, collaboration and even competition for achieving the social goals (Klijn, 2004). Driven by the need to explore the outcomes of PBF, as well as its potential impact on state-building, we ask: What are the outcomes of strengthening the health system by means of PBF in the context of state-building in the DRC?

This study explores the effectiveness of PBF in the DRC in light of its contextualised theory of change. A theory of change is the articulation of the underlying beliefs and assumptions that guide a service delivery strategy and are believed to be critical for producing change and improvement (INSP, 2005). Theories of change indicate causal connections between activities and outcomes (Stein & Valters, 2012), which require insights on a contextual baseline and the intended changes. This investigation focused on PBF's outcomes in three areas which are among the most affected by statehood fragility in the DRC health sector: 1) strengthening health governance; 2) management of service provision processes; and 3) demand-side empowerment for social accountability.

Strengthening Health System Governance

A health system consists of all the organisations, people and actions whose primary intent is to promote, restore or maintain health (World Health Organization, 2007). Health system strengthening refers to improving six building blocks of the system, as well as managing the interactions between them in ways that achieve more equitable and sustained improvements across health services and outcomes (World Health Organization, 2007). These building blocks are leadership/governance; health service delivery; the health workforce; health information/intelligence; health financing; and medical products, vaccines and technologies (World Health Organization, 2007).

As one of these crucial blocks, 'health system governance involves ensuring that a strategic policy framework exists and is combined with effective oversight, coalition-building, regulation, attention to system design and accountability' (World Health Organization, 2014). Two types of indicators have been proposed for measuring such governance (World Health Organization, 2010a): *rule-based indicators* measuring whether countries have appropriate

policies, strategies and codified approaches for health system governance, and *outcome-based indicators* assessing whether rules and procedures are effectively implemented based on the experience of relevant stakeholders. The present study focused on the outcome-based approach.

The role of structural governance in strengthening the health system

Structural governance is about 'how to structure or organise the state services, what strategic functions the state should perform, what to delegate to agencies, and which services to contract out; it is the question of how to manage the whole system' (Bresser-Pereira, 2007). Health governance shapes the rules determining the behaviours of actors and establishes relevant networks and other institutions. Because of three characteristics of health care (information asymmetry, the difficulty of evaluating the product and the high costs of error) (Tuohy, 2003), strengthening health governance is essential for community wellbeing.

Through better governance, a health system can improve its ability to respond to various challenges, such as demographic, epidemiological, economic, political, medical and social changes (Joseph, Matthias & Scott, 2016). Joseph and colleagues (2016) have shown that, when governance is weak, the health system is plagued by corruption, misaligned incentives, unintended effects of ill-conceived policies, nepotism, incompetence, lack of trust and difficulties with long-term planning.

In this vein, Lewis (2006: 6) argued that 'in health care, good governance implies that health care systems function effectively and with some level of efficiency'. Lewis further asserted that the production function represents the core of public healthcare systems, embodying capital, labour and governance, which together determine health outcomes. He maintained that increases in labour and capital can improve outcomes, but governance may either dampen or enhance these effects (Lewis, 2006).

Health governance involves at least three sets of actors: state actors (policy makers and/or politicians), providers and beneficiaries/health service users (Health-Systems-20/20, 2012). Building on the World Bank's service delivery and accountability framework (Malena & Forster, 2004), Brinkerhoff and Bossert (2008) have created a health governance triangle framework that defines the roles, rules, responsibilities and institutions that shape the interactions among the three main sets of actors. These interactions include how governments respond to citizen demands, how providers and citizens engage to improve service quality and

how citizen and provider groups advocate and report on health concerns (Brinkerhoff & Bossert, 2008).

Figure 9: Health Governance Triangle Model
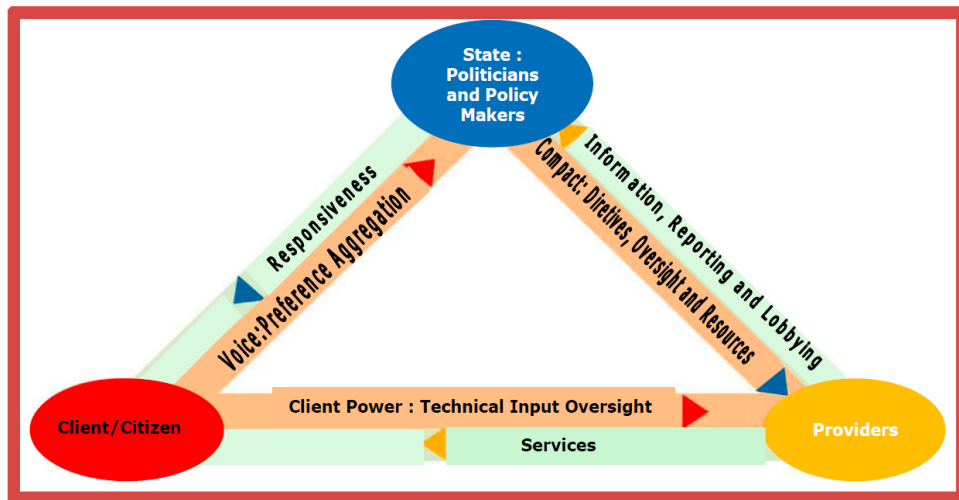
Source: Brinkerhoff & Bossert (2008)

Ideally, the state actors and health providers establish a compact in which the state provides directives, assumes oversight and ensures funding; the providers guarantee service delivery, provide information, report and lobby where necessary; and the citizens/clients have voice, sharing their preferences and expecting responsiveness from the state and providers. The citizens and health service providers develop a relationship, where the population provides feedback, inputs and oversight on expected services (Brinkerhoff & Bossert, 2008). In this kind of ideal situation, clients/citizens convey their needs and demands for services, as well as their level of satisfaction, directly to the health service providers, who, in turn, offer a mix of quality services that satisfy the expressed needs and demands. From a networked governance perspective, the links between clients/citizens and providers are fraught with power and information asymmetries, capacity gaps, accountability failures, and inequities (Brinkerhoff & Bossert, 2008).

In fragile states, such an imbalanced relationship becomes even more problematic because fragile statehood disempowers citizens. Good health governance therefore rationalises the role of the government by 'reducing its dominance and sharing roles with non-state actors;

empowering citizens, civil society, and the private sector to assume new health sector roles and responsibilities; and creating synergies between the government and these actors' (Brinkerhoff & Bossert, 2008: 10). The main difference from the literature and triangle above in the DRC is of course that donor governments and international organisations also play a crucial role in promoting and funding PBF. They sustain the health system. They support policy making and the financing of policy implementation and processes of service delivery at the operational level. Donor organisations thus simultaneously substitute for and strengthen the government.

The underlying principles of PBF

The underlying principles of PBF have the potential to strengthen governance. They emphasise the operational relevance of the market and corporate governance for the health system. The fundamentals of PBF, as applied in the health system, include the division of labour, commitment to health quality, constructive competition among the involved actors, public–private partnership, management autonomy of health structures, contracting, the financial viability of health facilities and, most importantly, the consideration of the population as both beneficiaries and clients, whose voice counts (Cordaid & SINA-Health, 2012; MINISANTE/CTFBR, 2012; Toonen & Bertam, 2012; Witter et al., 2013).

The consideration of the population as clients relates PBF to the principles of person-centred care and support, which place service users at the centre of delivery by supporting their needs; protecting their rights; respecting their values, preferences and diversity; and actively involving them in the provision of care (HIQA/Ireland, 2012). Ideally, person-centred care promotes kindness, consideration and respect for service users' dignity, privacy and autonomy (HIQA/Ireland, 2012: 25). Additionally, the emphasis on the division of labour reportedly ensures transparency (Cordaid & SINA-Health, 2012; Toonen & Bertam, 2012; Witter et al., 2013). PBF's operational set-up promotes interdependent actors, complementary and clearly distinct roles for stakeholders, and mechanisms for service quality verification. The inclusion of community-based organisations (CBOs) in the verification of intervention outcomes reflects the ideals of empowering beneficiaries and promoting social accountability. The above principles promoted by PBF—especially person-centred care, the clear distinction of roles for stakeholders, sector management transparency, providers' motivation and social accountability—are deficient in the DRC health sector.

Overview of the Introduction of PBF in Low-income Countries

The use of PBF in lower- and middle-income countries as a health sector financing tool can be traced to early experimentation with market forces in primary health care (Fritche et al., 2014). This experimentation took place in a publicly funded and provided health system in Zambia's Western Province in the late 1980s and early 1990s, with the purpose of co-financing primary health care (Fritche et al., 2014). In Cambodia and Haiti in 1999, NGOs were contracted either to provide health services or to give management support to government-provided health services (Eichler et al., 2009). In both countries, these contracts were output-based or fixed-price contracts known as performance-based contracts (Loevinsohn, 2008). In Afghanistan, performance-based contracting was introduced as a national strategy for health service delivery in 2003 (Fritche et al., 2014).

The Cambodian experiments exhibited operational differences between two contracting models: Sotnikum and Pearang (Mayaka Manitu, 2015). The Sotnikum experiment was implemented within the public sector as a *contracting-in* model with a purchasing agency and steering committee closely linked to the health sector hierarchy (Mayaka Manitu, 2015). The Pearang experiment adopted a *contracting-out* model in which the autonomous external purchaser agency (e.g. an international NGO) assumes responsibility for the monitoring and follow-up of implementation. Contracting out has become the model advocated by donors, who lack trust in the public sector in crisis countries (Mayaka Manitu, 2015).

Since 2002, PBF has been developed further in Rwanda (Fritsch et al., 2014). The Rwandan government adopted the contracting-out model to decentralise and improve governance (Mayaka Manitu, 2015). However, it later adopted the contracting-in approach, because it was reluctant to shift power to international NGOs and wanted to introduce PBF in the whole public sector (Mayaka Manitu, 2015). Following this shift, PBF has expanded rapidly in Africa. In 2008, the Rwandan government scaled PBF up at the national level by adopting it in its national health policy. In 2013, there were three countries (Sierra Leone, Rwanda and Burundi) with nationwide PBF programmes and 17 with ongoing pilots (Fritsche et al., 2014).[24]

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[24] Benin, Burkina Faso, Cameroon, the Comoros, the Central African Republic, Chad, DRC, the Republic of Congo, Kenya, Lesotho, Liberia, Malawi, Mozambique, Nigeria, Tanzania, Zambia and Zimbabwe

Research Methods

Research Design, Data Collection and Participants

Empirical data for this qualitative study were collected mostly in the Katana health zone (HZ), which is located in Kabare territory, 50 km north of Bukavu, South Kivu province's capital. This HZ is composed of one general referral hospital (Fomulac hospital), one smaller hospital (Birava) and 17 health centres, which took part in the PBF experiment. We visited 15 of these health centres. To explore the national-level PBF design, adoption and uptake, complementary research was conducted in Kinshasa at the national Ministry of Health (MoH), in Bukavu at the Provincial Public Health Department, at Cordaid offices (in Bukavu and Kinshasa) and in the Idjwi HZ. We also interviewed health management officers from International Rescue Committee (IRC), Integrated Health Project (*Projet de Santé Intégré*, PROSANI), *Louvain Coopération au Développement* and *Bureau Diocésain des Oeuvres Médicales* (BDOM). Most of the primary data were collected using three methods over a period of 19 months.

Participant observation

This kind of observation took place in two settings: first, at the Provincial Department of Public Health, where we investigated PBF outcomes on policy coalition-building between state institutions, donor/INGO organisations (especially Cordaid), *Agence d'Achat de Performances* (AAP) and providers at both the Provincial Health Department and operational (HZ) levels. The second setting was at health facilities in Katana, selected to explore the level of internalisation of PBF principles regarding patient-centredness, providers' motivation and good health governance practices.

Focus groups

These were organised with providers, CBOs such as *Comité de Développement de l'Aire de Santé'* (CODESA) and community members.

Interviews

In-depth interviews were mostly conducted with key informants from the state, donors/INGOs and FBOs in both Bukavu and Kinshasa. Semi-structured interviews were designed for all potential participants, but their applicability depended mostly on the profile and availability of the respondents.

Baseline assessment

To assess the baseline situation in the health sector, we also conducted a content analysis of the four main policy papers:

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

Fieldwork Challenges

For health providers working at the health facilities without state pay, there is a tendency to believe that, with PBF, the money follows the patient and good figures make good rewards; hence, they feel tempted to exaggerate positive PBF outcomes. Gaining access to representatives of some international NGOs also proved to be a challenge. Finally, in the DRC, corruption is rife, and can be a survival strategy, but it is dangerous or shameful to talk openly about it.

The Introduction of PBF in the DRC

During the height of the Congolese crisis in the late 1990s, Medical Emergency Relief International (Merlin) attempted to enforce a contracting system in the health sector to improve access to health care while strengthening the capacity and quality of the local healthcare system in a situation of chronic crisis (Dijkzeul & Lynch, 2005). This approach, which pioneered the contract system in the DRC, made a subsidy dependent on the performance of each health facility, although Merlin did not enter into the internal running of the health facilities or, especially, human resource management. However, the implementation of this contract approach did not fully succeed, because Merlin needed to build the capacity of the health system first (Dijkzeul & Lynch, 2005).

Just Crossing Ruzizi River: From Rwanda into South Kivu

In 2005, with Cordaid funding, the Bukavu BDOM embraced PBF. To introduce PBF, a learning mission to Rwanda (where Cordaid was implementing a project in Cyangugu) took place in 2004. This visit enabled Cordaid to launch its first Congolese PBF experiment in

2006 on Idjwi island in South Kivu (Mayaka Manitu, 2015; Peerenboom, de Weerd, Mushagalusa, Zabiti & Vroerg, 2015).

Since then, various PBF experiments have been carried out, differing in terms of design, contextual operationalisation and level of effectiveness (Bertone, Mangala, Kwete & Derriennic, 2011). The most important PBF experiments took place through the World Bank (in the provinces of former Equateur, Maniema, former Katanga, Bandudu and Kishansa), the European Commission with EU funding from the 9th European Development Fund (EU-PS9FED) (in the provinces of Kasai Oriental, the former Kasai Occidental, the former Province Oriental and North Kivu) and Cordaid (in South Kivu and Bas-Congo) (Bertone et al., 2011).

In 2010, PBF initiatives covered 26 million people and took place in 189 of 515 HZs (Bertone et al., 2011), but used different operational models. The EU projects experimented with contracting in, whereas Cordaid's projects tested a contracting-out model. Cordaid initially had a contracting-in model under the EU-PS9FED funding, but it failed to show conclusive evidence of its effectiveness (Bertone et al., 2011). The EU- and World Bank-funded PBF experiments did not successfully apply the underlying principles of PBF, especially division of labour and rational use of funding by public actors. For example, the work funded by EU-PS9FED was impaired by unclear definition of roles and division of functions between health system management and providers (Lafort, Letournmy & Koussémou, 2012). Moreover, in the DRC, where corruption is pervasive, contracting in through state institutions faces obstacles related to weak management and low financial accountability. However, Cordaid's PBF experiments in South Kivu—the focus of the present study—and Bas-Congo have done relatively well.

PBF in Katana HZ: The story of Cordaid's Engagement with Health System Strengthening
Fomulac Hospital (*Fondation Médicale de l'Université de Louvain en Afrique Centrale*) became part of Katana HZ during the subdivision of the national territory into HZs in 1985 (RDC/MINISANTE, 2006). Fomulac hospital was founded in 1928 and became one of the most famous health facilities in the African Great Lakes region during the colonial period. Until 2002, the Fomulac general referral hospital was managed as a Belgian project and had a strong reputation for service quality. From 2002 to 2005, the management was transitioned from Louvain University to BDOM. This was meant as a return to self-reliance in the

aftermath of the wars, but it plunged the HZ into an emergency situation. The effects of war on the population's lives, poor livelihood and the localisation of management severely challenged operations in the HZ. To improve service quality and strengthen the HZ management, Cordaid introduced PBF in Katana HZ in 2006.

Cordaid has supported PBF programmes in the health, education and rural development sectors, as well as, since 2011, in selected public administration offices (KIT, 2013). Cordaid and the Netherlands Cooperation have so far been the main funders of PBF for health interventions (Peerenboom et al., 2015). Stakeholders consider Cordaid's experiments to be the showcase of the underlying PBF principles. Because of the success of these experiments, Cordaid 'has been facilitating networking and sharing of experiences and lessons learnt with PBF to improve access to and quality of health services' (Cordaid, 2013).

Based on its theory of change, Cordaid aims to establish a new division of labour among the actors in the health system, where they mutually control each other. Cordaid provides financial support as an incentive for them to strengthen their governance, policies and service delivery. Its interventions intend to strengthen the role of the state as a regulatory body, promote social accountability at the system management and service provision levels, and meet providers' expectations regarding decent payments for the delivered outputs. Hence, PBF anticipates agency problems that arise when the desires of the principal and agent conflict (Einsenhardt, 1989). It thus strongly engages these actors during implementation and carries out regular monitoring and evaluation activities, ultimately hoping to instil real transformational change towards more patient-centred care in the health sector. Transformational change denotes an intrinsic motivation or desire based on internalised social values.

AAP as a Crucial Actor for the Effective Implementation of PBF
AAP is the local fund-holder agency for PBF in South Kivu (*Agence d'Achat de Performance,* 2011). It is in charge of mobilising funding, managing donor funding, rational management of PBF finances, solving agency problems at service delivery level, overseeing implementation of PBF principles and contracting with providers (Peerenboom et al., 2015). According to PBF's underlying principles, AAP is accountable to the state and the community through the CODESA (Peerenboom et al., 2015: 4–7). According to DRC health policy, the CODESA not only own the local health facilities, but, as community-based committees, they also ensure interactive communication between the community and health providers. In the current

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contracting-out model, AAP is a private but public interest-oriented organisation that interacts with all key actors involved in the implementation of PBF experiments in South Kivu. Therefore, AAP confers with state actors and donors organisations at provincial level and purchases health services at every level of the health system.

At the operational level, AAP contracts health service providers at the HZ level (especially the HZ Management Board, the Referral Hospital Management Board and the Health Centre Committee—under the leadership of the health centre's principal nurse or *infirmier titulaire*). AAP purchases health outputs and also plays the role of the health facility record 'verifier' (*le vérificateur*). At the provincial and HZ levels, AAP participates with providers and regulators in defining performance indicators in light of the national health policy and professional standards of health care provision. At both levels, AAP plays a key role in the process of output evaluation.

PBF and the DRC National Health Policy

Since the renewal of international cooperation in 2001–2002, donors' engagement in the DRC has grown exponentially (Arnould & Vlassenroot, 2016). Through donors' initiatives, the government engaged over time in the contracting model in the health sector, issuing a first policy framework ('*Vade-Mecum du Parténariat dans le Secteur de la Santé*') for these contracting arrangements (RDC/MINISANTE, 2002). In terms of the official uptake of the approach, the process of promoting contracting initiatives was endorsed nationally with the adherence of the government to the Paris Declaration in 2005. This was followed by the adoption of a strategy to strengthen the health system in 2006.

As shown, external donors initiated PBF in the DRC's health sector. The first PBF experiments in South Kivu did not include the national level. Mayaka Manitu (2015) has characterised this initial lack of collaboration between the project and the central level as disconnecting PBF from institutional memory. A review of experiments was held in Kinshasa in 2010. This high-level meeting opened the way for the government to consent formally to using PBF as an approach to health sector financing. The meeting assessed PBF's strengths, weakness and the modalities of its implementations in light of the different experiments. It concluded that the underlying principles of PBF and its outcomes regarding health system-building and health service quality outperformed the traditional input model, which is a procedural/processual financing model (Ssengooba, McPake & Palmer, 2012). Without

abolishing the traditional model, the national MoH adopted the PBF model and encouraged its implementation at the operational level. At the end of the meeting, a memorandum of understanding on the adoption of PBF was signed between the DRC and its partners (RDC/MINSANTE, 2012a). A direct outcome of this memorandum was the set-up of an ad hoc PBF branch (*Cellule Technique du Financement Basé sur les Résultats*, CTFBR) at the national MoH tasked with the internalisation of PBF principles (RDC/MINSANTE, 2012a).

Cordaid and the CTFBR have concentrated efforts to mobilise state officials to adopt PBF at both national and provincial levels. As for South Kivu, the Provincial MoH declared PBF along with community-based health insurance as health system financing models for the province in 2011. However, at present, PBF survives only because of its external promotors.

Findings on PBF and Health System-building Outcomes

This section first discusses the baseline for assessing the outcomes of PBF. It then examines whether the PBF experiments have 1) built a policy coalition for improved governance of the health sector; 2) improved the management of service delivery; and 3) empowered local communities.

The Baseline Situation for Grasping Outcomes of PBF's Theory of Change

Based on the content analysis of official national-level policy papers, we identified the different types of problems affecting the health system in the DRC. Table 3 presents the main types of problems.

Table 3: Problems

Affected areas of health system	Problems noted
Governance and/or leadership	1. Defective policy making, policy implementation and social accountability; 2. Poor normative power and weak coordination capability; 3. Politicisation of the sector management; 4. Absence of anti-corruption mechanisms; 5. Low concern about the broader social determinants of public health; 6. Poor empowerment of the population regarding their roles in public health and social accountability of both providers and the state
Human resource management	1. Little or no salary paid to health providers especially nurses; 2. Staff demotivation and frustration; 3. Uneven distribution of health staff between rural and urban/semi-urban HZs; 4. Unethical advancement in position and the absence of provision for honourable retirement (and no severance pay at all); 5. Profusion of below-standard health training institutions.
Health sector funding	1. Weak public funding and low disbursement rate of the budget; 2. Over-dependence on donors;
Supplies and management	1. Poor availability and management of drugs and health technologies; 2. Weak compliance with both procurement mechanisms and the state supply policy through the National System for Medical Essentials Procurement
Service delivery	1. Poor coverage in terms of geography and financial affordability; 2. Survival strategy (fending for yourself to survive) resulting in a high rate of turnover and commodification of health services, gaming, multitasking and parallel structures; 3. Unclear referral procedures 4. Low proportion of specialised/qualified staff members 5. Inadequate conditions in a number of health facilities, many of which are housed on privates premises
Health system information management	1. Regulatory texts for health system information are obsolete 2. Poor information flow 3. Poor vertical dissemination of public policy

Source: Compiled by the authors based on information from the International Monetary Fund (2007), RDC/MINIPLAN (2011) and RDC/MINISANTE (2006, 2010, 2011)

Analysis of these policy documents reveals the extent to which deficiencies permeate the entire health system. These malfunctions relate to the weakness of the state and, hence, governance functions. As stated, Cordaid's theory of change for PBF initiatives aims to strengthen state leadership. It offers a contextualised approach oriented towards state-building.

PBF Experiments and Strengthening Health Sector Governance in South Kivu

Reinforcing a policy coalition for structural health governance

We assessed the extent to which PBF has created a policy coalition among its stakeholders. Almost all informants were enthusiastic about PBF, which they praised as being better than the input model for health system-building. However, this enthusiasm was mainly based on the experiences of other countries and pilot experiments in South Kivu and Bas-Congo. Stakeholders praised the PBF approach for promoting policy coalition-building based on the ideals of service productivity and quality improvement. They mentioned strategic interdependence and division of labour among the actors, the decentralisation of operational decisions, operational flexibility and social accountability as the distinguishing features of PBF. At each level, the actors involved seemed to be aware of their roles and the outcomes of their engagement.

PBF promotes interactive collaboration among stakeholders to strengthen the networked governance of public health institutions. The implementation of PBF occurs at all three levels of the health system: central, provincial and operational (MINISANTE/CTFBR, 2012). State agencies from the three levels constitute the regulatory body, and health care providers include clinical staff members, as well as public organisations and NGOs.

The structural set-up of PBF and its theory of change require coalition-building around a set of values for active partnership between the state, providers, civil society and donor organisations. In Kinshasa and Bukavu, as well as at the service provision level in Katana, we witnessed actors' readiness to collaborate and their awareness of strategic interdependence and the necessary roles at these three levels of structural governance.

At the national MoH, PBF interventions revolve around macro-level national health governance, especially in terms of policy making and regulation. The *Comité National de Pilotage Santé* (CNP, National Health Steering Committee) is the high-level national platform for state and donor interactions. Donors, the state and national PBF-related organisations such as CTFBR and *Agence de Gestion Financière* (AGF, Financial Management Agency) participate in the CNP, where they meet to take high-level decisions regarding health sector governance: policy making and implementation, sector priorities, sector management and harmonisation and coordination of interventions. At this level, PBF is referred to as an

approach that reinforces health sector funding, rationalises health system management and promotes the internalisation of good health governance principles.

At the provincial level, the PBF approach focuses on implementing national policy and enforcing its management principles. However, regulators from state institutions act as verifiers from CBOs and as providers under PBF principles. Hence, Cordaid established performance-based agreements with the Provincial Health Inspectorate. Pursuant to PBF guidance, the Provincial MoH evaluates the performance of the Provincial Inspectorate, which is the technical wing of the Provincial Health Department. With donors' support, the Provincial Inspectorate and AAP evaluate the performance of HZs and, in turn, the HZ Central Office (*le Bureau Centrale de Zone de Santé*, BCZ) evaluates the performance of its health centres. Every structure has its respective action and quality assurance indicators for performance evaluation. The main regulatory structure at this level for the enforcement of PBF, overall health sector governance and stakeholders' coalition-building is the *Comité Provincial de Pilotage Santé* (CPPS, Provincial Health Steering Committee), which is the Provincial CNPS. The CPPS is under the administrative direction of the governor.

In South Kivu, the PBF approach promotes and strengthens coalitions among state institutions, international NGOs, CBOs and the community. For example, all PBF stakeholders in South Kivu are involved—at health department level—in context analysis, identification of needs, setting objectives, defining indicators and performance evaluation. The state representative, as a regulator, endorses the identified indicators and contracts with external partners. AAP takes the lead in monitoring and fund management and contracts with all of the providers, including frontline service providers, public health sector officials and other institutions involved in the process, and CBOs.[25] Not only do donor organisations and INGOs such as Cordaid support the activities of the state and AAP; they also participate in monitoring and outcome evaluation of PBF experiments. Cordaid's officer in charge of health described the contextualised philosophy behind PBF's theory of change as 'neither working for, nor against, but with the state in order to reinforce its leadership role'.[26]

PBF sensitises stakeholders about health financing reform at the national and provincial levels. At both levels, the MoH viewed PBF as a good model for health system financing and

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[25] Interview, Bukavu, 11/11/2014
[26] Interview, Cordaid Office, Bukavu, 22/10/2013

implementing a division of labour among key stakeholders. The MoH bodies assume the regulatory role, the HZs play the role of provider and AAP raises and allocates funding. CBOs provide the community voice. According to AAP, this division of labour was initially difficult because many actors were not ready for accountability.[27] An AAP representative noted that the state actors had not experienced a system where they would not have control over the financial management. A Provincial MoH official asserted that 'we do appreciate Cordaid mostly for the introduction of [the] PBF approach, which actually entices providers to positive competition for health quality'.[28]

Operational implementation of PBF at the health centres concerns mostly the process of health services delivery and the working conditions. The DRC local health system is also organised with a hierarchical architecture, with the levels being the *Bureau Central de Zone de Santé* (BCZS), the *Comité de Gestion de l'Hopital Général de Référence* (HGR, General Referral Hospital) and the *Centre de Santé* (Health Centre) supported by CODESA. The BCZS/HZ Office is the regulatory body at the operational/local level. The Hospital Management Board (for the General Referral Hospital) and the CODESA (for the health centre) are the organs for community participation in the management of the health facilities. Every health facility has its managerial structure and personnel. AAP contracts with individual facilities regarded as operational structures for PBF implementation.

The state, donors and providers have constructed a PBF community policy for the health sector financing reform. In its implementation, PBF supports capacity-building, which is an essential function of health governance. Capacity-building, in turn, contributes to the institutionalisation of good governance practices.

PBF as a tool for institutionalising regulatory mechanisms for internalisation of good governance practices
PBF supports the regulatory function of the Provincial Department and the MoH. The regulatory outcomes can be identified at multiple levels. State-level entities improve their knowledge regarding their roles and obtain the necessary financial support to fulfil them. At the Provincial Department of Health, both the head of the Health Inspectorate and the Provincial MoH officials asserted that the approach has been motivating public officials to internalise good practices through contracts. A primary health care official within the

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[27] Interview, AAP, Bukavu, 11/11/2014
[28] Interview, Provincial MoH, Bukavu, 03/11/2013

Provincial Health Inspectorate maintained, 'In line with PBF, staff members understand that when you deliver expected results, you gain; when you do not perform, you put yourself in the situation of a loser'.[29] At the Provincial Department of Health, contracting has improved output performance and administrative accountability. Although not all Provincial Health Department offices have thus far initiated PBF contracts,[30] in those that have, the culture of accountability instilled by PBF was acknowledged by the head of Health Inspectorate. The Provincial Health Inspectorate noted that 'PBF improves service quality at its level in terms of department functioning, effective administration, monitoring and local participation'.

Capacity-building and collaboration place PBF at the cutting-edge of human resource development. Cordaid's repeated interactions and meetings with the state entities promoted good health governance, provider performance, patient-centredness and strengthened outcomes. Observations from PBF stakeholder meetings revealed how important these interactions have been for improving health governance. Although PBF cannot right all of the wrongs that have long impaired the sector, its contribution is certainly appreciated. In this respect, a representative of Cordaid Kinshasa stated, 'we do not say PBF will solve all problems in the health sector; but PBF rationalises health sector governance, promotes creativity and raises awareness on state, providers' and beneficiaries' responsibilities'.[31] Regular meetings between the Cordaid and AAP teams and the Department/Provincial MoH dealt mostly with PBF uptake and implementation, health sector management and community needs assessment, joint endorsement of PBF-covered HZ reports, monitoring initiatives and accountability. These meetings also considered department output reporting, health facilities' action plans submitted to donor organisations and health service provision processes. These iterative interactions are important for the internalisation of good governance practices in the health department and HZ regarding health service provision processes. However, for AAP, the internalisation of good governance practices requires a great deal of patience, because it has been a challenge to change the mentality of the actors involved.[32]

PBF and Improving Health Service Provision Management in the Katana HZ

Health providers' motivation and strengthening management

The entrenched carelessness of the state for social welfare has ossified lax public service. Everyone struggles firstly for their own survival, transforming public services into assets that

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[29] Interview, Bukavu, 03/03/2015
[30] Only five offices had implemented PBF at the time of this study.
[31] Interview, Kinshasa, 26/01/2014
[32] Interview, AAP, Bukavu, 11/11/2014

civil servants exchange for their personal benefit. Describing this tendency, an official at the national MoH noted that 'civil workers get recruited but cannot live off their jobs'. This was confirmed by another official at the Provincial Department of Health: 'You manage your life from what you do on a daily basis; we live from hand to mouth [such] that it is hard to apply for holiday [or] be ready for [an] occupational retreat'.[33] This accounts for the persistence of the self-serving behaviours that were repeatedly reported.

Through performance contracting, PBF anticipates this problem by providing guarantees to both the principal and the agent. In one of the focus groups with the Katana management board, the participants brainstormed about the relevance of the PBF approach according to their professional experience. For them, PBF enables the providers and the community to focus on the common ideal of public health improvement. In contrast to input-based interventions, which are mostly procedural, PBF prescribes analysing the baseline situation and the overall context before defining intervention objectives. Importantly, the participants stressed extrinsic rewards, which they presented as a distinguishing factor of PBF: 'PBF allows for motivating the agent and living up to the population needs'.[34]

Nurses at a remote health centre (in Izimero) unanimously lauded PBF as it was implemented by AAP. According to one of nurses, 'without AAP/PBF we would not have survived. May God bless AAP. May it live long as a lake' [*arhame nka-ngadja,* in the Mashi language]. For a nurse, this stance is understandable, because most nurses either erratically receive a small monthly payment or nothing at all from the state. The best paid may get at most 27,000.00 CDF (27.00 USD), and some may receive less than 9,000.00 CDF (9.00 USD a month), but most receive nothing at all. The magnitude of dysfunction in human resource management affects performance, service quality and professionalisation. In South Kivu, in 2012, there were 8,121 known health workers, of which only 732 received the nominal salary; the rest received nothing from the state'.[35] The economic survival of civil servants presents an existential problem with professional repercussions. Hence, PBF helps in solving the agency problem and is crucial for rational health reform.

Although motivation through financial incentives is crucial in PBF, there are also other sources of motivation. In this respect, providers praised capacity-building. A member of the

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[33] Interview with medical doctor, Bukavu, 06/11/2013
[34] Interview, Katana, 11/04/2014
[35] Provincial Department records

Katana HZ noted that all contracting agents undergo on-the-job training to enhance productivity and quality. In a similar vein, the HZ administrator maintained that, before the introduction of PBF, it was difficult to recruit paramedical staff such as laboratory technicians. As PBF responds to the basic needs of the facility and population, staffing gaps were closed in all covered HZs: 'PBF […] has really contributed much to improving work regarding both inputs and infrastructure'.

PBF also leads to improvements in task-oriented behaviour. Staff members tended to respect the performance principles promoted by PBF, striving for efficiency and expected outputs. Although their motivation is still mostly transactional (incentive-based), it has been a good starting point. Improved task-oriented behaviours were reported in many dimensions, such as reporting, industriousness and human sensitivity, as well as in information accuracy and timeliness. Provincial Departments asserted that the reports received from PBF-covered HZs were clearer and more accurate than those received from non-PBF sites, because reporting quality and the reliability of intelligence are among the indicators.

PBF and improving service delivery

For many health officials and providers such as the Provincial MoH, 'PBF is a good initiative that improves the quality of services'.[36] Hence, the Katana HZ Administrator held that, since PBF was introduced, the rate of health service utilisation, which had plummeted when the Belgians handed over the management of the hospital, has increased again.[37] There is a causal relationship between governance and management, and between the improvement in service delivery outcomes and the implementation of PBF. Above all, improvements in patient-centred care are being championed.

Health providers and community members generally agreed that PBF has had positive outcomes regarding responsiveness in Katana. Some people complained about the unsympathetic attitudes of some providers and a disconnect between the claimed service provision improvements and the real quality of services. However, the limited number of these grievances does not call into question the overall effects of PBF on health outcomes. For example, across health centres, when community members were asked whether they were satisfied with the way health care services were being delivered at their health facility, they

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[36] Interview, Bukavu, 03/10/2013
[37] Interview, Katana, 25/02/2015

attested to significant improvements in the provider–patient relationship, context-sensitive pricing and the availability of drugs and other medical supplies. Of the 15 health centres visited, only one was criticised for uncaring behaviour. This means that, with PBF, the community's perception of health service provision and health providers is improving.

The rational management of drugs and other medical supplies achieved through operational planning is another aspect of PBF. On the basis of health facilities' action plans and indicators, medical products should be managed carefully with PBF indicators. The users of health services in different communities testified to improvements in terms of drug availability, frequency of visits, utilisation and professionalism.

However, not all health centres received the same appreciation of their performance. Additionally, from a longitudinal perspective, the improvement in the availability of drugs has differed among health centres. Community members complained about recurrent shortages of drugs in many health centres, and the prevailing practice was to prescribe medications for patient self-procurement. Nevertheless, the situation was generally reported to be improving although reaching a satisfactory level will require further commitments from both the state and donors.

PBF and Demand-side Empowerment for Social Accountability

Active community participation in the process of verifying health facilities' performance empowers the population as key stakeholders in health service provision and management. Such verification is a crucial requirement for validating health facilities' performance reports. There are two kinds of verification: internal/technical or objective verification and external or subjective verification (RDC/MINSANTE, 2012). *Internal verification* refers to technical tools and/or administrative principles regarding clinical or biomedical consultation guidelines and administrative reporting effectiveness. This kind of verification is conducted regularly (on a monthly and quarterly basis) by AAP and state representatives within health facilities. *External verification*, also known as quality verification, is conducted by an independent team of experts and CBO representatives. Quality verification focuses mostly on crosschecking with the beneficiaries the reliability of the data provided by the health facilities, as well as

their degree of satisfaction. AAP noted that community members had rejected fraudulent statements incorporated in some of the facility reports.[38]

PBF empowers communities through promoting patient-centred care, recognising their legal and legitimate rights to contribute to the process of service provision as both clients and beneficiaries. PBF engages CBOs, which, in turn, are requested to raise awareness of community entitlements. In the rural zones, such as Katana, community empowerment is crucial for social accountability and voice. In the DRC, community participation was 'poorly understood' (RDC/MINISANTE, 2006). However, 'with PBF, the community has become an active stakeholder aware of their statutory roles'.[39]

Cordaid also implements a programme called *PBF–community*, which aims to empower the community to interact productively with health care providers. The community is represented mostly through its CODESA, which also serves as the interface between the health facilities and the community. As such, a CODESA works to convey the population's aspirations to the health facilities but also to sensitise the community on health-related issues. Community members stated that, although the situation has not yet sufficiently improved, there have been some promising changes. Participation patterns have begun to shift from nominal participation to interactive participation. The community-empowerment initiative has strengthened the collaboration between health facilities and the community through performance verification.

Unfortunately, state weakness disempowers active participation in the provision of health services. The population's voice is still too weak to achieve full social accountability. Four factors explain this weakness. First, the concept of community is blurred; in a context permeated by social patronage, it is not always clear who the community is or how one becomes a community representative. Second, health workers have become increasingly self-regulated and lax in the quasi-absence of the effective regulatory power of the state. Third, in rural zones, providers enjoy social power over most poor communities. Fourth, there is inadequate understanding of the quality and social determinants of visits to health facilities in rural communities.

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[38] Interview, Bukavu 11/11/2014
[39] Focus group, Katana, 25/02/2015

Analysis

In sum, health officials consider PBF interventions more important than interventions of any other type to improve performance and strengthen health sector governance. However, there are critical challenges to institutionalising good governance practices related to both the shift among providers from a transactional incentive-based motivation to transformational behavioural change and the assertiveness of the state in its stewardship role through which the welfare of the community and the providers should be championed.

For some participants, multitasking observed at AAP level as fund holder, purchaser and especially verifier is a weak-spot in the implementation of PBF. Multitasking was mentioned as a potential obstacle to both rational management of funding and administrative accountability. Nevertheless, most respondents expressed their (relative) optimism about further strengthening health service governance, service provision management improvement and community-centred health care.

We found that almost all participants appreciated PBF outputs and even outcomes regarding institutionalising good governance practices, but only a handful—even in the public sector—could imagine the sustainability of PBF without donors. Moreover, the current socioeconomic system, insecurity and especially fragile statehood continue to influence PBF negatively, as they have with other donors' interventions in the DRC. The overall context of public management, characterised by endemic corruption (Trefon, 2011), undermines social accountability and the success of development interventions. Therefore, scaling up PBF to the whole country and achieving sustainability appear to be insurmountable challenges at this moment. However, the findings of this study have underlined the potential of PBF as a networked governance system in the DRC that motivated organisational staff increasingly to deliver commendable outputs, despite fragile statehood.

Conclusions

This study explored PBF's health-building outcomes and the strengthening of health governance in light of PBF's contextualised theory of change. Our analysis revolved around three aspects of structural networked health governance: i) strengthening health governance, which concerns PBF's effectiveness in terms of the state's health regulatory capacity and coalition-building; ii) health service provision management, which concerns providers and

service delivery processes; and iii) demand-side empowerment, which is requisite for social accountability.

Regarding *strengthening health governance*, PBF reinforces structural networked governance of health sector organisation, management and accountability. PBF empowers the state with organisational capacities while also helping to institutionalise good governance practices. The approach supports the government's regulatory role, coalition-building and social accountability through enforcing national policy, division of labour and patient-centred care. Through structural governance building and institutionalisation of good practices, PBF mediates the setting of goals and ideals, as well as building a coalition to work for their implementation. In contrast to other interventions, PBF renders the state more actively visible in system design, coalition-building, regulation and stakeholders' interactive collaboration.

Concerning the *outcomes of service provision processes management* in Katana, the majority of participants in this study viewed PBF favourably. This study found that contracting dealt with the agency problem by motivating health workers and providing performance incentives, thus addressing the laxness observed in the public sector. PBF also provides useful support regarding the rationalisation of health management. Through promoting contract-based market principles and integrated management, PBF inputs not only help attract new health staff, but also improve task-oriented behaviour. This study noted some progress in terms of behavioural change and good practices such as readiness for financial accountability, commitment to quality, productivity and patient-centred care in the Katana HZ.

In terms of *demand-side empowerment*, PBF gives power to communities through promoting patient-centred care and recognising communities' legal and legitimate rights to participate in the process of service provision as both clients and beneficiaries. PBF engages with CBOs, which, in turn, work to raise awareness within the community regarding their entitlements. Active participation of the community in the process of verifying health facilities' performance records empowers the population as a key stakeholder in health service management. It allows the interactive participation of the community, which is necessary to establish a more effective state–society relationship. Although the capacity to participate effectively for social accountability is still weak, the community in Katana testified that PBF efforts raise social awareness on the relevance of their interactive participation in health service provision.

Although there are many indications of positive effects, PBF interventions in the DRC face structural challenges that make achieving sustainability difficult. As a result, the approach remains confined to pilot experiments that so far fail to scale up. Many of these challenges are related to state fragility. PBF implementation relies mostly on inputs from external donors, which creates dependency and anxiety regarding their withdrawal. The MoH itself is dependent on donors' financial incentives for implementing performance policy. Thus, PBF seems to be about transactional—or incentive-based—motivation for the state at governance and management levels, as well as for providers at the grassroots level. It is challenging to move beyond transaction-based motivation to create a real behavioural transformation among providers. Moreover, there is a need for a real division of labour, an issue that was raised by many respondents as a critical way to prevent unpredictable outcomes related to conflicts of interests and unreliable reporting. In sum, it is costly to scale up and achieve sustainability in the absence of a working state. Strengthening the state's willingness and capacity is necessary for the success of any donor-inspired scheme. PBF supports health sector-based state-building, but it cannot repair a collapsed, corrupt state. Further research is needed on achieving transformational change in a context where the state itself is a main cause of social weakness.

Chapter 5: Community-based Health Insurance/*Mutuelles de Santé*, Local Health System Governance and Universal Health Coverage Outcomes in the Democratic Republic of Congo, a Fragile Setting

Birava *Mutuelle de Santé* Branch Office, fieldwork photo

This chapter was presented at the Development Association Conference in September 2016 in Oxford, United Kingdom, and was submitted to a Journal as 'Community-based health insurance in a fragile setting: community health coverage outcomes in the Democratic Republic of Congo', authored by Aembe Bwimana and Dorothea Hilhorst.

Embedded in the community: The researcher interviewing women in Birava about the relevance of *Mutuelle de Santé* and family planning beliefs in the area, fieldwork photo

Abstract

In fragile states and war-affected societies, the access of poor individuals to health services is a major problem that undermines the achievement of the universal health coverage agenda. In recent years, there has been an upsurge of community-based insurance schemes in fragile settings that aim to improve this access. This chapter explores the outcomes of such a scheme, *Mutuelles de Santé* (MUS), which began operating just after the wars in South Kivu in the Democratic Republic of Congo. Based primarily on case studies in a rural area (Katana) and in a semi-urban area (Uvira), this research examined MUS outcomes in terms of equity in access to health services, protection from the financial risk of disease and the financing of health services. Our findings indicate that MUS schemes led to improvements in access and social protection 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 facing MUS schemes that are compounded by state fragility. To contribute effectively to universal health coverage, the state should reinforce its stewardship presence in strengthening MUS. This dimension should be explored in depth by future research and is of great importance for the improvement of health outcomes in fragile settings such as the Democratic Republic of Congo.

Introduction

The access of poor individuals to health services is a major problem that undermines the achievement of the universal health coverage agenda in fragile states and war-affected societies. Since the 1970s, universal health coverage (UHC) has been a worldwide public health ambition, which was translated into a global commitment at the 1978 Alma-Ata Conference, where World Health Organization (WHO) member states engaged to pursue equitable primary health care systems providing universal access to point-of-entry services (Stuckler, Feigl, Basu & McKee, 2010). However, progress in primary health care has remained elusive, and some have stressed that many countries, especially in low-income contexts, cannot afford UHC (Stuckler et al., 2010). In Sub-Saharan Africa, for instance, the lack of public funding of the health sector has been identified as the main factor preventing countries from progressing towards universal coverage. Over the past three decades, community-based health insurance (CBHI) initiatives have gained currency as an alternative means for achieving UHC in countries where public funding is insufficient. This began with the 1987 Bamako Summit, which encouraged community participation in the financing of health services in an attempt to achieve universal primary health care in African countries (McPake, Hanson & Mills, 1993). CBHI schemes usually adopt three working principles: the enhancement of access to health through insurance, equitable risk pooling and financial affordability for vulnerable groups, and stakeholders' interactions through CBHI schemes.

UHC is challenging in poor countries, but it becomes truly daunting in areas undergoing conflict or recovering from war. Extreme poverty, coupled with an intense weakening of institutions and services in these settings, makes achieving UHC very unlikely. Nonetheless, in the past decades, a number of CBHI schemes have been set up in conflict-affected settings. During the 1980s and 1990s, community-based initiatives were developed in the Democratic Republic of Congo (DRC) following the withdrawal of the state from service provision. One such initiative was the *Mutuelles de Santé* (MUS), which was the first provincial CBHI set up by the Bukavu Catholic Archdiocese in South Kivu province to reduce the disease burden among poor households. MUS materialised in earnest in South Kivu in the 1990s, a time when the country became immersed in war. This study examined two MUS initiatives (in a rural and in a semi-urban area of South Kivu), with the aim of studying outcomes achieved through MUS on equity in access to health services, protection from the financial risk of disease and the financing of health services.

Our interest in these multi-actor initiatives stems from a wider interest in the local realities of conflict-affected institutions. Early assumptions that institutions in conflict settings would cease to function have been replaced by recognition that, especially at the local level, these institutions may continue to function, albeit in a weakened or altered condition. Nonetheless, it is common to model early recovery on humanitarian formats where services are provided for free and are often delivered while bypassing existing services and government institutions. In this chapter, we examine attempts to strengthen the sector governance and build access to health through micro-insurance schemes, with the objective of contributing to current debates on whether this approach can indeed increase access to health, and on how post-conflict recovery can be grounded in local institutions and based on the resilience of individuals.

Background

CBHI in African Fragile States: Social Protection Initiatives for UHC

A lack of health sector financing has been a challenge for many African countries since gaining their independence. The situation has been compounded by the effects of neo-liberalism on African economies. Through contracting out public sector health services beginning in the 1980s, neoliberal structural adjustment programmes prompted the emergence of private care in Africa (Pfeiffer & Chapman, 2010). During these years, almost all countries in Sub-Saharan Africa implemented user fees at government health facilities to supplement inadequate national health budgets (Smith & Sulzbach, 2008). However, user fees adversely affected access and equity in the health sector in contexts of economic hardship (Smith & Sulzbach, 2008). Due to low and unstable revenues made worse by the cutbacks in public budgets, African countries were not able to achieve the goal of providing free health care for all (Wiesmann & Jütting, 2000). CBHI initiatives were increasingly viewed as a way to increase health care access and protect households from high health care expenditures (Smith & Sulzbach, 2008).

CBHI is broadly defined as any scheme managed and operated by an organisation other than a government or private for-profit company that pools risks to cover all or part of the costs of health care services for individuals (Bennet, 2004). CBHI schemes are characterised by 'voluntary membership, [a] non-profit character, [the] pre-payment of contributions into a fund and entitlement to specified benefits, [the] important role of the community in the design and running of the schemes [and an] institutional relationship to one or several health care providers' (Jütting, 2004). These systems pursue the goal of fairness in health financing by

asking members to pay according to their means while guaranteeing the right to receive necessary health services (Carrin, Waelkens & Criel, 2005). This is where CBHI meets social equity principles. Health equity implies 'a fair distribution of the benefits and burdens of health services among groups and individuals' (Marmot et al., 2008). CBHI has been lauded as a promising new tool for improving the health system for rural populations in low-income countries, particularly in Sub-Saharan Africa (Dong, de Allegri, Gnawali, Souares & Sauerborn, 2009). Further, developing 'a financial risk pooling system that provides cross-subsidies in health systems where ability to pay determines financing contributions and the use of services is on the basis of need for care' has been described as a crucial aspect of achieving UHC (Wang & Pielemeier, 2012).

Based on the WHO definition, UHC 'ensures that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship' (Bristol, 2014). The WHO definition emphasises three correlated tenets: accessibility of essential health services, protection from financial risk and equity in health service financing where the amount of contributions is based on ability to pay (Stuckler et al., 2010). This definition of UHC places CBHI in the category of social protection schemes, which comprise 'the public actions […] taken in response to levels of vulnerability, risk and deprivation which are deemed socially unacceptable within a given polity or society' (Norton, Conway & Foster, 2001).

Social protection thus deals with the absolute deprivation and vulnerabilities of the poorest individuals and also with the need of the non-poor for security in the face of shocks and life-cycle events (Norton et al., 2001: 7). Social protection interventions have a range of objectives, including protective (providing relief from deprivation), preventive (averting deprivation), promotive (enhancing real incomes and capabilities) and transformative (addressing concerns of social equity and exclusion) (Hervey, Holmes, Slater & Martin, 2007). Social protection principles are consistent with the WHO concept of primary health care and with the programming goal of 'Health for All', which form the foundation of CBHI. CBHI/MUS schemes in the DRC have bearing on the protective objective, aiming to provide relief from severe financial risks using funding mechanisms based on prepayment and pooling, and on the transformative objective, striving to achieve social equity in access to health services.

For the WHO, even where funding is largely prepaid and pooled, there will be trade-offs between the proportion of the population covered, the range of services made available and the fraction of the total costs paid (World Health Organization, 2010b). Figure 10 illustrates these three dimensions.

Figure 10: Three Dimensions to Consider When Moving towards Universal Coverage
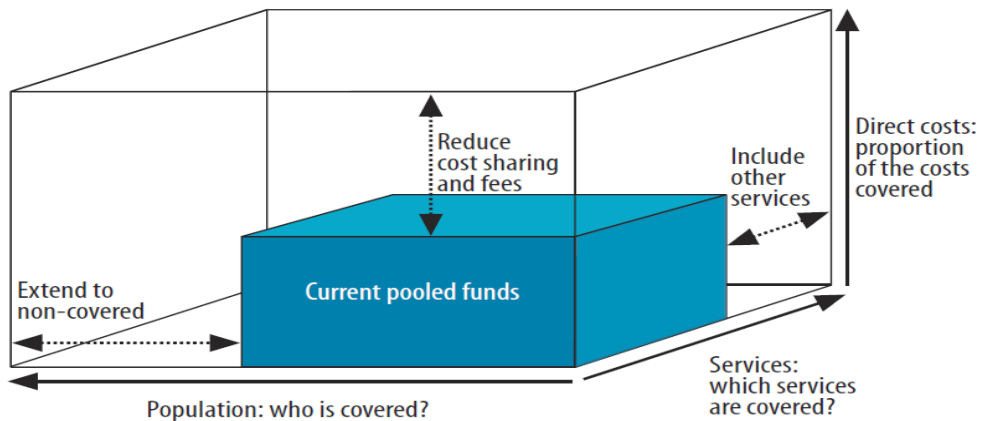
Source: World Health Organization (2010b)

In Figure 10, the box labelled 'current pooled funds' depicts the current situation in a country where about half of the population is covered for about half of the possible services, but where less than half of the cost of these services is met from pooled funds (World Health Organization, 2010b). According to the WHO, to get closer to universal coverage, the country would need to extend coverage to more people, offer more services and/or pay a greater part of the costs (World Health Organization, 2010b).

Health Systems and CBHI Schemes in Fragile Settings

Regarded as lacking both the capacity and the willingness to perform key government functions, fragile states suffer deficits in governance that hinder development, and, as the conditions are too unstable for long-term planning and investment, society focuses on short-term coping strategies to secure basic needs (Massing & Jonas, 2008). These states are unable to perform basic functions such as maintaining security, enabling economic development and ensuring the essential needs of the population are met. Further, these states are characterised by weak policy, institutions and governance (Haar & Rubenstein, 2012b).

In fragile states, particularly those that have experienced extended periods of conflict, health systems have typically been seriously eroded: The health infrastructure has been destroyed or is not functional, services are fragmented and differentially available and financial resources are scarce (Brinkerhoff, 2008). As public finance for health declines, private spending on health increases. Better-off citizens may still be able to purchase care, but the poor and marginalised have fewer options (Brinkerhoff, 2008).

Sub-Saharan Africa accounts for 11% of the world's population, yet bears 24% of the global disease burden and commands less than 1% of global health expenditure (IFC, 2008). Moreover, half of Sub-Saharan Africa's total health expenditure is financed by out-of-pocket payments from its largely impoverished population (IFC, 2008: vii). In contexts of deteriorating governance, arrested development or the early stages of post-conflict transition, humanitarian responses are the primary means of health sector support; however, this support is not designed to be long-term (Sondorp, Ter Veen & Howard, 2012). Development assistance requires greater stability than is found in fragile states (Sondorp et al., 2012).

In this kind of context, institutional weakness and its resultant societal fragility detrimentally impact the functioning of CBHI schemes (Leppert, 2012). In most cases, dysfunctional states fail to facilitate the achievement of social goals through CBHI schemes. Despite the appeal of the CBHI concept, it is unclear whether CBHI improves community health outcomes in fragile states (Dong et al., 2009; Jütting, 2004; Smith & Sulzbach, 2008). The coverage of CBHI schemes in Africa remains relatively low (Tabor, 2005; Wiesmann & Jütting, 2005). Additionally, unlike social health insurance schemes, which are generally provided to citizens by governments (Acharya et al., 2011), in many fragile African countries, CBHI schemes have been promoted and largely driven by external organisations. Health insurance schemes in countries with long-standing social health protection mechanisms originated as home-grown initiatives that involved social actors in designing and implementing the schemes, but, in many fragile African states, CBHI schemes are simply community-based and state adopted. They have been initiated by health facilities, NGOs, local communities or cooperatives and can be owned and run by any of these organisations (Wiesmann & Jütting, 2005). Without functioning state endorsement and political engagement, it is difficult to envision micro-health insurance's viability, enhancement or scaling-up. Indeed, this problem has been faced by programmes in China, Ghana, Rwanda and Thailand (Wang & Pielemeier, 2012). Nonetheless, in many African countries such as the DRC, where the state role is nominal and

scarcely visible, CBHI is presented as a rational step towards health system financing for achieving UHC.

CBHI Initiatives in the DRC

Since the later stages of the Mobutu regime in the 1980s–90s and the subsequent social turmoil, the population of the DRC, especially in the eastern part of the country, has experienced the social effects of state fragility and the consequences of repeated wars. In its bids to improve primary health care coverage, the DRC government has formally subscribed to the global UHC agenda (RDC/MINIPLAN, 2011). However, the state has also acknowledged that it faces multiple obstacles making it difficult to fulfil population UHC needs. Health system governance, public funding and the financial management of public health accounts are weak spots that have negatively impacted the entire health system and community health status (RDC/MINIPLAN, 2011). Although improvements in education and the health sector are considered to be of strategic benefit for long-term development, both sectors are poorly funded by the state (World Bank, 2015). This means the overwhelming burden of current community health expenses is born by poor households and international actors.

In the DRC health system, the management of the health service provision process and community health coverage is carried out at the level of the health zone (HZ). The HZ is an operational unit in the health system network entrusted with enforcing national health policy and state public health strategy. HZs vary in size depending on population density, covering at least 100,000 inhabitants in rural areas and 150,000 in urban areas. Each HZ is composed of at least of one general referral hospital and a network of health centres.

To address the lack of access to health services, in the second *Poverty Reduction Strategy Paper*, released in 2011, the DRC government first promoted CBHI. *Le Programme National de Promotion des Mutuelles de Santé* was a national strategy for the promotion and the development of CBHI. This strategy aimed to institutionalise, streamline and professionalise CBHI management in light of the UHC agenda. The promotion of CBHI schemes is recommended in the DRC's Health System Strengthening Strategy as part of the aim to improve health service funding and population coverage. This overall strategy is based on the idea of public mobilisation of funding and the necessity for the state to improve its financial interventions while the population is also held responsible for financing their health through CBHI (RDC/MINISANTE, 2006).

This chapter explores how CBHI mediates the access of war-torn communities to primary health care in a context of structural fragility of political and administrative institutions. The chapter examines MUS health coverage outcomes in Katana and Uvira, guided by the question of how non-state actors' inspired arrangements such as community-based insurance schemes affect networked governance and the achievement of universal primary health care coverage in war-torn communities experiencing excessive financial hardship and statehood fragility in South Kivu.

The relevance of this study lies in its examination of MUS health coverage outcomes in a war-affected context with a state too weak to implement the UHC agenda. Until recently, most of the debate around UHC addressed health coverage in middle-income countries and in emerging economies; how the debates play out in fragile and transitional states is largely unknown (van de Looiji, 2014). Our findings are significant for the policy-making process in the DRC, because the study brings to light the limitations of MUS, which, despite the potential of community resilience, cannot deliver on expected outcomes without the earnest involvement of a working state. The study is also of theoretical relevance, as it raises awareness of the pertinence of considering statehood fragility in the endeavour to achieve health equity and UHC.

Methods

The research was conducted in South Kivu province from early 2014 to mid-2015, focusing on the Katana and Uvira HZs. Katana is rural HZ with a long history of MUS, which was introduced in the area in 2007. In contrast, Uvira is a semi-urban HZ that is relatively new to MUS, which was introduced there in 2012. The selection of these two HZs enabled the comparison of the workings of MUS in two very different environments. Katana is a Catholic Church-led, rural HZ. The MUS in Katana has benefitted from the support of the *Bureau Diocèsain d'Oeuvre Médicale* (BDOM, Diocese Office for Medical Activities) and international NGOs through their promotion of community health improvement. Uvira is a state-led HZ with no substantial faith-based organisation foothold. The MUS operating in the area relies mostly on population engagement. The semi-urban, ethnically diverse population in Uvira differs from that in the rural zone of Katana, whose inhabitants' sociodemographic characteristics are almost uniform. Although most of the research was conducted in Katana and Uvira, complementary data on MUS management and the role of different stakeholders were collected during field visits to Idjwi and Bukavu.

We drew heavily on semi-structured interviews with state officials, health facilities managers, MUS management teams (at provincial level and in Uvira, Fomulac, Bukavu and Idjwi), community members and MUS organisational stakeholders (from the Catholic Church, a Protestant church and international NGOs). State officials were selected from the Ministry of Health (MoH) offices, which are in charge of primary health care coverage and the management of health facilities. Health facilities management and front-line provider participants came from the Katana and Uvira HZs and the island of Idjwi. Data were collected from 15 of 17 health centres in Katana and 10 of 22 in Uvira.[40] In every health centre, the head of nursing and the accountant were interviewed. The former provided information regarding the impact of MUS on UHC in terms of health services utilisation; the latter was asked about social protection and health facility financial sustainability outcomes of MUS schemes in both settings. Because village community connectedness and bonds are strong in rural setting such as Katana, community contacts and snowball sampling at the village level were used to select MUS members for participation in the study. In more urban areas, MUS offices were the contact point that mediated the identification of and interactions with MUS members.

To unearth the salient themes in our data and to structure these themes in a useful way (Attride-Stirling, 2001), we used NVivo software to conduct a thematic network analysis revolving around three main themes: i) provincial governance of MUS schemes (history, membership procedures and stakeholders interactions); ii) MUS schemes and community health coverage in the HZs (local management and MUS uptake along with community penetration of the schemes); and iii) MUS health system financing and equity improvement outcomes in the HZs.

Results

Provincial Outlook and Governance of MUS Schemes in South Kivu

MUS schemes profile: History, membership procedures and stakeholders

MUS schemes were initiated in South Kivu in 1990 (SK/MINSANTE, 2011) as private non-profit patterns of partnership with the state for the public interest. MUS is based on the voluntary subscription of households, participatory democracy, empowerment-ownership, community solidarity, non-profit engagement and preventive care (SK/MINSANTE, 2011). By 2012, MUS membership in South Kivu had risen above 100,000, with this number more

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[40] *The whole Katana HZ contracted with MUS schemes, whereas only 10 of the 22 health centres in Uvira contracted with them.*

than tripling in five years from 29,648 members in 2007 to 109,908 members by 2012 (Dusoulier, Rugarabura & Zawadi, 2014). By 2014, there were 23 MUS schemes operating in 14 of the province's 34 HZs, and MUS schemes had 121,163 members—5% of the population in covered HZs (Dusoulier et al., 2014).

Organisational stakeholders interacting through or with MUS at provincial level include national and international organisations as well as health facilities. Among the relevant national organisations, BDOM through the *Cellule d'Appui aux Mutuelles de Santé* (CAMS) plays the flagship role for MUS in the province. BDOM is the representative of the Catholic Church, which has championed and promoted MUS in the province. The *Programme Solidarité-Santé* (PSS) is a public structure serving as the interface between MUS schemes and the state. International organisations at the foreground of MUS include *Mutualité Chretienne Hainaut Picardie*, Malteser and Cordaid. These donor organisations provide MUS with technical and financial support. Health facilities are a critical stakeholder, as they provide community health services and in turn expect MUS schemes to support their financial sustainability. The PSS is the representative of the state, and CAMS is the operational representative of BDOM, playing a technical role for the provincial management of MUS schemes. At the local level, MUS schemes reflect community ownership to a greater extent than at the provincial level, because all MUS schemes are locally independent structures with similar management structures across the province.

The procedures for setting up MUS schemes and their local management follow the same pattern across the province. Every MUS at community level is a decentralised entity that does, however, depend on Bukavu for guidance on some issues of administration and management. For opening a local scheme, the community organises itself and sends a letter to BDOM requesting permission to open a local MUS. BDOM examines the local possibilities for opening a viable scheme. According to the CAMS coordinator, 'this process is justified, because poor groups may express the desire to open a MUS scheme without having the ability to make it viable'.[41] To be accepted, then, the group applying must be able to mobilise a certain number of community members to assure funding for the scheme. For example, in 2008, the Bukavu/Ibanda community, led by Catholic priests, was asked to mobilise 3000 community members before being granted a MUS scheme.

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[41] Interview with provincial coordinator of CAMS, Bukavu, 16/10/013

Most community MUS schemes were initiated by the Catholic Church and endorsed by BDOM. Once accepted by BDOM, every community scheme elects an executive board and the two members of the management committee (*Comité de Gestion*, COGES). The executive board consists of a president, a vice-president, two secretaries and four advisers. An auditing commission comprises two staff members and is set up for financial and administrative control. The two on-the-ground staff members of the COGES are preferably appointed with gender balance (one man and one woman).[42] They are tasked with the day-to-day running of MUS scheme activities such as community mobilisation for enrolling, membership registration at the community MUS office, reporting, paying health service costs invoiced by health facilities and monitoring the quality of the health care provided by health facilities to insured members. This entity is critical as an arena of interactions between the community and the MUS scheme and between the community and the health facilities, as well as serving as the interface between local schemes and the provincial management. The general assembly convenes twice yearly; all other administrative entities meet two times each quarter. Only the management committees work on a daily basis.

 The COGES completes contracts with health facilities for preferential costs and mobilises both the community and the health facilities, serving as the interface between the community, MUS and health care providers. Members report ratings of services received through the MUS to the COGES. The committee also conveys the needs of MUS members to health facilities and issues credentials (i.e. membership cards and vouchers required to access health services). Additionally, the COGES monitors mutual compliance to the terms of the contracts between MUS schemes and health facilities. Providing quality services through the MUS schemes and health facilities is understood to be required by national policy, and providers are ethically bound to follow professional clinical processes during consultation sessions in the procurement of pharmaceuticals. To ensure high quality in health care provision, COGES staff members visit health facilities and collect feedback on MUS members' experiences.

The household is the subscribing unit to MUS and is expected to enrol all family members on a yearly basis. For budgeting purposes, the enrolment period for the next year runs October–December each year. However, as of January 14, 2016, the Uvira MUS did not yet know the exact number of insured members for 2016, because the enrolment process was ongoing. The premiums charged for membership vary significantly among different local MUS schemes and sites, even within the HZs. For example, in the urban MUS of Bukavu (Ibanda) and in the

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[42] In Idjwi this was not the case. There, there were two men.

semi-urban setting of Uvira, according to the Ibanda MUS office, a yearly premium in 2014 amounted to 7.00 USD per member;[43] this figure was 5.00 USD in the village settings of Katana and Idjwi.[44]

Allocations made for health care payments appear to be standardised across the schemes. An insured patient pays a 20% co-payment for hospitalisation fees, while the scheme pays the remaining 80%. For ambulatory care, an insured outpatient's co-payment is 50%. The pricing system is standardised throughout individual HZs. The premiums collected are allocated along operational lines as follows: 75% for members' health care, 15% for an investment fund to cover potential declines in membership and 10% for pooling funds for any other MUS scheme incurring bankruptcy.

The MUS contracting process covers minimum (medical care at health centres) and complementary (medical care at hospitals) service packages; tertiary (care in special hospitals at provincial or national level) interventions are not covered. The schemes try to achieve risk pooling while guaranteeing financial viability for their health facility partners. The negotiated fees vary according to the type of sickness, resources invested and service package.

Showing a CBHI membership card at a health facility is required to access preferential services. A primary health provider referral is also required. However, our findings indicate that not all facilities adhere to the agreed fees. Most claims of this type were made in Uvira, where the general hospital, which has signed a contract with the MUS and participates in a state-led referral structure, was repeatedly criticised for not complying with the tariff agreement. Health facilities were also critical of the practices of the MUS, noting delays and irregularities in payments from MUS schemes.

MUS as a networked governance arrangement for multi-stakeholder processes

MUS schemes serve as an arena of interaction for civil society, the state and international NGOs. As an open arena with the mission of serving the public interest, MUS schemes bear the marks of public space, where the state operates alongside non-state actors (Animashaun, 2009). These schemes are an example of networked governance for the Congolese health system. The Catholic Church has also played a leading role in this sphere. This is both an asset and a challenge for CBHI schemes. The Catholic Church has an outstanding record of management of community-based initiatives and civil service organisations. It is the most

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[43] Interview with Ibanda/Bukavu COGES staff, 20/02/2015
[44] Interview data from Katana and Idjwi, 2014

populous faith-based organisation in the region, and it has a great capability for social framing and social mobilisation. However, many view MUS schemes as Catholic-affiliated, and this has restricted the schemes' reach in non-Catholic settings. The Uvira COGES president asserted that, although the MUS is an open public space, 'Catholic priests are more involved in the MUS than are Protestant pastors, but also the power is more scattered among Protestants than in the Catholic Church'.[45] Nevertheless, MUS managers and state officials throughout the province asserted that the schemes are being transformed into a nonreligious public space. MUS leaders acknowledged the predominance of Catholic members but said that Catholics receive no preferential treatment within the MUS schemes.

The state is—or is expected to be—another key player regarding MUS. In the view of those associated with both MUS and the health facilities, state involvement is required for achieving positive MUS health outcomes. Many knowledgeable key informants believed that MUS could be a beneficial approach for the population if the state would become seriously involved and collaborate with other stakeholders, and that groundwork should be conducted prior to the introduction of MUS. These informants maintained that there are still many 'grey zones' relating to organisational management, the allocation of roles among stakeholders and the management of the expectations of both the population and the health facilities. Some state officials maintained the same opinion. For instance, a provincial public official noted that 'the role of the state resides only in providing laws, regulation and technique advice'.[46] For another state official in the Public Health Department, 'the state will not engage earnestly for fear that it should be required to start paying MUS personnel'.[47]

Officially, the state claims to engage actively through the coordination structure of the PSS, which has operated since 2011. The state also declares that it enacted MUS schemes as an official mode for health sector financing (SK/PSS, 2011). However, in this research, state actors had no clear answer when asked how MUS would work in rural zones in the context of abject poverty. From the state perspective, the collaboration between the state and the MUS is a public–private partnership based on public ownership. In this respect, a state official working in the health sector maintained that the state expects that the 'community organises itself, formulates its by-laws and submits them for the review and approval of the state,

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[45] Focus group with Uvira's COGES staff,16/09/2014
[46] Interview with the head of PSS, 20/10/2013
[47] Interview at a Provincial Health Department, 21/11/2014

because MUS schemes are in essence non-state initiatives, but their provincial coordination is a state-led structure with the mission of accompanying them on behalf of the state'.[48]

Donor organisations have a substantial influence on MUS governance. *Mutuelle Chretienne* is the main supporter providing MUS with administrative means, especially to fund the payment of provincial staff members. However, the reluctance of the state to engage effectively in supporting MUS schemes led donor organisations to rethink the governance of the schemes to ensure their continual support in 2015, concluding that the office of the bishop itself for each area should take the lead role. Unfortunately, this will confirm the idea that MUS schemes are Catholic Church-owned initiatives. This change is currently underway for the Uvira MUS.

This raises questions regarding the extent to which MUS governance is community-based. Empirical observations on the ground revealed that MUS schemes are community-based in that their success is dependent on community members joining. However, in most cases, MUS schemes were only adopted—not designed—at community level. In other words, MUS schemes in South Kivu are not yet community-driven. One of provincial MUS managers made it clear that 'although they are called community-based, there are some limits communities cannot cross'. For all of the participants in this study, MUS sustainability depends upon improvements in population uptake, scheme penetration and social protection engagement from the state.

MUS and Community Health Coverage in the Katana and Uvira HZs

Local management, MUS uptake and community penetration in Katana and Uvira

MUS governance follows the same standards in the two HZs, with both schemes following BDOM guidance. In both HZs, the MUS scheme has a permanent office comprising two management staff members and an executive board, within which the Catholic Church has a large influence. In the management of the local MUS, the COGES develops ties with influential social actors such as churches, civil society, the HZ Central Office and state representatives. The HZ Central Office plays the role of providing technical advice regarding public health issues, but it also represents the MoH locally.

The HZ board was observed to have more influence over the MUS in Katana than in Uvira. During a field visit to the Birava MUS branch in the Katana HZ, the local coordinator was very reluctant to provide information on MUS activities without clear authorisation from the

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[48] Interview with the provincial coordinator of PSS, Bukavu, 20/10/2013

HZ board. Despite being presented with an authorisation letter from the HZ office, this coordinator phoned the head of that same HZ Central Office to ask whether she should respond to the questions. The Uvira case proved very different, as the coordinators went as far as to voice critical opinions regarding the HZ and its relationships with the MUS.

MUS schemes first appeared in Katana in 2007–2008, and MUS membership in Katana has been growing since then, although not in proportion to population increase in the region. In 2015, MUS members accounted for 5.2% of Katana's HZ catchment population (10,907 members out of 209,746 inhabitants, July). This population is distributed across 17 health centres plus the Fomulac referral general hospital.[49] In Uvira, MUS schemes were first introduced in 2012. In that same year, the MUS registered 4,501 of 305,535 people. In 2013, the membership increased slightly (to 4,576 people) before decreasing steeply to 3,282 in 2014 and to 2,883 in 2015.[50] By July 2015, the catchment population for the Uvira HZ was 315,008, distributed across 22 health centres.

Regarding the membership profile in both HZs, the MUS schemes must rely on expanding community penetration for improving UHC but also for ensuring the MUS's sustainability. However, we found that the MUS concept of 'community members' was not well defined. Both MUS schemes strived to enrol staff members from public and private organisations such as schools, micro-credit financial cooperatives, health facilities and governmental offices in the name of the community. From the MUS and health facilities' accounts in both HZs, it was clear that enrolling organisation staff members in this way constituted a safety net for the financial sustainability of the MUS schemes and health facilities. Workers, unlike many ordinary community members, had the capacity to pay the necessary membership premiums. In most cases, arrangements were made with employers for enrolling staff members. The premium pricing system is standardised according to the setting, regardless of the income of the subscriber. This situation undermines equity and social justice principles in the community-insured health care sector. Increasing the rate of registration of 'common' community members was nevertheless repeatedly stressed by all of the MUS schemes.

Clearly, MUS penetration and population uptake remain low in both HZs, although the membership is not at the same level in the two areas. In Katana, the trend is towards small increases in membership, but membership is declining in Uvira. However, in both settings, most community members acknowledged the benefits of MUS schemes. According to

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[49] Data provided by the administration office of Katana HZ, May 2016.
[50] Data provided by the Uvira MUS office, May 2016

experience-based accounts from members, MUS contributes significantly to health service affordability for those without livelihoods incomes, although some noted that certain health facilities valued international NGO vouchers utilised by their (INGO) personnel above MUS membership cards. Therefore, MUS members felt that they faced a situation of skewed consideration, especially in terms of individual conditions and social rankings. A number of informants maintained that the client's social position impacts the consideration they will receive in many health facilities. Some public health officials attributed this situation to the fact that health facilities are self-reliant without public funding.

Differences between Katana and Uvira

The differences in findings in the two geographical settings result from multiple factors. For example, in Katana, a Cordaid programme supported the enrolment of poor people in MUS schemes. There was no such programme in Uvira, where the scheme received no donor support. Although Cordaid's engagement in Katana was declining, its impact on the overall trend was still perceptible in 2014. Another difference concerned the required cost for enrolment: In 2014, the yearly premium fee in semi-urban Uvira was 7.00 USD, whereas Katana charged 5.00 USD. However, different locations might not correspond to income opportunities or livelihood capital differences, especially for the poor. The relatively high degree of ethnic homogeneity found in Katana might be another factor facilitating quick adherence to community-driven initiatives, because social bonds tend to be closer in this type of context.

Another plausible explanatory factor for the differences observed concerns the duration of the presence of MUS schemes and the population's experience of previous community-based micro-credit schemes. The Katana MUS has been operational since 2007, so it is supposedly well-embedded in the community. Uvira is a new MUS, introduced in 2012. Additionally, Uvira had negative experiences with former micro-credit cooperatives. In the 2000s, many risk-pooling initiatives, such as a *tontine*,[51] Gala Letu's Community-Based Credit Cooperative and Imara Cooperative, pooled monies from the population, who adhered massively to their schemes. Eventually, all of these schemes went bankrupt and disappeared without compensating their members. This experience contributed to people's current suspicion of initiatives championing fund pooling for social protection.[52]

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[51] A *tontine* is a system for raising capital in which individuals pay into a common pool of money and then receive a dividend based on their share.
[52] Interview Uvira/MUS branch office,01/10/2014

However, interactions with community members in the present study revealed that, in addition to the obstacle of mistrust based on past exploitative experiences, many people do not have a good understanding of the schemes or their relevance. This points to a weakness in the process of awareness raising. Our findings indicate that much remains to be done so that community members can better understand the relevance of MUS.

Another explanatory factor for declines in MUS enrolment in Uvira is related to the attitude of Uvira General Hospital. In both studied HZs, most health facilities representatives mentioned delays in payments from the MUS. In Uvira, MUS representatives described the unsupportive attitudes of health facilities, especially the referral general hospital, which disregarded a signed agreement with the MUS. The MUS scheme in Katana is being implemented throughout the HZ, whereas only 10 of 22 health centres in Uvira have made agreements with the MUS. In both locations, participants mentioned that there was weak follow-up from provincial structures and a weak involvement of the state in the promotion of community health, despite MUS schemes being adopted by the provincial government as a public model for health sector financing.

MUS Health System Financing and Equity Improvement Outcomes in Uvira and Katana
Examining how MUS schemes improve equity in the allocation of health services and the effectiveness of the fund-pooling process opens the venue for understanding MUS outcomes regarding the UHC agenda in both Katana and Uvira.

Health service equity improvement outcomes
Assuring equity is among the underpinning principles of CBHI. Building on the WHO dimensions for universal coverage (see Figure 10), MUS outcomes can be scoped on three key dimensions of CBHI coverage: *breadth/width* (population coverage), *depth* (coverage of services) and *height* (financial coverage) (Soors, Devadasan, Durairaj & Criel, 2010).

Breadth of MUS schemes. Trends in MUS population coverage can be assessed through examining the MUS uptake density and gauging the expansion of the covered geographical area. As was described earlier, there is a low rate of MUS uptake in both study sites. In Uvira, the geographic coverage is limited to a few health centres, whereas almost the entire HZ is covered by the scheme in Katana.

In Uvira, MUS members made up 0.92% of the population (2,883 of 315,008 people) in 2015. Most of these members were the personnel of organisational institutions and health facilities

partnering with MUS schemes. These are not those community members most in need, whose adherence is prevented by the financial unaffordability of the schemes although these schemes were purportedly designed to assist community members with the greatest need. In Katana, the relatively higher MUS membership level does not mean that the population coverage is broad or equitable. The fact that the 2015 MUS membership in Katana made up 5.2% of the population (10,907 of 209,746 people) betrays the shallowness of the scheme's penetration. The major difference between the two HZs is that, although its coverage is only superficially penetrating, the Katana MUS seems to be more embedded in the community, compared with the Uvira MUS. In many villages, there are MUS branches in charge of raising population awareness about the schemes. This means Katana is more community-rooted, even if they rely on health facilities' and schools' personnel adherence as safety net for membership stability. In both contexts, equity in terms of breath of coverage is still a distant goal, as adherence seems better for employed personnel than for the poorest community members, who lack access to both health services and the MUS schemes.

Depth and height of MUS schemes

According to CAMS, 'MUS insurance is earmarked for minimum and complementary health care package provided locally'.[53] This means that covered services include primary health care (minimum package), with second-level care (complementary package) provided through referrals. However, it cannot be taken for granted that these services will be covered, because many health facilities remain reluctant to participate in the MUS schemes. Additionally, MUS insurance does not cover tertiary or special care outside of the HZ, and not all sicknesses are covered by the scheme. Furthermore, an insured member is able to receive treatment only up to four times in one operational year. For these reasons, some people did not consider MUS schemes to provide real insurance coverage.

MUS schemes have not yet achieved equity improvements in either depth or height in the provision of health services. Considering equal access to available care, equal utilisation and equal quality of care for all, equity remains a challenge for the DRC health system. Equity improvements call for a comprehensive approach in terms of opportunity distributions and social justice in the social system as a whole. Without the influence of a working state, equality of access in terms of geography and affordability, equality of opportunity, equality of treatment and service distribution according to needs are beyond the purview of MUS schemes.

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[53] Interview, Bukavu, 16/10/2013

MUS resource mobilisation for health sector financial sustainability

MUS schemes face problems regarding resource mobilisation and the financial sustainability of health services, mostly related to the unreliability of MUS resource mobilisation systems and to the management of membership enrolment. The situation is compounded by extremely difficult living conditions for most of the population.

Fund pooling system–population purchasing power equation

The system of collecting premiums inspires no hope for the sustainability of either MUS schemes or health facilities. Membership premiums constitute a regressive system, where everyone pays the same amount regardless of earnings. This differs from a progressive tariff system, where the percentage of income paid is higher for higher levels of income, and from a proportional system, where everyone pays the same percentage (Roach, 2010). In MUS schemes, everyone pays the same amount for membership and expects the same advantages. Thus, this amount is exorbitant for some and almost nothing for others. For example, in Bukavu, the staff of COOPEC Nyawera, Bukavu municipality and members of parliament are asked for the same 7.00 USD required from unsheltered households living in Nyamugo shantytown. This reveals the prevailing lack of vertical equity and fairness in the Congolese health system, as was explained by a key informant in Uvira:

> The prospects of MUS sustainability is questionable. They do enrol both rich and poor in the same manner with the same co-payment, whereas at health facilities the rich are treated better than the poor. The rich also demand special care and expensive services. The poor, in contrast, have no preference. The health care needs of the poor and of the rich vary according to their social situations and yet they must rely on the same membership card.[54]

Another challenge relates to how institutional employees hinder MUS financial sustainability. The Uvira MUS office said that members from some public institutions, such as the *Office Congolais du Contrôle,* consumed a large share of the yearly pooled fund. They were said to be abusing the MUS membership paid by their employers. To obtain drugs such as paracetamol, they used a MUS scheme voucher. According to the MUS office, in minor cases (e.g. a simple headache), members cannot use their MUS membership cards, especially when they do not need medical consultation and follow-up, and membership vouchers can only be used four times a year. However, members from certain institutions were not abiding by those basic regulations. Because this occurred many times, the overall amount of spending was

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[54] Interview with a key informant in Uvira, 16/09/2014

influenced by trivial health care. By October 2014, the Uvira MUS had no more funds to cover members' health expenses for the remainder of the year.

According to the MUS management in Uvira, this trend could explain some of the overdue payments for which the scheme was being blamed. It also accounts for the mistrust observed between the MUS and several health facilities regarding the financial impact of MUS schemes, especially in terms of their capacity to ensure the financial sustainability of the health system at the service provision level. According to the head of nursing at a health centre in Katana, 'MUS schemes are not prompt in paying the bills for the treatment of their members; at times, they even go up to six months of 'indebtedness'.[55] Similar to other health workers in different health centres in both sites, the same participant also noted that 'when MUS schemes want to pay accumulated arrears, some months are omitted—wittingly or unwittingly'. He then concluded that 'by the time you are trying to urge them for payment, they just give a flat sum without considering the real cost'.[56] This declaration is one of several expressions of frustration and uncertainty made by research participants regarding MUS financial sustainability.

The delay in paying health facility invoices is a critical issue that undermines the trust between health facilities and the MUS. Irregularities and delays in paying invoices affect not only the financial sustainability of health facilities but also the moral ground for MUS schemes regarding monitoring the quality of the health services. Some health facility managers maintained that it is hard for their structures to work on the basis of the contract signed with the MUS. They asserted that MUS advocates for a preferential health service pricing system although the health facilities have no other source of income. Some of these participants said that they preferred receiving out-of-pocket payments because they are higher and are made up front. At Wanume Hospital in Uvira, for example, a surgical operation for uninsured patients costs 140.00 USD in cash, whereas MUS-insured patients pay only 80.00 USD and on credit. For this reason, some health facilities expressed the intention to withdraw from the MUS schemes, which they saw as undermining the viability of their facilities.

Membership enrolment uptake and population social conditions
Most of the participants mentioned abject poverty as one of major factors affecting the social penetration and population uptake of MUS schemes in both HZs. For example, in an attempt to explain the declining Uvira MUS membership, the provincial head of CAMS noted that the

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[55] Focus group with Mugeri Health Centre staff in Katana, 24/05/2014
[56] Statement of a health centre head of nursing in Katana, 24/05/2014

population is poor and that there is a high degree of what she calls 'adverse selection'. In her view, which was echoed by MUS coordinators, because the MUS scheme charges 7.00 USD per household member and the population is poor, households enrol only household members with the highest potential of ill health. She further maintained that the 'adverse selection that is prevailing is turning MUS into a sick-based health insurance rather than being community-based'.[57] Adversely selected members consume relatively more resources, meaning that it is harder for the yearly MUS budget to cover all of the expenses realised. Accounts from beneficiaries evidenced this trend regarding the motives for subscribing. A woman in Katana, for example, noted that 'because she did not fall sick in the year she had subscribed to MUS schemes, the following year she refrained from renewing the membership, as MUS is for the sick people'.[58] This has a negative effect on both the MUS scheme and the financial sustainability of health facilities. It also undermines the overall vision of risk pooling, because adverse selection puts MUS schemes and health facilities at risk of bankruptcy.

Interviews with community members, especially in Katana, revealed that some insured MUS members were unable to afford the co-payments, and many more were unable to afford membership. The context of poor living conditions and the lack of prospects for a better future positions MUS schemes at the forefront of a huge crowd of deprived bodies whose health needs are beyond the only medical care available.

Conclusions

MUS schemes have gained the attention of multiple stakeholders involved in primary health care. These schemes are a form of networked governance. Although relevant for mediating health care access, MUS schemes' penetration and uptake rate, and thus equity, remain low across South Kivu. Regarding the equitable access and social protection effects, MUS schemes do mediate access to health care for a portion of the population. However, achieving equity in health requires systems thinking, which deals with the broader social determinants of health inequities. This is why MUS penetration remains shallow in both study sites, with population uptake stagnating in Katana and declining in Uvira.

Concerning the resource mobilisation and health sector financial sustainability outcomes, MUS schemes in South Kivu have not yet proven to be reliable for mobilising resources for health services. The regressive fund-pooling system and its management have not lived up to

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[57] Interview, 16/10/2013
[58] Focus group at Katana centre 26/04/2014

the principles of CBHI. This has led to extended indebtedness and failure to pay for health service, undermining the trust between health facilities and the MUS, as well as weakening the MUS schemes' ability to monitor the quality of health care services and the state's ability to perform its regulatory role. Because of prevailing social and financial conditions, most potential members from the community are not financially able to access MUS membership. This is a paradox, because a primary goal of the MUS schemes was providing help to the very needy. This most disadvantaged group currently faces problems accessing both health care and MUS membership.

Examining the MUS schemes' UHC outcomes in South Kivu revealed that the schemes are relevant for community health coverage. However, the schemes continue to face management and institutional challenges that are compounded by contextual fragility. To enable these schemes to contribute effectively to the universal coverage of primary health in South Kivu, the state should reinforce its stewardship presence by supporting the schemes, streamlining interactions between stakeholders, providing financing and strengthening the management of MUS schemes. The state's role in this process is very important for improving health outcomes in fragile settings like the DRC and should be examined further in future work.

Chapter 6: Non-state Health Service Provision, Population Perceptions and State Legitimacy in the DRC

The author in the marketplace researching the population's perceptions of the state, fieldwork photo

The author conducting a direct observation on how the community members were medically being consulted at Tchiranga health centre/ Katana, and interviewing some of them about their experiences and perceptions of multi-actor healthcare provision.

This chapter was presented at the 'Transition and Local Development in Eastern DRC' conference in December 2016 in Bukavu and is currently prepared to be submitted to a journal under the title of 'Whom does the population see and how? Non-state health service

provision, population perceptions and state legitimacy in the DRC', authored by Aembe Bwimana and Bart Weijs.

The author gratefully receiving the feedbacks and responding to questions on empirical statehood and popular legitimacy of the state in the DRC— after presenting his research at the Réseau d'Innovotion Organisannelle (RIO)/Bukavu

Abstract

Non-state providers (NSPs) have long played a fundamental role in the delivery of primary social services in the Democratic Republic of Congo (DRC). NSP involvement has increased in recent decades, as wars and corruption have amplified the state's dependency on external actors to meet the population's basic needs. This chapter explores how the population's perceptions of the state are influenced by the provision of public health services by NSPs in the DRC. The research was primarily conducted in the Katana health zone (HZ). The findings indicate that the population's perceptions of the state reflect a collective frustration, because the state has failed to live up to the population's needs. Additionally, the presence of non-state providers has mixed effects on the population's perceptions of the state. Through their involvement in service delivery, NSPs can contribute to state-building in terms of statehood effectiveness. However, the performance of NSPs may also reinforce their benevolent image at the expense of the image of the state, which is generally viewed as a predatory and exploitative entity comprised of self-serving and exploitative actors. In contrast, when NSPs engage with the state on the ground, such as during vaccination campaigns, people also see the state in action and then assign credit not only to the NSPs, but also to the state, and this is important in the processes of state-building and legitimacy.

Introduction

Non-state providers (NSPs) have a long history of significant involvement in the delivery of primary social services in the Democratic Republic of Congo (DRC). In recent decades, wars in the country have made the state even more dependent on external actors to meet the population's basic needs. NSPs aim to achieve humanitarian outcomes and system-building in a context of the longstanding disruption of statehood, which is amplified by the corruption and laxness of the political elites. Although NSP arrangements have limited the negative consequences of the state's incapacity to provide basic services, it is unclear how the NSPs' involvement in service provision may affect perceptions of state legitimacy.

This research examined how NSP interventions in the DRC health sector have affected people's perceptions of the state and state legitimacy. The findings revealed complex relationships between NSP interventions and both state-building and state legitimacy. Though the link between legitimacy and state service delivery has been widely studied in previous research, to this point, basic service provision by NSPs and state legitimacy in fragile states has been under-researched. This chapter study investigates how the population perceives the state in the context of NSP provision of public health services to explore how NSP involvement affects state legitimacy.

NSPs in Fragile States and the Tenets of State Legitimacy

International community interventions in fragile states have ascribed much importance to state-building policy, in which strengthening the state–society relationship—labelled as state legitimacy—is one of the fundamentals. From this perspective, legitimacy is considered not only an intrinsic component of state-building processes, but also both an expected positive outcome and a policy goal for state-building interventions in context of disputed statehood. However, although the concept of legitimacy has gained currency, its meaning eludes simple conceptualisation.

As a political concept, legitimacy has no univocal definition (Bellina, Darbon, Erksen & Sending, 2009; Boege, Brown, Clements & Nolan, 2008; Milliken & Krause, 2002; OECD, 2008), but legitimacy can be said to be a 'generalised perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions' (Suchman, 1995: 571–610). Therefore, the

more a state is treated by its citizens as rightfully holding and exercising political power, the more legitimate it is (Gilley, 2006b).

The ability of a state to provide its citizens with basic service delivery is widely acknowledged as one of the sources of state legitimacy. Scholars have argued that service delivery supports the building of 'effective, legitimate and resilient states' (Batley & Mcloughlin, 2010: 131–154). According to OECD (2008: 7), together with the maintenance of security and the enablement of economic development, public services underpin the social contract between states and citizens, and, as such, are an indicator of the health of a society. Likewise, some scholars have concluded that strengthening the health sector can contribute to state-building (Eldon, Waddington & Hadi, 2008; Haar & Rubenstein, 2012a). However, others have emphasised the complexity and context-specificity of the relationship between social service delivery and state legitimacy (Carpenter, Slater & Mallet, 2012; Gordon, 2013; Gordon, Baker, Duten & Garner, 2010; Waldman, 2006).

For scholars such as Waldman (2006), a single approach to improving services will not result in increased legitimacy, because complex emergencies are bound to have complex solutions. In a similar vein, others have mentioned 'multi-pronged and multi-layer solutions' (Gordon, 2013: 29–44) and both complex and nonlinear potential (Carpenter et al., 2012).

Though a theoretical relationship between basic service delivery and state legitimacy has often been taken for granted, the nature of this relationship is unclear, and empirical evidence to this point remains scant and inconclusive. A factor complicating the analysis is that, in many fragile settings, services are not delivered directly by the state; in fact, it is often non-state actors who are the major providers of health services. The impact of this 'external' provision on the state–citizen relationship is a matter of debate. While the role of service delivery in building the legitimacy of a state or nation has been widely discussed in past work, there is little empirical evidence on how the provision of public services by non-state actors contributes to state legitimacy in a fragile setting.

The Health Sector in the DRC as an Arena and a Public Sphere
The provision of public services by non-state actors under conditions of limited statehood is not found only in the DRC. The provision of services by non-state actors is 'a large-scale and "normal" phenomenon at least in Africa and South Asia' (Batley & Macloughlin, 2010: 131–

154). In Sub-Saharan Africa, the private health sector is large and constitutes an important, diverse component of the region's healthcare systems (IFC, 2008). In the DRC, decline in the provision of services by the government has not led to a complete vacuum, but rather the involvement of an array of other actors that have become important players in the provision of public services (Kooy & Bailey, 2012; Seay, 2013). In this context, non-state actors constitute the cornerstone of social services (Seay, 2013).

Partnerships between state and non-state actors in service provision are not a feature of fragile states per se. Modern approaches to New Public Governance place a premium on partnerships, requiring a shift from 'management skills' to 'enablement skills'—'the skills required to engage partners arrayed horizontally in networks, to bring multiple stakeholders together for a common end in a situation of interdependence' (Jooste, 2008: 11). Thus, what points to fragility in terms of public service provision is not the involvement of NSPs, but rather the state's incapacity or lack of will to deliver on state functions and to meet the needs of the population. In fragile contexts, these deficiencies lead to waning social control, an overreliance on non-state actors and a failure to enforce national policy and coordinate the NSPs.

In light of the partnership engagement observed in the DRC, the country's health system can be seen as an arena where state and non-state actors engage to deal with public problems through multi-stakeholder processes (Stel et al., 2012). As a form of networked governance, multi-stakeholder processes are 'processes which aim to bring together all major stakeholders in a new form of communication, decision-finding (and possibly decision-making) on a particular issue' (Hemmati, 2002). In those processes, a range of non-state actors are involved in service delivery, creating a 'hybrid situation of multiple layers of governance and responsibility' (Noor et al., 2010: 25).

However, in a fragile context where the state is too weak to deliver on social outcomes, networked governance raises the question of who obtains legitimacy. Legitimacy is contested between state actors and other key social actors whose aims and engagement outcomes may range from responding to the population's basic needs and statehood expectations, to competition for social control.

The realm of health service provision can also be approached as a basic kind of 'public sphere', where the population convenes and communicates their perceptions and opinions of the state. This idea of a public sphere was developed by Habermas as a body of 'private persons' assembled to discuss matters of 'public concern' or 'common interest' (Fraser, 1990; Herbermas 1989). Originally used to describe 'bourgeois public spheres as counterweights to absolutist states' in early modern Europe (Fraser, 1990: 56–80), the emergence of the public sphere 'opened the way […] to individuals and groups to shape public opinion, give direct expression to their needs and interests while influencing political practice' (Douglas, 2013: 4).

In fragile states such as the DRC, the process of public management is mostly based on the aspirations and social survival strategies of the elite. However, as service provision engages with the social welfare of poor people, it provides a space for the population to express their opinions in line with their empirical experience and social expectations, which shape their views of the DRC state.

From Perception to Legitimacy

Approaching the health sector as an arena for engagement for the different actors involved and as a public sphere where the population can express their opinions and communicate their frustrations, it is important to explore people's perceptions of the relevant actors (including the state) in an investigation of how NSP involvement in service provision affects state legitimacy. The term 'perception' is used here as synonymous with 'view, and sometimes with the related terms interpretation, belief or critical opinion' (Dijkzeul & Wakenge, 2010: 1139–1170). Perception is the process by which people 'interpret and organise sensation to produce a meaningful experience of the world' (Pickens, 2005: 43–75).

From the psychological perspective on legitimacy and legitimation, perception and legitimacy are closely related (Tyler, 2006). This means that perception provides room for probing how the population imagines the state, as well as how NSP involvement in service delivery affects this imagining. It must be emphasised that these processes of imagining evolve interactively (Hilhorst, Weijs & van Wessel, 2012). Hence, interacting with the population about their experience of the stakeholders engaged in public service provision makes it possible to identify which factors determine how the population's image of the state is shaped. In our view, perceptions of statehood are thus mediated by both popular experience and social actors' interactions and negotiations.

The perception of what the state does and is in relation to the population's needs and expectations determines their beliefs and attitudes towards the state. Unsworth (2010) has argued that state legitimacy in fragile and conflict-affected countries is concerned with people's perceptions and beliefs—with the question of 'whether, how and why people accept a particular form of rule as being legitimate', rather than with the observance of normative rules (Unsworth, 2010: 15).

The perception of state legitimacy can create in citizens 'a sense of obligation or willingness to obey authority' (Brinkerhoff, Wetterberg & Dunn, 2012: 273–293). This is where population perceptions and state legitimacy converge, and how people's perceptions of the state can serve as a measure of state legitimacy. The present study sheds light on the population perceptions of the state through the role played by NSPs in answering the following research question: How do the health services provided by non-state actors in the DRC affect the population's perceptions of the state in this context, characterised by limited statehood?

Methods

To answer the above question, we conducted ethnographic fieldwork from August 2013 to April 2015 in South Kivu.

Description of the Research Site

The fieldwork took place mainly in South Kivu, with a particular focus on the case of the Katana health zone (HZ). The Katana HZ has 17 integrated health centres spread over an area of 400 square kilometres straddling two administrative territories: Kabare (16 health centres) and Kalehe (one health centre). Fomulac Hospital is the main general referral. In 2015, the HZ had an estimated catchment population of 209,746 inhabitants.

Participants and Data Collection

People's perceptions of the state and of other actors were elicited through participant observation, semi-structured interviews and focus groups. In Katana, the research participants primarily comprised three categories: community members; representatives of community health development committees called *Comité de Développement de l'Aire de Santé* (CODESA); and frontline health service providers including medical doctors, administrative staff members and nurses. Individual interviews and focus groups were conducted with 101 community members in the villages of Chiranga, Nuru, Katana-centre, Luhihi, Izimero,

Mushweshe, Birava, Ihimbi, Mabingo, Fomulac Mugeri, Lugendo, Muhanda, Kadjuch and Chegere.

Where relevant, this study also drew upon supplementary information from 27 interviews conducted in Bukavu with members of community-based health insurance networks (*Mutuelles de Santé*) in the municipalities of Ibanda, Kadutu and Bagira. In addition, we visited 15 of the 17 health centres in Katana. There, we interviewed 35 people from CODESAs and 33 health service providers. We also interviewed additional relevant actors, including state officials, community-based organisation (CBO) representatives, faith-based organisation (FBOs) representatives (especially from BDOM for the Catholic Church and ECC-DOM for the Protestant Church), public health servants, herbalists (traditional healers)[59] and international and local NGOs in Bukavu and Kinshasa.

Because state legitimacy is a sensitive topic in the DRC, our inquiry into population perceptions was embedded in a framework of inquiry on state/non-state interactions around the provision of public goods. For this reason, the questions we asked related to the population's experiences with stakeholders in the realm of health service delivery, although we were primarily interested in responses clarifying their perceptions of the state.

Researcher Positioning and Reflexivity

The first author, who conducted the data collection, is originally from South Kivu and has been affected by the situation of statehood fragility. The topic of the research and the misery of people participating in the study raised multiple questions regarding reflexivity. Moreover, it proved challenging to convey the notion of the state as understood in formal, Western ideas, because many people in the rural zone of Katana had a low level of education. The researchers maintained the ethical principles of doing no harm, free consent of participants and assuring and maintaining confidentiality at all times. The research visits to health centres were formally authorised by the head of the HZ management board.

Findings

The research findings can be summarised by four key themes: i) The DRC health system as a public arena where the state, NSPs and the population encounter each other; ii) population perceptions of the state emerging as a symptom of a breach of social contract; iii) the

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[59] We organised a focus group of five herbalists in Ihimbi village.

counterintuitive effects of NSPs on the image of the state revealing how legitimacy is disputed; and iv) the relevance of the active visibility of the state in the process of health service provision by NSPs.

The DRC Health System as an Arena Where the State, NSPs and the Population Interact

The health sector in the DRC can be seen as a public arena for the encounters and interactions among multiple stakeholders making up the social service provision landscape. This section broadly outlines these stakeholders and the three different levels at which they interact to govern the health sector: the national level, the intermediate level and the community level.

At the first level, through the national Ministry of Health (MoH), state and non-state actors (both faith-based and non-confessional, as well as national and international) interact in macro-level health sector governance, through which public health policy and system design processes are interactively produced. Similarly, at the level of the Provincial MoH and intermediate public health department, the state and NSPs—especially churches and INGOs—engage in the process of system management; their inputs determine the maintenance of the sector. The state and its non-state organisations proceed with provincial public needs assessment at this level, based on the empirical evidence reported by the HZs. Development organisations such as international NGOs (INGOs) provide state departments with institutional support in terms of technical capacity and financial endowments for specific interventions. Churches are the most active in the process of health system management and service delivery.

The peripheral level, that is, the HZ acting at population level, is the arena where service provision processes take place. The HZ comprises three sub-levels:

o First, the HZ board is the HZ-level representative of the MoH. The board is entrusted with administrative management, system streamlining, monitoring and supervision of the health care provision process, and engagement with NSPs at both health centre and community levels.

o The second level is health care provision. This level includes primary health care at health centres (*aires de santé*), which provide a minimum package of health care;

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hospitals, which provide a secondary package of health care; and tertiary care hospitals, which provide special health care.

o The population, as beneficiaries and clients, forms the third level of the HZ system architecture. This level constitutes the health system end-users who legitimise the work and engagement of the stakeholders involved in service provision. This is also where the health system gets its political face, as it is the public space at the grassroots where public authority is tacitly or openly disputed and where actors implicitly contend for legitimacy.

The visibility of actors' interventions through information boards, stickers, leaflets and workshops or rallies plays a critical role in their self-assertion. At the same time, the community level also reflects the interdependency between the state and NSPs.

Figure 11: Mabingu Health Centre, Description of Stakeholders on an Information Board

Source: Photograph taken during fieldwork

Figure 11 shows an information board on the front wall of the newly built Mabingu Health Centre. This image is indicative of how the community level of the health sector is an arena

where the state and NSPs meet and collaborate, but also assert their own presence. On the board, the DRC and Belgian flags are displayed as a token of these governments' collaboration and involvement. It is clearly stated that the facility was built by *Louvain Développement*, a Belgian INGO, with the financial support of the Belgian Development Cooperation. The *Bureau Diocesain des Oeuvres Medicales* (BDOM) is represented as a local interface for *Louvain Développement*.

The board illustrates the bids for visibility of different actors engaged in the health sector. Surprisingly, even the benches for patients inside the facility were marked '*Don de la Coopération Belge au Développement*' (Gift from the Belgium Development Cooperation, Figure 12).

Figure 12: Benches inside Mabingu Health Centre with Text about the Funding Organisation

Source: Photograph taken during fieldwork

As can be seen in these illustrations, the sector has evolved into a public arena mediating social interactions and bids for legitimacy between the population, the state, international/national NGOs and FBOs, and health service providers. Moreover, the emblems reveal how development-oriented INGOs such as *Louvain Cooperation au Développement* incorporate a state-visibility dimension into their interventions. In this way, the state becomes a factor in the development-oriented INGO interventions, which are integrated into the recipient's state policy.

Population Perceptions of the State: A Symptom of a Breach of Social Contract

When people become ill, where do they go for treatment? And what do the answers to this question and the way health services are delivered mean for people's perceptions of the state? This section explores the population's utilisation of health services and the prevailing image of the state they develop through exposure to NSPs.

Trends in the Utilisation of Health Services in the Katana HZ

Most of the people interviewed said they attended modern health facilities for medical care. This was confirmed by the providers, who had witnessed an increase in the utilisation of health services. It was further substantiated by records kept by health facilities logging monthly beneficiary attendance trends. In view of this increased attendance, some providers sought to expand their capacity: 'Since 2015, Fomulac Hospital has been willing to increase the number of patient beds from 131 to 200'.[60]

Along the same lines, the Katana HZ reported an incremental increase in the use of curative health services, from a curative consultation rate of 59% in 2012 to 89% in 2014 (KATANA-HZ, 2014).
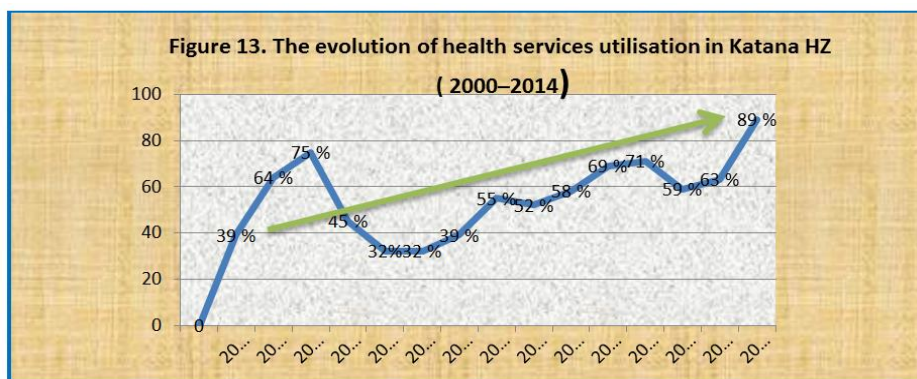
Source: Adjusted from *Katana Health Zone Yearly Report: 2014*.

Figure 13 presents a longitudinal view of the evolution of the utilisation of curative health services in the Katana HZ from 2000 to 2014. As can be seen in the figure, the rate of use of curative health services in the Katana HZ has increased since 2000, although the trend has not always been smooth. The percentage of the population using health services increased from 39% in 2000 to 89% in 2014 (KATANA-HZ, 2014). In light of these statistics and the

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[60] Telephone interview with HZ administrator, 24/05/2016

corresponding explanations from the HZ management, there were three essential stages in the trend in health services utilisation that can account for the fluctuation in use over this period. From 2000 to 2003, the International Rescue Committee (IRC) provided health care that was free to users. This explains why the rate of service utilisation soared.

The 2004–2006 period followed the IRC free health care intervention and was generally characterised by the decreasing presence of INGOs in the Katana HZ. Only *Louvain Coopération au Développement* supported the HZ during this period. From 2007 to 2014, the HZ saw synergy in partner interventions, especially through the introduction of PBF (implemented by *the Agence d'Achat de Performance*, AAP), the Integrated Health Services Project, BDOM and *Projet de Santé Integrée* (KATANA, 2014: 14–15).

In light of the HZ reports of health service utilisation and the trends documented above, the increase in the population's uptake of health services appears contingent on the INGO presence and the portfolios of their interventions. The 2014 yearly report for the Katana HZ highlights that two INGO interventions accounted for most of the trend: the IRC free health care intervention and the implementation of PBF in the HZ (KATANA-HZ, 2014). It is worth noting that, in the Katana HZ, both humanitarian relief interventions and system-building experiments were alternately—and even concurrently—conducted in recent history.

Although the health care service utilisation improved, some community members interviewed indicated that they still consulted traditional healers or herbalists. Some people could not afford the costs of health services, and others thought that illnesses could not be cured at the health centre. For the latter group, some diseases cannot be cured or diagnosed by modern medicine; these are only curable by herbalists. This is why, during a focus group with traditional healers in Ihimbi village, participants claimed to be 'complementing and at times collaborating with health facilities'.[61] Other respondents said they consulted non-integrated health facilities, known as private for-profits, because of service quality and, especially, drug availability. The issue of availability of medical commodities was critical; in all visited villages, the communities recounted times when their health facility did not have the needed pharmaceutical products.

Perceptions of the State

Have the increasing utilisation of health services and perceived improvements in the availability of drugs and other medical supplies affected how people in the Katana HZ

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[61] Focus group, Ihimbi, 27/05/2014

perceive the state? This section explores perceptions of the state among three categories of respondents: community members, frontline health service providers and CODESA members.

Community members' perceptions of the state

The majority of the respondents complained about the unstable engagement of the state in community health. Very negative views about the government were clear among community members whenever the role of the state was mentioned. Some respondents argued bluntly that there was no state at all, because those who claim to be the state do not care for the people's welfare. Of the 101 community members interviewed in Katana, 60 were pessimistic concerning the social engagement of the state. This was clearly articulated by one of the respondents: 'There is no state, and if there is, then it does not care about our health'. The same attitude was conveyed by another research participant: 'I have never seen the work of the state'. The same position was corroborated by another participant, for whom 'the state authorities, be they national or peripheral, only care about their own interests and not those of the people'. For most of the research participants at community level, the state has been predatorily preying on them: 'The state means bring what you have, thus dispossessing us of the little that we have?' This is how one female participant responded to a question related to what the state does in Tchiranga village.[62] This statement was representative of popular opinion about the state—and especially the political elite and public institutions. Frustration-laden reactions regarding the population's perceptions of the state were ubiquitous in Katana HZ. This research found that, on many occasions when the state was mentioned in a question, the local people tended to react instead of responding.

Remarkably, negative perceptions of the state were shared across different age groups. For young people, it is understandable that they say they have never seen what the state does for them, because the state stopped providing public services such as education and health by the late 1980s. People who experienced the years before the outright failing of the state and grew up in a context where the state took a certain level of responsibility for providing services might be expected to recall some of the state's earlier positive deeds. However, this group described the same image of the state as did the younger group. An elderly woman with no education noted, 'The state doesn't know us', referring to people like her at lower levels of society. Another participant, an elderly man, was very articulate: 'The state is dead since long ago, and there is no heir for it [*leta ya fwire bufashizo* in Mashi]'. This man had experienced

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[62] Focus groups, Tchiranga, 26/04/2014

both colonial public management and the post-colonial period of public governance, and, for him, the current situation was tantamount to an absolute absence of the state.

Frontline health service providers' perceptions of the state

According to the interviewed providers (medical doctors, administrative personnel and nurses), the health sector owes its survival to external partners and population financing. Providers' perceptions are intimately connected with both their civic expectations and their professional ideals; the state is considered an untrustworthy and failed leader. During a focus group, a nurse at Izimero health centre expressed a frustration shared by many others: 'They tell us about the state, but where is it? Why does the state abandon us?'. Many expressed the same opinion in various forms, and the following statement by a head of nursing at the same health centre is a telling instance of many people's all-pervasive frustration: 'In the DRC, the state is anti-social; it is a state that is against their own population'.[63]

In their role as health services providers, these participants referred to their experience: A hospital medical doctor and director argued, 'How can we talk of the state here in Birava Hospital? Look, we have 34 staff members and yet only four get what is called *prime de risque.* [*Prime de risque* literally means hazard pay and is the common name used for the (slim) state payment, as it does not fulfil the legal requirements to be called salary.] We cannot see the contribution of the state to the functioning of population health'. In this example, only four of 34 were receiving any form of payment of the state; the others got nothing and depended fully on the fees paid by the users and possibly NGO support. The management office of Fomulac Hospital expressed a similar frustration: By May 2015, of the 217 nurses in the Katana HZ, only 75 received hazard pay. This was 10,000 CDF[64] (approximately 10.6 USD, based on the exchange rate at the time of the data collection), and was paid erratically. The office also explained that not a penny is given for the administrative costs or medical supplies. For funding, health facilities rely on user fees and international partners whose sustainability is not guaranteed.[65]

In interviews, providers would point to the example of Rwanda: If the DRC state would regulate NSP interventions and follow up their development initiatives like Rwanda, it could strengthen the functioning of the health system. However, under the current state in the DRC,

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[63] Focus group, Izimero 22/05/2014
[64] Congolese Franc
[65] Statement elicited from the management office by phone, 21/05/2016

most of the respondents found it difficult to envision the viability of any NSP-inspired intervention. This was made clear by a hospital administrator during a focus group at Fomulac General Referral Hospital: 'Health schemes in Katana would be sustainable if our state were like the Rwandan state, which involves itself in making things work out'.[66]

CODESA members' perceptions of the state

The CODESAs, or community health development committees, form the statutory interface between health facilities management and the community. In line with national health policy, every integrated health centre is owned by the host community, which is represented by an elected CODESA. CODESA members work on a voluntary basis. In rural zones, their role is vital for health service utilisation and price system setting. In its 2014 report, the Katana HZ recognised that CODESA staff members' performance had exceeded expectations (KATANA-HZ, 2014). These people work with communities, providers and even intervening organisations, where CODESA participation guarantees the presence of the community voice in their interventions. Interactions through CODESAs at the grassroots level are very important for providers' social accountability and raising the population's awareness concerning their health-related obligations.

Speaking from their position as the interface between community members and health professionals, CODESAs conveyed both the population's disappointment and the providers' frustrations. The general perception expressed by CODESA members does not markedly differ from that of providers and community members. CODESA members specifically expressed their frustration and disappointment concerning the way the DRC deals with community health actors. Their frustration can be understood in light of the magnitude of their social work for community health, especially in rural zones, where they face the challenge of commuting from one place to another on foot during the hot vaccination season, but they receive nothing in return from the state. In a focus group with CODESA members in Muhanda/Katana village, one woman voiced a commonly held opinion that 'the state does not know us, and it does not care about the population's health'.[67] This opinion was confirmed by many of the interviewed CODESA members, community members and even providers, conveying the prevalent perception of the state as a failure and an antagonistic entity made up of self-interested and predatory elites.

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[66] Focus group with Fomulac HZ Central Office staff members 12/02/2015
[67] Focus group, Muhanda Katana, 26/04/2014

The Effects of NSPs' Work and the Image of the State in a Context of Disputed Legitimacy

The common wisdom, based on the Weberian ideal-type of the state, correlates service provision and state legitimacy, but the DRC's health sector reveals how public legitimacy is a disputed variable in fragile settings. Building on this study's findings, we realised that NSPs' work has not only contributed to state effectivity regarding basic service delivery; their interventions have also had effects regarding population perceptions of the state. Depending on how the services are provided, NSP engagement for community welfare may result in a benevolent image while solidifying the negative perception of the state by the population.

The community's perceptions of the state through (I)NGOs and national NSPs

The variety of public health service providers is an empirical fact observed by the community. Nevertheless, it might not be easy at times for community members to distinguish what exactly is done by whom, especially in terms of the management of health facilities led by both the state and FBOs/churches that are fully integrated into the national healthcare system. Integrating health facilities in this way means that they must conform to national health policy. This transforms the facility into an entity that is co-managed by the state and public interest-oriented NSPs. For INGOs, the integration of their interventions means aligning with the national sector policy. To this effect, integrated facilities are different from private facilities, which are easily identified by their individual owners. However, although private for-profit health services are mostly associated with urban areas, there are also a few of these facilities in rural zones. For instance, Katana HZ records show that, by 2014, there were five private dispensaries and one private medical centre in the HZ (KATANA-HZ, 2014).

In practice, the general influence of churches and INGOs is obvious at the grassroots level. The majority of interviewed community members were pessimistic concerning the engagement of the state. In contrast, most of the respondents were generally very positive about churches regarding their management and about NGOs in terms of their financial and technical inputs. However, they did make some critical observations. Specifically about the Catholic Church, the most dominant FBO in the health sector, people repeatedly expressed criticism of priests and decried their behaviour as a domineering class capitalising on the vulnerability of the people. It transpired that a major reason for this criticism was priests' involvement in land conflicts,[68] specifically land expropriation. This shows that service

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[68] Land-related conflicts are common in Katana and Kalehe.

delivery is not the only factor that determines perceptions. However, irrespective of these issues, the community still recognised the engagement of church, as an institution, in the provision of public services.

The support of INGOs was repeatedly mentioned by communities as something that facilitates health care affordability and the availability of health commodities. In the areas where there was more than one health facility, such as Katana centre, Luhihi, Mushweshwe and Ihimbi, people preferred attending INGO-supported health facilities. Regardless of whether the facility was church-co-managed or simply state-led, people mostly preferred to go where there was INGO support: 'I like to attend a health facility supported by non-governmental organisations, because this is where the needs of old people like us are well cared for', declared a 60-year-old.

In fact, people perceived the NSPs to outshine the government as the caretaker of the population in the Katana HZ. This point was made clearly by one of the respondents: 'If not for the church's and INGOs' commitment to population health services, the DRC population would be savagely dying in the face of the state'. Even INGO representatives acknowledged that their interventions contributed more to the recognition of their organisations than to state legitimacy. During an interview, a representative of Malteser—one of the leading INGOs committed to health system-building in South Kivu—asserted clearly how the population gives more esteem to the work of NSPs: 'The more NSPs improve their performance for population welfare in the health sector, the worse the image of the government becomes'. This is an unintended situation, which mostly results when national NSPs as INGOs engage alone on the ground, because the population is not sufficiently informed of the administrative role played by the state in its partnership with non-state actors.

Thus, the population ascribes high esteem to INGOs at the expense of the state. One of the top state officials at the health department in Bukavu maintained, 'When things go well, they see INGOs, but when they go bad, they blame the state'. This means that, by compensating for the shortcomings of the state, INGOs not only contribute to population welfare; they also build the legitimacy of their organisations.

Providers' and CODESA members' perceptions of the state through non-state interventions

Providers, and to a certain extent CODESA members, have a better understanding of the management and operational roles played by NSPs in producing health outputs at the HZ level. This understanding, coupled with their empirical experience, shapes their expectations and perceptions of both the state and NSPs.

Among national NSPs, health facility staff members and CODESA members widely acknowledged the church as the most active in community health welfare. In interviews, the CODESA members and health care personnel recognised the inputs of FBOs. From the accounts of health care personnel and CODESA members, the church, supported by INGOs, was able to salvage the HZ in Katana in the aftermath of the large-scale war in 2002. Health care personnel also recognised the relevance of the church in the process of linking the local health system with potentially involved INGOs and donors. However, a number of health care personnel were unhappy about the clientelistic behaviour exhibited by some churches, which exert a paternalistic influence on the processes of health facility staffing and health structure management.

The presence of INGOs has inspired hope among the health care personnel. INGOs have facilitated improvements in working conditions, population outreach and health care accessibility. Through this work, INGOs have made it possible for frontline health care providers to 'responsibly discharge their duties and decently live as human being', a nurse maintained. During a focus group with Fomulac HZ staff,[69] the participants concurred that, without INGOs, the situation would have been catastrophic. One of these staff members argued, 'I would have left the health sector, but thanks to PBF/AAP, I am still there, [because] I work for the state, but I have never been paid by the state'. This sentiment was echoed by a medical doctor, who, during an interview, maintained that 'it is quite hard to effectively work as a health provider in a rural zone without the support of INGOs'. A number of frontline health service providers were very anxious about the withdrawal of INGO partners and thus about the sustainability of their interventions.

In spite of these positive views of INGOs, many of the health staff members' statements also revealed feelings of frustration with the engagement of these organisations. At Izimero Health Centre, for example, nurses, although they were grateful to the INGOs, expressed discomfort

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[69] Focus group, Fomulac, 12/02/2015

with this long-lasting dependence. They noted that they would like to see the state take over and assert its leadership, which is impossible without caring for social needs of the population. In this vein, one of nurses asserted that 'the state leaves us at the mercy of external actors as a kind of new colonisation; this time, the colonisation is imposed by our own state, that we may always be dependent on external actors and lead parasitic lives'. This frustration among providers may be explained by several reasons, such as conflicts between national health policy and guidelines, and some INGO representatives' attitudes. Some health care personnel confided that 'at times, health providers faced clashes on administrative duties between what one should normally do regarding state guidance and what the funding partner requires'. They found that, in spite of INGOs' good intentions, it is difficult for them to meet all of the population's needs and providers' expectations as would a working state. These findings imply that, although still weak in terms of capacity to respond to population needs, in the health sector's networked governance, people look to the state—not NSPs—to take the lead in case INGOs withdraw.

Increases in State Visibility on the Ground When Working with NSPs

NSPs' contribution to state legitimacy in the fragile Congolese state is an open question. The research revealed that NSP interventions may have both a positive and a negative impact on the population's perceptions of the state. We found that the outcomes of NSP processes in terms of improving the state image depended on how services were provided by NSPs at the HZ level.

Expressing his frustration on the weak presence of the state in the sphere of health service provision, a public health official noted the following:

> It seems that the state has abandoned the sector of public health to INGOs. Actually, on the ground, we do not see the state, but only the [INGO] partners. In a normal situation, the partners come just for supporting the state policy and engagement. But in the DRC, only partners are visible on the ground. The population cannot see the state; they only see the non-state organisations.[70]

Different accounts and claims from the population and health personnel revealed that how active the state is seen to be in the process of NSP involvement is of great importance. Active visibility of the state not only marks its presence; it also conveys the message to the

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community that the state cares for their social welfare and is mediating NSP engagement. At the grassroots level, we found that the community wanted to see the state working closer together with NSPs. From statements made by the interviewed community members, it became clear that they perceived a deep gap between the population and the state and that they desired more consideration from state actors. NSPs—especially churches, *Mutuelles de Santé* and INGOs—seemed to fill the vacuum created by the state, which was seen as aloof from the population's concerns. This has made it difficult for the state to penetrate society through direct interactions with the population, especially in rural zones where the most obvious state symbols, such as administrative infrastructure, public institutions and civil service offices, are hardly visible.

In some instances, communities considered churches and INGOs to be closer both geographically (locally based) and psychologically (sympathetic). State representatives were perceived as distant, either both geographically and psychologically, or just psychologically. Community members expressed a great deal of understanding for certain local institutions and elites, who were seen as being closer both geographically and somehow psychologically.

This closeness and social bonds in rural zones are crucial for building trust. Trying to explain what the situation looks like and how the population experiences the absence of the state as abnormal, one key informant from an HZ management board said that, in the health sector 'the population wants to see where the state is, but, alas, the state has so far failed to assert itself; it does not show up in the realm of social goods'. In bids for social recognition and intervention, visibility is a determining factor for the population's perceptions of different stakeholders. This recognition can facilitate the state's legitimacy, FBOs' social influence, and, for INGOs, both the accreditation of expertise and the building of a trustworthy profile in funding mobilisation processes.

Although the bulk of the participants in this study expressed negative perceptions of the state on the basis of their experiences, a minority of the community members interviewed (28 of 101 people) recognised the joint work of both the state and NSPs, especially concerning the child vaccination campaigns, which were regularly conducted under the supervision of the state. These respondents stressed their positive perceptions of the state for taking this role in caring for the children. For example, a woman from Katana maintained, 'I prefer the state facility, because the state is the one that cares about the health and welfare of our children'.

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During these vaccination campaigns for children under age five, the MoH, HZs, and CODESAs played the mobilising role for population uptake, with the financial support of external partners such as UNICEF, Global Alliance for Vaccines and Immunization (GAVI) and the WHO. This contributed significantly to state visibility at the grassroots. People saw the state through the vaccination campaigns, because state officials were mobilised and deployed alongside external partners on the ground. For this reason, people gave credit not only to the NSPs, but also to the state for caring about the wellbeing of their children.

The above suggests that, when NSPs fruitfully collaborate with the state through networked governance and let the state appear in the process of providing public services, people come to appreciate the state as well as the non-state actors. However, when NSPs do not implement and follow up the processes along with the state, the population does not see the state's presence, despite the fact that the state works with INGOs at the health system management level to make administrative arrangements. In this regard, this research has two major findings. First, most people interviewed at the community level were not aware of the functions played by the state in the work of NSPs, and this lack of information reinforces the negative image of the state as provider in the health sector. Second, when the state appears along with NSPs in health service delivery on the ground, this presence gives the state some credit, which is important in the process of state-building and legitimacy.

Conclusion

This chapter set out to explore how population perceptions of the state are shaped through the provision of health services by NSPs in the DRC. In our pursuit to understand whether and how NSPs contribute to building state legitimacy in fragile states, the health sector in the DRC provided a good entry point, as both an arena of interaction for different stakeholders and a public sphere where the population forms and communicates their perceptions and opinions of the state. For eliciting population perceptions of the state, we interviewed community members, service providers, health system managers, state officials and representatives of INGOs. The fieldwork took place mainly in South Kivu, focusing especially on the Katana health zone (HZ).

One of the main findings of this study was that the DRC health sector takes the shape of an arena where the state and non-state actors, as well as the population encounter each other. The sector has evolved into a public arena mediating social interactions and bids for legitimacy

among the population, the state, NSPs and health service providers. The NSPs compensate for the empirical vacuum of the state in many areas. Although the state has been judged as malfunctioning in terms of its role in health financing, policy enforcement and actor coordination, it is still regarded as the main guarantor for the institutional framework. The national policy framework in which the state is supposed to play the lead is necessary for streamlining NSP engagement. Unfortunately, the materialisation of the state's leadership role has been delayed. This has made it difficult for the state to penetrate society through direct interactions with the population, especially in rural zones, where the most obvious state tokens are hardly visible.

In contrast, the population's perceptions of the state convey a breach of a social contract. Although there has been an increase in the utilisation of curative health services, community members interviewed in this study were very frustrated by the lack of earnest engagement from the state aimed at improving their social wellbeing. The discontent regarding the government was perceptible when people were asked about the role of the state. This frustration was also seen in some community members' characterisation of the Rwandan state as a role model of a working state. The prevailing image the DRC state conveys to the population is that of a failed and unsympathetic entity made up of self-serving, corrupt and predatory elites.

Moreover, we found that NSPs may have a counterintuitive influence on the population's view of the state; NSPs have the potential to contribute to state-building in terms of the state's empirical effectiveness, but also they may increase disputes over public legitimacy within the community. From our findings, it is obvious that the image of NSPs outshines that of the government as the caretaker of the population in the Katana HZ. Some INGO representatives also acknowledged that their interventions contributed more to INGO recognition than to state legitimacy, asserting that the population gives more esteem to the work of non-state actors. Thus, we conclude that NSP interventions may or may not have a positive impact on population perceptions of the state; the influence of NSP processes on the state's image depends on how services are provided by NSPs.

Clearly, the state's active visibility in service provision matters. The community members and providers interviewed in this study revealed that the extent to which the state appeared in the process of NSP interventions is of great importance. Active state visibility not only marks the

state's presence; it also makes the community believe that the state cares for their social welfare and that NSP engagement is mediated by the state. Some community members recognised the work of the state and NSPs through the child vaccination campaigns that are regularly conducted under the supervision of the state. During those campaigns, which are financially supported by external partners, the MoH, HZs and CODESAs play the mobilising role for population uptake. These activities have contributed a great deal to state visibility at the grassroots. For this reason, people give credit not only to the NSPs, but also to the state. Appearing alongside NSPs gives the state some credit, and this is important in the processes of state-building and achieving legitimacy. Future research should further our investigation by examining more deeply how the population's opinions of state are formed and whether there are opinion brokers influencing perceptions of the state.

Chapter 7: General Conclusion

Introduction: Networked Health Governance and the Dilemma of State Legitimacy in the DRC

In war-affected settings and 'fragile' states, the provision of social services is not solely the responsibility of the state, and the state is not the only actor striving for social control. Both state and non-state actors engage in the provision of social services. This shared responsibility for population welfare transforms the public sector into a space where public authority and social control are disputed between the state and non-state actors. This chapter presents the general conclusions regarding the engagement of non-state actors in the provision of public health services, networked health sector governance and the legitimacy of the state in the fragile setting of the Democratic Republic of Congo (DRC).

Public health governance in the DRC is the reflection of a public policy sphere characterised by interaction, cooperation and even competition between state and non-state actors. In this public policy sphere, the effectiveness of the state mostly depends on non-state service providers' (NSPs) engagement and interventions, which take the form of networked health governance. However, this contributes to a state legitimacy dilemma, with empirically weak state institutions and multiple stakeholders disputing public authority. Hence, networked governance through interactions between the state and NSPs can be a double-edged sword for state-building legitimacy in conflict-affected and fragile states: On the one hand, networked governance through multi-stakeholder interactions does undoubtedly contribute to empirical statehood. However, on the other hand, this networked governance also turns the public service sphere into a field of competition and dispute over popular legitimacy. Legitimacy of the state, understood in the sense of how the citizens treat the state as rightfully holding and exercising political power (Gilley, 2006b), is a social variable with multiple factors.

This thesis attempted to unravel questions about the health sector networked governance and its contribution to the legitimacy of the state in the DRC. The study explored the state-building outcomes of networked health sector governance, especially concerning policy coalition-building and resource-based interdependency, the strengthening of system management, and the effectiveness of health service provision through state and non-state interactions. Embodied through these interactions between state and non-state actors, the health sector networked governance is operational in the structural governance of policy-

making processes at national level, health system management at intermediate level and health service provision processes at the operational/grassroots level.[71]

Non-state actors such as I/NGOs, faith-based Organisations (FBOs), community-based organisations (CBOs), UN agencies and a range of donor organisations fill the vacuum left by the weak state in the provision of basic public services. In the public health sector, NSPs act as either state partners or surrogate state-like service providers. NSPs may be categorised as traditional or situational partners. FBOs are classified as national but also traditional partners. Most INGOs fall into the category of partners that were spurred by situational variables of state fragility, population vulnerability and the humanitarian consequences of the wars. Traditional international partners—in collaboration with the Ministry of Health (MoH)—contribute to the process of national policy making, sector funding and system strengthening. This is regarded as a horizontal approach. Humanitarian actors mostly use a vertical approach, which aims to implement un-integrated projects and humanitarian interventions that focus on (extreme) vulnerability.

A great deal of previous scholarly work has focused on the link between legitimacy and state service delivery, but there has been little investigation of the link between basic service provision by NSPs and state legitimacy in fragile states. This study focused on the state-building outcomes of networked health sector management concerning effective public health governance, the strengthening of system management and health service provision through state–non-state interactions. The study also explored state legitimacy and the population's experiences and perceptions of the state. Hence, the present work problematised service delivery and state legitimacy where the state is deemed fragile, has been affected by entrenched conflicts (or is contested) and relies heavily on NSP inputs. This led to the central research question of this study:

> How does the networked governance of health services, involving state and non-state actors through multi-stakeholder interactions, affect state-building and legitimacy in the fragile setting of eastern Democratic Republic of Congo?

In view of better tackling the research problem, the above fundamental question was split into five sub-questions, which were addressed in the empirical chapters of this thesis:

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[71] Please See Chapter 4 for an explanation of structural governance.

1. How does the health system management characterised by multi-stakeholders' engagement function, and how has this de facto networked governance been relevant for the state-building process in the fragile context of the DRC? (Chapter 2)

2. How do key stakeholders—especially state and donor organisations—intervening in the health sector use the discourse on state fragility in their interactions, and how does this impact intervention programming and policy coalition-building in the fragile state of the DRC? (Chapter 3)

3. What are the outcomes of strengthening the health system governance by means of networked governance through multi-stakeholder process initiatives such as the introduction and implementation of performance-based financing (PBF) in the health sector in the context of state-building in the fragile state of the DRC? (Chapter 4)

4. How do arrangements inspired by non-state actors, such as community-based health insurance (CBHI) schemes, affect networked governance and the achievement of universal primary health care coverage in war-torn communities experiencing excessive financial hardship and state fragility in South Kivu? (Chapter 5)

5. How do health services provided by non-state actors in the DRC affect popular perception of the state in the context of limited statehood? (Chapter 6)

Research Findings and Policy Implications Regarding Networked Health Sector Governance and State-building (Legitimacy) Outcomes in the Fragile State of the DRC

The findings of this research revolved around three main themes through which the state-building outcomes of networked health sector governance were explored: i) the design of networked governance and international intervention models; ii) review of the two multi-stakeholder governance schemes fostering networked governance—PBF and CBHI/MUS; and iii) the exploration of population perceptions and the popular legitimacy of the state. These three research areas gave rise to five empirical chapters answering the five questions above. The findings are summarised in this section.

Findings on the Functioning of Networked Governance, its State-building Outcomes and International Intervention Models

This sub-section answers the first two questions, which played a key role in understanding the overall workings, challenges and state-building outcomes of health sector networked governance through multi-stakeholder interactions. The first question concerns the workings and state-building outcomes of health sector networked governance in the fragile DRC health sector. The second question is mostly about the impact of state fragility discourse on health policy coalition-building, health sector intervention planning in light of the Paris Declaration on Aid Effectiveness, and the mutual perceptions of the state and international organisations.

Networked health sector governance through interactions of the state and NSPs may contribute to state-building in a fragile context.

A wide range of stakeholders interact to solve public and community health-related issues in the DRC. Four principal themes emerged from the analysis.

First, and above all, Chapter 2 revealed that the DRC health sector is an arena of networked governance. Although networked governance is not yet fully developed or completely institutionalised, throughout the health sector, there are many examples of state and non-state service providers negotiating, cooperating and even competing. In this sense, the Congolese health sector can be seen as an arena fostering the networked governance.

Second, interactions between state and non-state actors through this networked governance explain the persistence of the health sector in a setting characterised by very weak empirical statehood and a corrupt political elite. All of the chapters of the thesis have shown the concrete value of state–non-state interactions and partnerships for the maintenance and development of the health sector. The value of these interactions was acknowledged by a wide range of actors participating in this study. It is clear that non-state interventions fill the void where the state exists in name only, and non-state actors have undoubtedly contributed to meeting the population's needs.

Third, during interactions with the state, power relations are skewed in donors' favour because of their dominance in terms of resources, causing the state to play a limited role in managing the health sector. Pervasive institutional fragility compounded by deep-rooted corruption results in acute social vulnerability and disputed statehood. This, in turn, deeply

influences donors' leverage, mostly in terms of intervention models and incomplete policy coalition-building. This was especially clear in Chapter 3, which dealt with the wide gap in the discursive understanding and the objectives of the state and its international 'partners' with regard to the state's role in the governance of the sector. The research showed that, in a context of fragility, the state has limited power in negotiations with its partners on public matters. In addition to being hampered by weaknesses in terms of a lack of capacity for governance and (allegations of) misconduct, the Congolese state has also faced the challenge of interacting with partners with fragmented and horizontally competing agendas. Consequently, building a policy community has been difficult, and the governance network continues to be strained in the DRC's health sector.

Fourth, although it remains weak, the shadow of state authority is present in stakeholders' interactions, and the state, as the legal sovereign, plays a determining role in providing a regulatory framework and hence in managing the formal room for manoeuvre available to non-state actors.

Ultimately, although health sector networked governance cannot fully address state weaknesses, the research revealed that networked governance facilitates the management of population health needs. However, strengthening the role of the state in networked governance emerged as a requisite for balancing power relations among key stakeholders to reinforce the state's stewardship role, which is crucial for the coordination and the harmonisation of stakeholder interventions. This is necessary for achieving state-building process outcomes. Therefore, the issue of networked governance effectiveness raises normative concerns about the nature, model and priorities of engagement for policy interventions in empirically weak states, as well as about the role of the corrupt elite.

The perceptions and use of state fragility discourse in health sector programming, stakeholder interactions and stakeholder engagement negatively affect the process of health policy coalition-building in the DRC health sector.
Chapter 3 explored the impact of the state fragility discourse in interactive processes of state, INGO and donor engagement in the health sector in light of the Paris Declaration on Aid Effectiveness in fragile states. In the health sector, state fragility and its discursive referent hamper the formation of a policy coalition, because the government and donors/INGOs have not harmonised their perceptions of fragility. The present study used critical discourse

analysis to understand the extent to which the state fragility discourse influences key stakeholders' intervention programming and policy coalition-building in the DRC health sector, yielding the following research findings:

- State fragility impacts donors' coordinative discourse on intervention programmes in the DRC health sector.
- Diverging perceptions and discursive referents of state fragility also affect compliance with the Paris Declaration on donors' alignment and recipient countries' ownership.
- In the domain of public health, state fragility appears to be a concept without a policy coalition, especially because the phrase means different things to different stakeholders.
- This divergence in discursive references to state fragility did not, however, stop state officials from recognising the role of the financial inputs of INGOs/donors in the survival of the health sector.

The inputs of INGOs and donors into health services in the DRC health sector have followed both vertical and horizontal models. Most INGOs follow the vertical, humanitarian intervention model. However, state representatives emphatically expressed their aspiration to system/horizontal engagement for health system-building. Discursive references to state fragility were a sore issue among INGOs, donors and the state concerning health sector transition intervention models. Therefore, donors rationalised their emergency-based interventions, the shadow alignment (in place of a sector-wide approach) and indirect channelling of funding through INGOs by complaining about state fragility. State officials asserted political statehood and a desire for a paradigm shift. Dissent in perceptions of state fragility and the resultant model of engagement in the sector also affected the mutual perceptions of state and non-state actors. State fragility as a concept has therefore dominated interactive processes between the state and its partners.

State fragility is not a neutral concept in a context of contested statehood and disputed state legitimacy, where political elites attempt to assert statehood. In this study, discursive references to state fragility were viewed as empowering for INGOs and disempowering for the state. The research revealed how the use of state fragility as a perceptive discourse was interpreted differently by different actors in the DRC health sector. For government officials, the concept was seen as stigmatising, making it difficult for the state to assert its policy

perspective, especially regarding partners' compliance with the Paris Declaration. For INGOs/donors and UN agencies, it was necessary to take contextual fragility constraints into account when interpreting the Paris Declaration.

The defective financing of the public health sector nevertheless constituted a common ground on state fragility discourse for the state and donors. Both groups of actors recognised the state's weakness in terms of resource mobilisation, allocation, disbursement and control. The state's slim budget and low disbursement rate have exposed the sector to dependency on external assistance. Many participants in this study noted that, without donors, the sector would be further weakened and would possibly collapse. However, the choice of intervention model, informed by the organisational stance on the state fragility discourse, was a point of contention in the process of policy coalition-building.

Considering the current situation, building a policy coalition based on harmonised views is necessary for effective engagement and intervention sustainability in the health sector. This coalition-building should promote more than the implementation of the Paris Declaration on alignment, also facilitating the accountability and social responsibility of all stakeholders, which is key in responding to empirical fragility.

Multi-stakeholder Health System Management Arrangements: Strengthening Networked Health Governance and Increasing Community Health Coverage

This sub-section is concerned with the questions on the workings and outcomes of two multi-stakeholder health governance arrangements in the DRC. The first question deals with the outcomes of PBF for strengthening health system governance in the context of state fragility in line with its state-building-oriented theory of change in the DRC. The research explored PBF outcomes on structural governance, health system management and demand-side empowerment for social accountability. The second question concerns CBHI (known in the DRC as *Mutuelles de Santé*, MUS), a multi-stakeholder health sector governance arrangement at local level, and the achievement of universal primary health care coverage in South Kivu. The findings revealed how CBHI/*Mutuelles de Santé* has been a public sphere where different health sector stakeholders engage in the process of health system governance. The results also provide an understanding of the outcomes of MUS schemes regarding equity in primary health care coverage, social protection and health services financing at the community level in the diverse settings of the Katana and Uvira health zones (HZs).

PBF is a multi-stakeholder health sector governance arrangement that has contributed to strengthening health governance, improving health system management at intermediate level and ameliorating health provision processes at local level, especially in the Katana HZ.

In Chapter 4, PBF's health governance-strengthening outcomes were explored in light of a contextualised theory of change that was applied by Cordaid and *Agence d'Achat de Performance* (AAP). In line with the health governance triangle model, the analysis of the present study revolved around three aspects of structural health governance: i) strengthening health governance, which concerns PBF's effectiveness in terms of the state's health regulatory capacity and coalition-building; ii) health service provision management, which relates to providers' expectation management and the improvement of service delivery processes; and iii) demand-side empowerment, which is a requisite for social accountability.

In line with the structural health governance outcomes (see Chapter 4), the following results were found:

- *PBF as a tool for strengthening health sector governance outcomes*: This study found that PBF reinforces the structural governance of the health sector in terms of sector and work organisation, health system management and stakeholder accountability. PBF empowers the state with organisational capacities while also helping to institutionalise good governance practices. The approach supports the government's regulatory role, coalition-building and social accountability through enforcing national policy, a division of labour and patient-centred care. Through structural governance building and institutionalisation of good practices, PBF mediates the setting of goals and ideals, as well as building a coalition to work on their implementation. In contrast to other interventions, PBF renders the state more actively visible in system design, coalition-building, regulation and stakeholders' interactive collaboration.

- *PBF outcomes on service provision processes management in the Katana HZ*: It was found out that the majority of participants in this study viewed PBF favourably. Since PBF was introduced in 2007–2008, the rate of health service utilisation has increased. This study also found that contracting dealt with the agency problem by motivating health workers and providing performance incentives, thus addressing the laxness observed in the DRC public sector. PBF also provides useful support regarding the

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rationalisation of health management. Through promoting contract-based market principles and integrated management, PBF inputs not only attract new health staff, but also improve task-oriented behaviour. This study noted some progress in terms of behavioural change and good practices, such as readiness to improve financial accountability and a commitment to quality, productivity and patient-centred care.

- *PBF empowers the community for interactive participation*: Demand-side empowerment and social accountability are among the principles of PBF and are crucial for health system strengthening. PBF gives power to communities through promoting patient-centred care and recognising communities' legal and legitimate rights to participate in the process of service provision as both clients and beneficiaries. PBF engages with CBOs, which, in turn, work to raise awareness within the community regarding their social entitlements. Active participation of the community in the process of verifying health facilities' performance records empowers the population as a key stakeholder in health service management. PBF thus allows the interactive participation of the community, which is necessary to establish a more effective state–society relationship. Although the capacity to participate effectively for social accountability is still weak, community members in Katana testified that PBF efforts raise social awareness on the relevance of their interactive participation in health service provision.

Although there are many indications of positive effects, PBF interventions in the DRC face structural challenges that make achieving sustainability difficult. The approach remains confined to pilot experiments that fail to scale up. Many of these challenges are related to state fragility and corruption. PBF implementation relies mostly on inputs from external donors, creating dependency and anxiety regarding their withdrawal. The MoH itself is dependent on donors' financial incentives for implementing performance policy. Thus, PBF seems to be about transactional—or incentive-based—motivation for the state at governance and management levels, as well as for frontline providers at the grassroots level. It is challenging to move beyond transaction-based motivation to create a real behavioural transformation among providers. Moreover, there is a need for a better division of labour, an issue raised by many respondents, who thought that the AAP took on too many roles. For many of the research participants, a better division of labour is critical to prevent unpredictable outcomes related to conflicts of interests and unreliable reporting. In sum, it is

costly to scale up and achieve PBF sustainability in the absence of a working state. Strengthening the state's willingness and capacity is necessary for the success of any donor-inspired scheme. PBF supports health sector-based state-building, but it cannot fully repair a collapsed state.

CBHI/MUS is another form of a multi-stakeholder health sector governance scheme that may facilitate achieving universal health coverage in South Kivu in the long run.
CBHI/MUS outcomes in the fragile DRC health sector were explored in light of the universal health coverage agenda. This agenda advocates for the universal coverage of primary health care, the protection from financial risk of disease burden and health services financing in fragile states. The study focused primarily on the Katana and Uvira HZs. It also explored the provincial profile and the governance of MUS schemes to understand the regional history, functioning and membership procedures of these schemes, as well as the interactions among MUS stakeholders. The analytical focus on the Katana and Uvira HZs opened the venue for gaining understanding of the outcomes of MUS schemes regarding equity in primary health care coverage, social protection and health services financing at the community level in two diverse settings. These findings regarding CBHI/MUS in South Kivu indicated the following:

- *CBHI/MUS brings a wide range of actors into health sector governance for the improvement of community health*: MUS schemes serve as an arena of interaction for civil society, the state and international NGOs. As an open arena with the mission of serving the public interest, MUS schemes bear the marks of public space, where the state operates alongside non-state actors. They are an example of networked governance for the Congolese health system at the grassroots level. Organisational stakeholders interacting through or with MUS at provincial level include national and international organisations as well as health facilities.

- *CBHI/MUS as schemes with potential for improving health care access and equity in fragile states*: MUS schemes negotiate preferential health service costs and facilitate access to health care for the insured community. Although relevant for mediating health care access, MUS schemes' penetration and uptake rate, and thus equity, remain low across South Kivu. Regarding the equitable access and social protection effects in Uvira and Katana, the research found that MUS schemes mediate access to health care for only a portion of

the population. However, empirical research helped to realise that achieving equity in health requires systems thinking, which deals with the broader social determinants of health inequities in fragile states. This is why MUS penetration remains shallow in both study sites, with population uptake stagnating in Katana and declining in Uvira.

- *CBHI/MUS are health system financing schemes in fragile states, but they will remain ineffective without a working state*. MUS schemes face problems regarding resource mobilisation and the financial sustainability of health services, mostly related to the unreliability of MUS resource mobilisation systems and to the management of membership enrolment. The situation is compounded by extremely difficult living conditions for most of the population. The findings of this research indicate that MUS schemes in South Kivu are not yet reliable enough for mobilising resources for health services. The resource mobilisation and health sector financial sustainability outcomes of health are still weak, because the regressive fund-pooling system and its management have not lived up to the principles of CBHI. This has led to extended indebtedness and the delay and failure to pay for health services. This situation undermines the trust between health facilities, patients and the MUS, as well as weakening the MUS schemes' ability to monitor the quality of health care services and the state's ability to perform its regulatory role. Because of prevailing social and financial conditions, most potential members from the community are not financially able to access MUS membership. As a result, the most disadvantaged groups currently face problems of accessing both health care and MUS membership.

Nevertheless, this exploratory study on MUS schemes' universal health care outcomes also revealed that the schemes are relevant for improving community health coverage. However, in the case of the DRC, the schemes continue to face management and institutional challenges that are compounded by state fragility. To enable these schemes to contribute effectively to the universal coverage of primary health in South Kivu, the state should reinforce its stewardship presence by supporting the schemes, streamlining interactions between stakeholders, providing financing and strengthening the management of MUS schemes. Only in neoliberal thinking would the disengagement of the state be a legitimate approach.

Currently, the state's potential role in this process is very important for the improvement of MUS health outcomes in fragile settings like the DRC.

The Nonlinear Relationship between NSPs and the Legitimacy of a Fragile State

The findings of this sub-section relate to the fifth question, which revolved around NSPs in the health sector and the popular legitimacy of the state. This question was dealt with in Chapter 6 of this thesis. The health sector in the DRC provided a good entry point for understanding whether and how NSPs contribute to building state legitimacy in fragile states, as it is both an arena of interaction for different stakeholders and a public sphere where the population forms and communicates their perceptions and opinions of the state. For eliciting population perceptions of the state, community members, service providers, health system managers, state officials and representatives of INGOs were interviewed. The findings concerning the engagement of NSPs in the fragile DRC health sector revealed the following outcomes regarding population perceptions of the state and NSPs:

- *The DRC health sector is a public sphere where encounters among the state, non-state actors and the population shape their mutual perceptions and modes of intervention.*
  This study examined the health sector as an arena where state and non-state actors, as well as the population, encounter each other. The sector has evolved into a public sphere mediating social interactions between the population, the state, NSPs and health service providers. Compensating for the empirical vacuum of the state in many areas, NSP engagement in the health sector ranges from institutional support at the MoH through health departments and HZ offices and structures, to service provision at the health centre and community levels. However, the research found that the population expects a working state to improve their social welfare, but they recognise that the DRC state is too weak to live up to their expectations. From the population's experience-based feedback to research questions and stakeholder engagements, this study showed that the public health service provision realm is a public sphere, where the population form their opinions, not only of state, but also of other stakeholders working for the public interest. However, this public sphere created around service provision in the DRC is not institutionalised and generally not taken into account by the state. Still, public opinion is of great importance for state-building, as well as for achieving legitimacy and sustainable stability.

- *Although weak, the state still provides the institutional and legal framework to NSPs.*
  Although the state malfunctions in its roles of financing, policy implementation and enforcement, as well as in its coordination roles, it is nonetheless still regarded as the main guarantor of the institutional framework. The national policy framework in which the state is supposed to play the lead has been necessary for streamlining NSP engagement. Unfortunately, the materialisation of the state's leadership role has been delayed. This has made it difficult for the state to penetrate society through direct interactions with the population, especially in rural zones, where most state institutions are hardly visible. This explains why the population's recognition of NSPs in South Kivu is high; NSPs have been the most prominent providers of public health care.

- *Conveying the breach of social contract, the fragility of the DRC state has been a frustrating factor to the population.*
  Empirical research on the ground revealed the population's perceptions of the state, which conveyed a breach of the social contract. Frustration, disappointment and even anger ran high among the population whenever the social performance of the state was discussed. Some participants bluntly argued that there was no state at all, allegedly because those who claim to be the state do not care about the population's welfare. This frustration was also seen in some community members' characterisation of the Rwandan state, which many cited as a role model of a working state. The prevailing image of the Congolese state is that of a failed and unsympathetic entity made up of self-serving and corrupt elites.

- *NSPs may or may not contribute to state legitimacy in a fragile state.*
  The research found that NSPs may have a counterintuitive influence on the population's view of the state. They have the potential to increase disputes over public legitimacy within the community. Obviously, the image of NSPs outshines that of the government as the caretaker of the population. Anecdotal accounts from the interviewed community members explained that INGOs' and other NSPs' performance crystallised their benevolent image. Some INGO representatives also acknowledged that their interventions contributed more to INGO recognition than to state legitimacy, asserting that the population gives more esteem to the work of NSPs. This suggests that the performance of NSPs functions less to build state legitimacy and more to increase the appreciation for INGOs.

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- *The operational visibility of the state matters for its popular legitimacy.*

  This study revealed that the extent to which the state appears in the process of NSP interventions is of great importance. Active state visibility not only marks the state's presence; it also makes the community believe that the state cares for their social welfare and that NSP engagement is mediated by the state. The research found that the community aspires to see the state move closer in terms of social service provision. Some community members recognised the work of the state and NSPs through the child vaccination campaigns that are regularly conducted under the supervision of the state. During those campaigns, which are financially supported by external partners, the MoH, HZs and CODESAs play the mobilising role for population uptake. These activities have contributed a great deal to state visibility at the grassroots. People then see the state, because state officials are mobilised and deployed with the partners on the ground. For this reason, people give credit not only to NSPs, but also to the state. Thus, the overall finding is that NSP interventions may or may not have a positive impact on population perceptions of the state, depending on how services are provided by NSPs. The state's active visibility in service provision matters.

Eventually, there is a need to make the DRC state actively visible but also to increase population awareness about the role of the state in non-state service provision processes. Most people are unaware of the functions that the state actually carries out related to the work of NSPs, and this lack of information reinforces the negative image of the state in the health sector networked governance.

Study Limitations and Perspectives for Future Research

This research faced a number of limitations that should be addressed in future research projects.

Geographical Scope of the Research

The research was conducted mostly in South Kivu, although networked health governance is a social fact that concerns the health sector governance country-wide. A comparative study of the eastern and western provinces on health sector networked governance, especially regarding policy processes, health system management and population perceptions of the state

at the operational level through NSP engagement would convey more fully the workings and state(-building) outcomes of the networked health governance for the whole country.

Studying Non-state Humanitarian and State-building Interventions in Fragile States Where the Governing Elites are Corrupt, Causing Institutional and Social Weaknesses

The DRC's authoritarian political culture and corrupt elites are considered to have much to do with the state's malfunctioning. This resulted in a policy concern. It would require further research to address the challenge of reconciling humanitarian necessity with system-building requirements in a fragile setting, where the governing elite is concerned mostly with personal gain, potentially leading to increased fragility. The success of state-building interventions in a process where (fragile) state elites are viewed as excelling in gaming and capitalising on the fragility of the state is both a challenge for the DRC state-building process and a study area in which further research is required.

Exploring the Social Brokers Influencing the Population's Opinions of the State

The DRC is notoriously a weak state. This fact makes it tempting for both researchers and citizens to draw conclusions about its fragility even before conducting the research or experiencing the effects of its dysfunction. Other factors and agencies might also contribute to opinion formation, especially at grassroots levels, even for those who have had a negative experience with the fragility of the state. Therefore, future research should further this investigation by examining more deeply how the population's opinions of the state are formed and whether there are opinion brokers influencing population perceptions of the state.

Ultimately, non-state actors are limited in what they can achieve. They cannot bring security or fully rebuild a functioning state. Networked governance is as much an expression of NSPs trying to help the population and their state as of the state's weaknesses. However, in networked governance, the state remains important, albeit more like a *primus inter pares*, because of its legal status as a sovereign actor. The most difficult underlying issue is that the state and its corrupt elite are both the main problem and have to be part of the solution. Scholars and non-state actors alike may think of different state–society relations and forms of governance; however, they cannot think and act without the state. In the final analysis, we continue to seek or build a central actor, who has the interests of the population at heart. The DRC has often disappointed in this search. Nevertheless, this research has also shown that it is possible to continue to take steps to improve the wellbeing of the population.

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SUMMARY

State fragility in the Democratic Republic of Congo (DRC) has impacted the state's ability to provide public services, as well as and the population's experiences 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). The population has become dependent on non-state actors for the provision of basic social services, and NSPs are especially important in public health, where their engagement accounts for the survival of the sector. The state and NSPs interact through networked governance, where relevant actors are involved in a network through resource interdependency, cooperation, collaboration and even competition to achieve social goals (Klijn, 2004). Networked governance processes in the DRC public health sector take place at three structural levels: national, provincial and operational. Networked governance serves as an institutionalised public model for health sector management through these three levels.

A great deal of previous work has studied the link between legitimacy and state service delivery, but there has been little investigation of the link between basic service provision by NSPs and state legitimacy in fragile states. This study explored how the networked governance of the health sector contributes to state-building processes and to state legitimacy in the DRC, also examining how the image of the state is shaped by NSP service provision. The study focused on state-building outcomes related to effective public health governance, the strengthening of system management and health service provision through state–non-state interactions. The study also explored state legitimacy and the population's experiences and perceptions of the state, in a context where the delivery of public health services is mediated by non-state actors.

The research was guided by the following key question:

How does the networkedgovernance of health services, involving state and non-state actors through multi-stakeholder interactions, affect state-building and legitimacy in the fragile setting of eastern Democratic Republic of Congo?

Networked Governance in the Management of the DRC's Health Sector

Non-state stakeholders 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 strong inputs from NSPs, supported by international funding, gives the DRC's health sector its 'current resilient' outlook (Pearson, 2011: 12; Seay, 2013). Although these inputs have not been homogeneous across provinces or health zones (HZs) within provinces (Pavignani, Michael, Murru, Beesley & Hill, 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 categorised as national or international, and as traditional or situational partners. Faith-based organisations (FBOs) are classified as national and as traditional partners of the state. International actors recognised as traditional health policy partners mostly include bilateral and multilateral institutions that have long supported state-building in the DRC. In contrast, most international NGOs are situational partners whose emergence was spurred by state fragility and the humanitarian consequences of wars. In collaboration with the Ministry of Health (MoH), traditional international partners contribute to the process of national policy making and system strengthening. Situational partners are mostly engaged in unintegrated projects and humanitarian interventions focusing on circumstantial situations of social vulnerability. Through their frequent use of different policies and stand-alone projects, these organisations have involuntarily contributed to a decentralised and rather fragmented system. Traditional partners such as FBOs and international donor organisations 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 operate like surrogate state service providers, and both the state and NSPs are engaged in the process of health care provision through networked governance.

In this study's 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 how NSP interventions contribute to state legitimacy was treated as an open question in this study.

Actor-oriented Interactions in the Networked Governance of the DRC's Health Sector

Networked governance arrangements in the DRC's health sector have the characteristics of a social arena, which is 'typical of actor-oriented interactions' (Hilhorst & Jansen, 2010). As symbolic locations, arenas are neither geographical entities nor organisational systems; rather, they describe the political actions of all of the social actors involved in a specific issue (Kitschelt 1980 in Renn, 1993).

The Multilevel Nature of Health Sector Networked Governance Arenas

Health sector governance in the DRC has a pyramidal organisation involving the central (national), intermediate (provincial) and operational (HZ) levels (Bukonda, Chand, Disashi, Lumbala & Mbiye, 2012).

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 sector 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 and the oversight of the operational (HZ) level. The intermediate level organises and provides technical support to the HZ (World Bank, 2005). At this level, state and non-state actors interact to improve the structural system governance and to manage the provision of health services. Through the *Comité Provincial de Pilotage Santé*, stakeholders work towards harmonising interventions and establishing the model of engagement at the provincial level. Using HZ evidence-based reports, the *Comité Provincial de Pilotage Santé* defines provincial-level stakeholder priorities in line with the national health policy.

The HZ is the operational unit that integrates primary health care services and the first-referral level. An HZ covers an average population of 110,000 and consists of a central HZ office, an array of health posts and centres, and a general referral hospital (Carlson, Maw & Mafuta,

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 (Carlson et al., 2009). Many facilities have become in effect privatised, relying on patient fees to pay staff and operating costs. At the HZ level, networked governance of the local health system takes place through the *Bureau Central de Zone de Santé* (HZ Management Board). In this arena, interactions take place among representatives of the state, non-state actors (where possible) and community-based organisations—especially the community health development committees (*Comité de Développement Sanitaires*).

Research Methods

This research is part of the Secure Livelihoods Research Consortium, which focuses on state legitimacy, capacity for state-building and livelihood trajectories in conflict-affected situations (Levine, 2014). This study fell under the first two of these themes, with a focus on the population's experiences, perceptions and expectations regarding state legitimacy and on building effective states that deliver services and social protection. This study began in 2012, with the 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), which is 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. The second case was a community-based health insurance (CBHI) programme—*Mutuelle de Santé* (MUS). The case study of PBF focused on health system governance because of PBF's pivotal role in the process of building the health system. The CBHI case study explored MUS outcomes related to equity in access to health services, protection from financial risk and the financing of health services. The CBHI case study was based primarily on observations in a rural area (Katana) and a semi-urban area (Uvira).

Focusing on the multilevel networked governance of the DRC's health sector, this study drew on institutional ethnography, which examines work processes and studies how they are coordinated, typically through examining various texts and discourses (Smith, 2009).

Attention was given to discourses, relationship patterns, writings and multi-stakeholder governance arrangements throughout 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: three donor organisations, six international organisations and seven national NGOs); health service providers throughout the province (20 medical 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 last category of respondents, community opinions on health services, the state and NSPs were assessed through interviewees' personal storytelling, semi-structured interviews and focus groups. To assess the baseline situation in the health sector, a content analysis of the four main official policy papers was also conducted.

Main Research Findings

The findings of this research revolved around three main study concerns: 1) the institutional outlook, functioning and state-building outcomes of networked health governance and international intervention models; 2) the review of the two schemes fostering networked governance through multi-stakeholder governance engagement; and 3) the exploration of the impact of NSP interventions on the population's perceptions and the legitimacy of the state.

Institutional Functioning and State-building Outcomes of Networked Health Governance and International Intervention Models

Networked health sector governance and state-building outcomes (chapter 2). 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 to fill the void created by the lack of state health care provision. The findings demonstrate that state–non-state interactions in the DRC's health sector create a burgeoning form of multilevel networked governance and that these interactions play a role in explaining 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, 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, the 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 (Chapter 3)

State fragility is a discourse without a policy coalition in the DRC's health sector governance network. The government and donors/international NGOs have not yet harmonised their perceptions 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. The contentious nature of the concept of fragile statehood has hampered the construction of a policy coalition for health sector interventions. Donors rationalise the persistence of emergency-based interventions by emphasising fragile statehood, whereas state 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 getting international NGOs to comply with the Paris Declaration on Aid Effectiveness. However, representatives of the state and donor organisations agree that, because public health sector funding is lacking, donors' financial contributions ensure the sector's survival.

Multi-stakeholder Health System Arrangements: Strengthening Networked Health Governance and Community Health Coverage

International organisations and donors have supported schemes, such as PBF and CBHI/MUS, which have impacted the networked governance and system-building in the local health sector, as well as improving health care delivery.

PBF and strengthening public health governance (Chapter 4)

This study examined the effectiveness of PBF in three areas of health system governance: structural governance from a capacity-building perspective, health service provision management and demand-side empowerment for effective accountability. In general, the study found that PBF positively impacted the process of health system-building in these three areas. 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. The research 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. In addition to structural threats and uncertain sustainability, transforming transactional motivation into transformational change is a challenge. 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 (Chapter 5)

The MUS CBHI scheme began operating just after the wars in South Kivu. The research findings indicate that MUS schemes lead to improvements in access and social protection 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 facing MUS schemes. These challenges are compounded by state fragility. To contribute effectively to universal health coverage, the state should reinforce its stewardship presence in strengthening MUS.

NSPs and Local Perceptions of the State (Chapter 6)

Service provision—especially health care delivery—serves as a public sphere and an arena for interactions and multi-stakeholder processes. The findings indicated that the population's perceptions of the state reflect a breach of social contract, because the state has failed to live up to the population's needs and expectations. The presence of NSPs may have negative effects on the population's perceptions of the state, because NSPs' performance establishes their benevolent image while solidifying a negative image of the state. However, the state-building legitimacy outcomes of NSPs' engagement in this context are contingent on how the services are delivered: When NSPs engage with the state on the ground, people also see the state in action. People then assign credit not only to the NSPs, but also to the state, which is important for state-building and legitimacy. There is no direct correlation between service

provision by NSPs and the positive image of the state; what positively impacts the image of the state is its visibility on the ground.

Overall, this study explored state-building outcomes resulting from networked health sector governance in a war-affected context with an empirically weak state. In this context, the public health provision inputs of NSPs are crucial for the population's welfare. The findings indicate that NSP engagement contributes strongly to public health provision and the management of the health system. However, state fragility has a negative impact on networked health governance and donor-supported interventions. 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.

'' Gouvernance en réseau du secteur de santé et consolidation de la légitimité de l'État dans les contextes de fragilité et des conflits : l'impact variable de la prestation de services de santé publique par des entités non-étatiques en République Démocratique du Congo''

En République démocratique du Congo (RDC), la fragilité de l'État exerce un impact négatif sur sa capacité à assurer les prestations de service public, ainsi que sur les perceptions et l'expérience de la population quant à sa légitimité. En matière de santé publique et d'aide sociale, la contribution de l'État est faible, et tributaire de l'engagement des prestataires non-étatiques (NSP, « non-state service providers »). Généralement l'accès de la population aux services sociaux de base dépend aujourd'hui de ces acteurs non-étatiques. Les NSP tiennent un rôle central dans le domaine de la santé publique, où leur intervention s'avère déterminante pour la survie du secteur. L'État et les NSP interagissent par des processus de gouvernance en réseau, au sein desquels les acteurs développent des liens d'interdépendance en matière de ressources, ainsi que des liens de coopération, de collaboration, et même de compétition, dans la poursuite d'objectifs à caractère social. Les processus de gouvernance en réseau qui régissent le secteur santé en RDC sont observables à trois niveaux : national, provincial et opérationnel. La gouvernance en réseau s'est imposée en tant que modèle de gestion à tous les échelons institutionnels du secteur santé.

De nombreux travaux se sont penchés sur les liens entre légitimité de l'État et déploiement des services publics, mais la relation entre légitimité étatique et prise en charge des services de base par des NSP dans les États fragiles a été peu étudiée. La présente étude analyse en quoi la gouvernance en réseau du secteur de santé a contribué aux processus de construction de l'État et d'établissement de sa légitimité en RDC, et en quoi les prestations des NSP modèlent les perceptions relatives à l'État. L'étude se concentre sur les phénomènes de construction de l'État en lien avec la gouvernance effective de la santé publique, sur la consolidation des modèles de gestion, et sur la prestation de services de santé par le biais d'interactions entre acteurs étatiques et non-étatiques. Elle examine également la légitimité de l'État en lien avec l'expérience et les perceptions de la population dans un contexte où les prestations de santé publique sont assurées par des acteurs non-étatiques.

Cette étude vise à répondre à la problématique suivante : En quoi la gouvernance en réseau des services de santé influence-t-elle le processus de construction de l'État et de sa légitimité dans le contexte fragile de la RDC orientale ?

Gouvernance en réseau dans la gestion du secteur de santé en RDC

Des entités non-étatiques ont participé au déploiement des services publics de base tout au long de l'histoire de la RDC (Pearson 2011, Seay 2013, Waldman 2006). Certains chercheurs soutiennent que l'engagement important des NSP, financé par des bailleurs de fonds internationaux, explique les perspectives de « résilience » actuelles du secteur de santé en RDC(Pearson 2011, p. 12 ; Seay 2013). Ces investissements n'ont pas profité également à toutes les provinces et zones de santé au sein de ces provinces (Pavignani, Michael, Murru, Beesley et Hill 2013, Pearson 2011) ; mais dans sa globalité, leur contribution explique la résilience du secteur en termes d'élaboration et application des politiques, de gestion du système de santé, et de prestation de services.

Les NSP se divisent entre organisations nationales et internationales, et entre partenaires traditionnels et contextuels. Les organisations confessionnelles (FBO, « faith-based organisations ») sont considérées comme des organisations nationales et des partenaires traditionnels de l'État congolais. Parmi les acteurs internationaux reconnus en tant que partenaires traditionnels en matière de santé publique, on compte principalement des institutions bilatérales et multilatérales qui participent de longue date à la construction de l'État en RDC. Par contraste, la plupart des ONG internationales présentes sur le terrain sont des partenaires contextuels, dont l'intervention a émergé en réponse à la fragilité de l'État et aux conséquences humanitaires des conflits. Les partenaires internationaux traditionnels collaborent avec le Ministère de la santé publique à l'élaboration des politiques nationales de santé publique et à la pérennisation du système. Les partenaires contextuels agissent principalement dans le cadre de projets et d'interventions humanitaires autonomes, centrés sur des situations de vulnérabilité sociale à caractère ponctuel. En raison de leurs approches disparates, ces organisations ont involontairement contribué à la décentralisation et à la fragmentation du système. Les partenaires traditionnels que sont les organisations confessionnelles et les bailleurs de fonds internationaux jouent un rôle crucial dans la gouvernance en réseau du secteur santé et dans la prestation de services de santé publique.

Gouvernance en réseau et légitimité de l'État au sein du secteur de santé publique en RDC

La RDC est un État historiquement fragile, qui rencontre des difficultés dans l'exécution des compétences étatiques courantes. Les NSP agissent en tant que prestataires de service public par substitution, participant au côté de l'État à la gouvernance en réseau des services de santé.

La légitimité de l'État est ici évaluée en fonction de l'hypothèse selon laquelle « plus un État est légitime, plus les citoyens le traitent comme détenteur et exécutant de droit du pouvoir politique » (Gilley 2006). Un déficit de légitimité est un facteur majeur de fragilisation de l'État en ce qu'il sape l'autorité de ce dernier (Unsworth 2010). Dans la plupart des cas, on constate qu'une dégradation des services publics exerce un impact négatif sur le soutien accordé par la population à un État et à ses représentants (OCDE/DAC 2008). Peu de travaux ont toutefois analysé l'expression de cette hypothèse dans les contextes fragiles marqués par une hétérogénéité institutionnelle. C'est pourquoi cette étude pose la question de savoir si l'intervention des NSP contribue au renforcement de la légitimité de l'État dans un contexte de fragilité.

Interactions axées sur les acteurs au sein de la gouvernance en réseau du secteur santé congolais

En RDC, la gouvernance en réseau du secteur santé prend la forme d'une arène sociale, « typique des interactions axées sur les acteurs » (Hilhorst et Jansen 2010). En tant que lieux symboliques, les arènes ne représentent ni des entités géographiques, ni des systèmes organisationnels. Elles désignent plutôt l'ensemble des actions à caractère politique qui sont entreprises par des acteurs impliqués dans un champ d'intervention donné (Kitschelt 1980, cité dans Renn 1993).

Caractère multicouche des arènes de gouvernance en réseau du secteur de santé en RDC

En RDC, la gouvernance du secteur santé est organisée selon un modèle pyramidal à trois niveaux : central (national), intermédiaire (provincial) et opérationnel (zones de santé) (Bukonda, Chand, Disashi, Lumbala et Mbiye 2012).

Le niveau central relève du Ministère national de la santé, censé remplir une fonction stratégique en s'engageant dans la formulation des politiques publiques, l'élaboration de mécanismes de mise en œuvre, le financement du secteur, et les relations de haut niveau avec

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les acteurs non-étatiques (par exemple, via la signature d'accords-cadres ou autres accords). Le ministère est responsable de la gestion politique du secteur de santé et de sa réglementation, ainsi que des programmes de santé nationaux et des centres hospitaliers (Waldman 2006). Bien que la prise de décision politique soit une compétence exclusive du Ministère de la santé (Zinnen 2012), les bailleurs de fonds et autres partenaires de développement fournissent une assistance technique et financière en la matière.

Le niveau intermédiaire de gouvernance est chargé de la gestion du secteur de santé à l'échelle provinciale et de la supervision du niveau opérationnel (zones de santé). Il organise et délivre un appui technique aux zones de santé (World Bank 2005). À ce niveau, acteurs étatiques et non-étatiques entrent en interaction afin d'améliorer la gouvernance structurelle du système et de gérer les prestations de santé. Ces parties prenantes collaborent au sein du Comité Provincial de Pilotage Santé en vue d'harmoniser leurs actions et de définir un modèle d'intervention à l'échelle provinciale. Le Comité Provincial de Pilotage Santé s'appuie sur les rapports de terrain compilés par les zones de santé pour définir, dans le cadre de la politique nationale de santé publique, les priorités de chaque acteur à l'échelle de la province.

Les zones de santé recouvrent l'unité opérationnelle constituée des services de proximité et du premier degré de spécialisation des soins. Une zone de santé compte un bureau central, un ensemble de postes et de centres de santé et un hôpital de référence/rattachement, et couvre en moyenne 110 000 habitants. La pénurie de financements publics des dernières décennies a contraint les zones de santé et leurs infrastructures à une autonomie fonctionnel de fait, même si les instances ministérielles continuent d'exercer un contrôle administratif, en particulier en matière de ressources humaines (Carlson et al., 2009). Dans les faits, nombre de structures ont été privatisées, les frais demandés aux patients permettant de couvrir les coûts de personnel et d'opération. À l'échelle des zones de santé, la gouvernance en réseau des services de proximité est assurée par le Bureau Central des Zones de Santé. Au sein de cette arène, des interactions se tissent entre représentants de l'État, acteurs non-étatiques (le cas échéant) et organisations communautaires (Comités de développement sanitaire en particulier).

Méthodes de recherche

Cette étude a été réalisée dans le cadre du programme Secure Livelihoods Research Consortium (« Consortium de recherche sur la sécurité des moyens de subsistance »), centré sur la légitimité de l'État, ses capacités de construction étatique, ainsi que les trajectoires de

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subsistance observées dans les contextes de fragilité et/ou ceux touchés par un conflit. La présente étude relève des deux premiers thèmes de ce programme, et se concentre sur les expériences, les perceptions et les attentes de la population quant à la légitimité de l'État, et sur la construction d'un État efficace, en mesure d'assurer des prestations de service public et de protection sociale. L'étude a débuté en 2012, et les recherches de terrain ont duré 19 mois, d'août 2013 à avril 2015.

La plupart de ces recherches ont été conduites dans la province du Sud-Kivu, des données complémentaires ayant également été recueillies à Kinshasa. La forme de l'étude de cas a été adoptée pour analyser deux structures de gouvernance multipartites. Le premier cas concerne le Financement Basé sur la Performance (PBF, « Performance-based financing »), qui désigne le transfert de moyens financiers ou matériels depuis un donateur vers un bénéficiaire contractuel, à la condition que ce bénéficiaire entreprenne des actions mesurables ou atteigne des objectifs de performance prédéfinis. Le second cas concerne un programme d'assurance santé à base communautaire (CBHI, « Community-based health insurance »), les Mutuelles de santé (MUS). L'étude de cas portant sur les PBF est centrée sur la gouvernance du secteur santé, car ce mode de financement joue un rôle clé dans la construction du système de santé. L'étude de cas portant sur les MUS a examiné leurs effets en matière d'accès équitable aux prestations de santé, de protection contre les risques financiers et de financement des services de santé, en s'appuyant principalement sur des observations de terrain conduites en zone rurale (à Katana) et semi-urbaine (à Uvira).

Cette étude analyse la gouvernance en réseau multicouche du secteur de la santé publique en RDC par le prisme de l'ethnographie institutionnelle, qui s'intéresse aux processus de travail et à la manière dont ceux-ci sont coordonnés, en s'appuyant généralement sur l'examen de différentes sources textuelles et discursives (Smith 2009). Tout au long de l'étude, une attention particulière a été prêtée aux discours, aux schémas relationnels, aux documents écrits et aux modalités régissant la gouvernance multipartite.

Des entretiens ont été menés auprès de six catégories de participants : des fonctionnaires de la santé publique et des acteurs gouvernementaux basés dans les établissements du Ministère de la santé à l'échelle nationale et provinciale (environ 30 participants) ; des représentants des ONG et bailleurs de fonds nationaux et internationaux (16 organisations dont trois bailleurs de fonds, six organisations internationales et sept ONG nationales) ; des prestataires de soins

issus de l'ensemble de la province (20 médecins) ; des personnes chargées de différents niveaux de gestion des MUS, en particulier à Katana et Uvira (environ 68 participants) ; des organisations confessionnelles (35 membres du Comité de développement de l'aire de santé, CODESA) ; et des personnes issues des communautés locales (patients, clients, citoyens), principalement à Katana, Bukavu, Uvira et Idjwi (environ 1 000 participants). S'agissant de la dernière catégorie de participants, leurs opinions au sujet des services de santé, de l'État et des prestataires NSP ont été recueillies par le biais de récits personnels, d'entretiens semi-structurés et de groupes de discussion. Une analyse des quatre documents officiels comme sources principales de la politique publique en matière de santé publique a également été conduite afin de comprendre les fondements du système de santé congolais.

Principales conclusions

Les conclusions de cette étude relèvent de trois thèmes de recherche principaux : 1) les perspectives institutionnelles de la gouvernance en réseau, son fonctionnement et son impact sur la construction de l'État, ainsi que les modèles d'intervention internationale ; 2) l'étude de cas portant sur les deux mécanismes précédemment cités de gouvernance en réseau par le biais d'interactions multipartites ; et 3) l'impact des interventions non-étatiques sur la légitimité perçue de l'État.

Perspectives institutionnelles de la gouvernance en réseau, fonctionnement et impact de celle-ci sur la construction de l'État ; et modèles d'intervention internationale

Influence de la gouvernance en réseau du secteur santé sur la construction de l'État. On observe des interactions de longue date entre acteurs étatiques et non-étatiques travaillant au développement des services de santé publique en RDC. De manière récurrente, des acteurs privés ont dû palier à l'absence d'intervention étatique en la matière. Nos observations montrent que les interactions entre acteurs étatiques et non-étatiques du secteur de santé ont posé les prémisses d'un mode de gouvernance multipartite, et que ces interactions expliquent en partie la survie du système malgré un contexte de fragilité étatique. Cette fragilité critique réduisant les possibilités de coordination et d'alignement, il est difficile de mesurer le véritable impact de ces interactions sur la construction de l'État. Notre étude fait également apparaitre divers obstacles à la construction d'un secteur de santé cohérent, résiliant et durable en RDC : la nature fragmentée de la majorité des interventions conduites par les ONG internationales, les rapports de pouvoir déséquilibrés régissant les négociations avec les partenaires de développement, et les déficiences en termes de gouvernance. De manière

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générale, on observe néanmoins que la gouvernance en réseau via des interactions entre entités étatiques et non-étatiques est susceptible de contribuer à la construction de l'État.

Discours sur la fragilité de l'État et enjeu de l'établissement d'un consensus politique pour la planification des interventions et l'élaboration de modèles d'engagement multipartite. La fragilité de l'État ne fait pas consensus au sein de la gouvernance du secteur santé en RDC. Le gouvernement et les ONG et bailleurs de fonds internationaux ne tiennent pas le même discours à ce propos. Ces acteurs ne tombent pas non plus d'accord sur la politique d'intervention, et des logiques institutionnelles opposées s'affrontent dans le processus de décision politique et d'élaboration des interventions. La nature contentieuse du concept d'État fragile a entravé l'établissement d'un consensus politique en matière de santé publique. Les bailleurs de fonds justifient la poursuite des interventions d'urgence par la fragilité de l'État, tandis que les représentants de ce dernier cherchent à affirmer leur autorité politique et plaident pour un changement de paradigme en faveur de l'élargissement du contrôle de l'État. Cette absence de consensus autour de la notion de fragilité étatique influence les perceptions liées à l'État, ainsi que la participation des ONG et bailleurs de fonds internationaux à la planification des interventions de santé publique en RDC. Les représentants du gouvernement congolais estiment que le concept d'État fragile est stigmatisant, et qu'il conforte les ONG dans leur réticence à se conformer à la Déclaration de Paris sur l'efficacité de l'aide au développement. Cependant, représentants de l'État et bailleurs de fonds s'accordent à constater qu'à la lumière du manque de financement adéquat du secteur de la santé publique en RDC, ce sont plutôt les contributions financières des donateurs qui permettent au secteur de survivre.

Modes de gouvernance multipartite du secteur santé : renforcer la gouvernance en réseau et la couverture santé à l'échelle des communautés

Les bailleurs de fonds et les organisations internationales ont soutenu le développement de mécanismes comme les Financements Basés sur la Performance (PBF) et les mutuelles de santé (MUS), qui ont eu un impact sur la gouvernance en réseau et le déploiement du secteur santé de proximité, ainsi que sur les prestations de soin.

Financements PBF et consolidation de la gouvernance en matière de santé publique. Nous avons évalué l'efficacité des financements PBF dans trois domaines de gouvernance de la santé publique : la gouvernance structurelle (du point de vue du renforcement des capacités),

la gestion des services de santé, et la participation des bénéficiaires à l'évaluation des performances. De manière générale, on observe que les financements PBF ont eu un impact positif sur ces trois aspects de la construction du secteur santé. De nombreuses lacunes subsistent, mais la gouvernance et la qualité des services de santé se sont améliorées, tout comme la relation soignant-patient, qui a bénéficié d'une approche axée sur le patient et d'une prise de responsabilité sociale en termes de performance. Les contrats basés sur les incitations et les financements basés sur les résultats ont eu des conséquences positives.

Toutefois, bailleurs de fonds, représentants étatiques et autres acteurs remettent en question la pérennité de ces approches, d'autant que la fragilité de l'État affecte leur mise en œuvre. En plus des risques structurels et des incertitudes pesant sur la durabilité de ces initiatives, transformer des incitations transactionnelles en mutations de fond reste un défi. Au final, on constate que si les financements PBF sont utiles au développement de l'État via le déploiement de services de santé, ils ne peuvent pas remédier à l'effondrement de ce dernier.

MUS et couverture santé à l'échelle des communautés. Le programme MUS a été lancé au Sud-Kivu peu de temps après la fin du conflit. Notre étude montre que ce programme a favorisé l'accès aux soins et à la protection sociale d'une partie de la population seulement. Des observations similaires en matière de mobilisation des ressources et de pérennité financière du secteur santé mettent en lumière les défis de gestion que ce type de programmes doivent relever. La fragilité de l'État est source de complexité supplémentaire. Dans une optique de développement de l'assurance maladie universelle, l'État devrait intensifier son engagement en faveur d'une consolidation des MUS.

Prestataires NSP et perceptions locales de la légitimité de l'État
Le secteur de prestation de services, en particulier de services de santé, est représentative de la sphère publique et constitue une arène favorable aux interactions et aux processus multipartites. Selon nos observations, les perceptions de la population relative à l'État révèlent une rupture du contrat social, l'État ayant échoué à répondre aux besoins et aux attentes de la population. La présence des NSP pourrait également influencer négativement la perception de l'État par la population, car la performance de ces prestataires renforce leur image de bienfaiteurs et cristallise par contraste la mauvaise image de l'État. L'impact des interventions des NSP sur la construction de la légitimité étatique dépend alors de leur organisation opérationnelle : là où les NSP travaillent main dans la main avec l'État sur le terrain, la population est sensible à la présence de ce dernier. Elle reconnaît alors non

seulement l'engagement des NSP mais aussi celui de l'État, favorisant sa construction et l'établissement de sa légitimité. Les prestations des NSP n'influencent pas directement l'image de l'État : seule la visibilité des acteurs étatiques sur le terrain peut améliorer cette image.

En fin de compte, cette étude s'est penchée sur l'impact de la gouvernance en réseau du secteur santé sur la construction de l'État dans un contexte marqué par les conflits, où l'État se trouve fragilisé de fait. Dans ce contexte, l'intervention des NSP dans l'opération des services de santé publique est vitale à la protection de la population. L'étude montre que leur engagement contribue fortement à l'existence même de services de santé publique et à la gestion du secteur santé. Cependant, la fragilité de l'État a un impact négatif sur la gouvernance en réseau de ce système et sur les interventions financées par des bailleurs de fonds internationaux. Tout projet visant à réduire la vulnérabilité de la population et à répondre aux besoins humanitaires devrait comprendre un volet consacré à la construction de l'État, car la fragilité de ce dernier entrave l'efficacité et la pérennité de toute intervention conduite par des acteurs non-étatiques.

SAMENVATTING (SUMMARY IN DUTCH)

De bestuurlijke fragiliteit in de Democratische Republiek Congo (DRC) heeft het vermogen van de overheid om overheidsdiensten te leveren beperkt. Het heeft ook gevolgen gehad voor de ervaringen en percepties van de overheid onder de bevolking. Gezondheidszorg van de kant van de overheid is zwak en sterk afhankelijk van de betrokkenheid van niet-statelijke programma's (NSP's). De besturing van de gezondheidszorg heeft de vorm van een netwerk van actoren die door middel van interdependentie, samenwerking, en zelfs concurrentie sociale doelen bewerkstelligen (Klijn, 2004). Netwerkbesturing in de gezondheidszorg van DRC vindt plaats op drie structurele niveaus: nationaal, provinciaal en operationeel.

Veel eerder werk heeft de link tussen legitimiteit en staatsdienstverlening bestudeerd, maar er is weinig onderzoek gedaan naar de koppeling tussen de basisdienstverlening door NSP's en de legitimiteit van de overheid in fragiele staten. In dit onderzoek werd onderzocht hoe netwerkbesturing van de gezondheidssector bijdraagt aan staatsopbouwprocessen en legitimiteit in de DRC.

Het onderzoek werd geleid door de volgende sleutelvraag:
Hoe beïnvloedt de netwerkbesturing van gezondheidszorg, met betrokkenheid van gouvernementele en niet-gouvernementele actoren, de opbouw en legitimiteit van de overheid in de fragiele omgeving in het oosten van de Democratische Republiek Congo?

Netwerkbesturing in de gezondheidssector van de DRC

Niet-gouvernementele actoren zijnaltijd actief betrokken geweest bij basisvoorzieningen in de geschiedenis van de DRC (Pearson, 2011; Seay, 2013; Waldman, 2006). Sommige studies tonen aan dat de huidige veerkracht van de gezondheidssector van de DRC gedragen wordt door de bijdragen van NSP's, gesteund door internationale financiering (Pearson, 2011: 12; Seay, 2013). Hoewel deze bijdragen niet gelijk verdeeld zijn over de gezondheidszones (Pavignani, Michael, Murru, Beesley & Hill, 2013, Pearson, 2011), is hun totale bijdrage cruciaal voor het beleid en de uitvoering in de sector.

NSP's kunnen worden ingedeeld als nationaal of internationaal, en als traditionele of situationele partners. Geloofsgebonden organisaties worden gezien als nationaal en als traditionele partners van de staat. Internationale actoren die gezien worden als traditionele partners zijn meestal bilaterale en multilaterale instellingen die de opbouw van de

staatsopbouw in de DRC al voor lange tijd hebben ondersteund. Daarentegen zijn de meeste internationale NGO's situationele partners die door de fragiliteit van de staat en de humanitaire gevolgen van de oorlogen in het land zijn gaan werken. In samenwerking met het Ministerie van Volksgezondheid (MvG) dragen traditionele internationale partners bij aan het proces van nationale beleidsvorming en systeemversterking. Situationele partners zijn voornamelijk bezig met eigenstandige projecten en humanitaire interventies die zich richten op sociaal kwetsbare groeperingen. Door hun eigenstandige interventies hebben deze organisaties onbedoeld bijgedragen aan een gefragmenteerd systeem. Traditionele partners zoals geloofsgebonden en internationale donororganisaties spelen een cruciale rol in de netwerkbesturing van de gezondheidszorg.

Netwerkbesturing en legitimiteit van de state in de fragiele gezondheidssector van DRC

De DRC heeft een lange geschiedenis van fragiliteit van de overheid in het uitvoeren van moderne staatsfuncties. NSP's opereren als surrogaat overheidsdiensten, en zowel de overheid als de NSP's zijn betrokken bij zorgverlening door middel van netwerkbesturing.

In dit onderzoek wordt een overheid als legitiemer gezien naarmate 'meer burgers de overheid zien als de rechtmatige houder en beoefenaar van politieke macht' (Gilley, 2006). Een gebrek aan legitimiteit is een belangrijke bijdrage aan de fragiliteit van de staat, omdat het de overheid ondermijnt (Unsworth, 2010). Het is gebleken dat de afname in de dienstverlening de steun van de bevolking voor de overheid vermindert (OECD/DAC, 2008). Er is echter weinig bekend over hoe dit werkt in fragiele omgevingen die gekenmerkt worden door institutionele veelvoudigheid. Hoe NSP-interventies bijdragen aan de legitimiteit van de staat was een open vraag in deze studie.

Actor interactie in de netwerkbesturing van de gezondheidssector van de DRC
Netwerkbesturing in de gezondheidssector van de DRC heeft de kenmerken van een sociale arena, die 'typisch is voor actor interacties' (Hilhorst & Jansen, 2010). Als symbolische locaties zijn arena's geen geografische of organisatorische systemen; in plaats daarvan beschrijven ze het strategisch handelen van alle actoren die betrokken zijn bij een specifiek probleem (Kitschelt 1980 in Renn, 1993).

De gezondheidssector in de DRC heeft een piramidale structuur van centrale (nationale), intermediaire (provinciale) en operationele (GZ) niveaus (Bukonda, Chand, Disashi, Lumbala & Mbiye, 2012).

Het centrale niveau bestaat uit het nationale MvG, die de strategische taken heeft om beleid te formuleren, vormen van dienstverlening te sanctioneren, sectorfinanciering te coördineren en de zorg op nationaal niveau af te stemmen, bijvoorbeeld door ondertekening van kaderovereenkomsten. Het MvG is verantwoordelijk voor het algemene sectorbeleid en systeemregulering, nationale programma's en tertiaire ziekenhuizen (Waldman, 2006). Hoewel beleidsvorming een exclusieve functie is van de MvG (Zinnen, 2012), ondersteunen donoren en andere ontwikkelingspartners het proces door middel van technische en financiële bijstand.

Het intermediaire niveau heeft betrekking op het beheer van het provinciale gezondheidssysteem en het toezicht op het operationele (GZ) niveau van de gezondheidszones (GZ). Het intermediair niveau organiseert en biedt technische ondersteuning aan de GZ (Wereldbank, 2005). Op dit niveau interveniëren niet-gouvernementele actoren om het systeem te verbeteren en gezondheidszorg uit te voeren. Coördinatie gebeurt op provinciaal niveau in het *Comité Provincial de Pilotage Santé*.

De GZ is de operationele eenheid voor basisgezondheidszorg en eerste verwijzing. Een GZ heeft een gemiddelde bevolking van 110.000 en bestaat uit een centraal kantoor, een reeks gezondheidsposten en een algemeen verwijzingsziekenhuis (Carlson, Maw & Mafuta, 2009). Door het gebrek aan overheidsfinanciering van de afgelopen decennia, hebben de faciliteiten in de GZ's met veel autonomie gewerkt, hoewel MvG-structuren wel administratieve controle hielden, met name over personeel (Carlson et al., 2009). Veel faciliteiten zijn in feite geprivatiseerd en personeel en bedrijfskosten worden betaald uit patiëntvergoedingen. Op het GZ-niveau vindt netwerkbesturing plaats via het Bureau Central de Zone de Santé (de raad van bestuur van de GZ). In deze arena vinden interacties plaats tussen vertegenwoordigers van de overheid, niet-gouvernementele actoren en gemeenschapsorganisaties -met name de Gezondheidsontwikkelingscomités (Comité de Développement Sanitaires).

Onderzoeksmethoden

Dit onderzoek maakt deel uit van het Secure Livelihood Research Consortium, dat zich richt op de legitimiteit van de staat en bestaanszekerheid in (voormalige) conflict situaties (Levine, 2014). Deze studie viel onder het eerste thema, gericht op de ervaringen, opvattingen en verwachtingen van de bevolking met betrekking tot de staat. Het onderzoek begon in 2012, en het veldwerk vanaf augustus 2013. Het veldwerk duurde 19 maanden, tot april 2015.

Het grootste deel van het onderzoek is uitgevoerd in de provincie South Kivu, met aanvullende dataverzameling in de hoofdstad Kinshasa. Een case study ontwerp werd gebruikt, met twee gevalsstudies van netwerkbestuurde gezondheidsvoorzieningen. De eerste betrof een programma voor prestatiegerichte financiering (PGF), die de betaling van een financier naar een contractuele ontvanger afhankelijk maakt van vooraf bepaalde meetbare prestaties. Het tweede geval was een community-based health insurance (CBHI) programma: Mutuelle de Santé (MUS). De gevalsstudies van PGF richtte zich op het bestuur van de gezondheidszorg. De CBHI gevalsstudie heeft MUS-uitkomsten in twee gebieden vergeleken met betrekking tot de toegang tot gezondheidszorg, bescherming tegen financieel risico en de financiering van gezondheidsdiensten. De CBHI casestudy was gebaseerd op onderzoek in een gebied op het platteland (Katana) en een semi-stedelijk gebied (Uvira).

In deze studie ging het om institutionele etnografie, waarbij werkprocessen en hun coördinatie worden onderzocht, meestal door verschillende teksten en discours te onderzoeken (Smith, 2009).Aandacht werd gegeven aan discoursen, relatiepatronen, rapporten en bestuurlijke arrangementen gedurende de studieperiode.

Zes soorten deelnemers werden geïnterviewd: ambtenaren van volksgezondheid en overheidsactoren van MvG-kantoren op nationaal en provinciaal niveau (ongeveer 30 deelnemers); Vertegenwoordigers van donororganisaties, internationale NGO's en nationale NGO's (16 organisaties: drie donororganisaties, zes internationale organisaties en zeven nationale NGO's); Zorgverleners in de hele provincie (20 medische artsen); Personen die betrokken zijn bij het beheer van CBHI / MUS op meerdere niveaus, vooral in Katana en Uvira (ongeveer 68 deelnemers); CBO's (35 personen van Comité de Développement de l'Aire de Santé, CODESA); En burgers die gebruik maken van gezondheidszorg, met name in Katana, Bukavu, Uvira en Idjwi (ongeveer 1.000 deelnemers). Voor de laatste categorie

respondenten werden meningen over gezondheidszorg, de overheid en de NSP's bepaald door middel van diepteinterviews, semi-gestructureerde interviews en focusgroepen. Om de basissituatie in de gezondheidssector te beoordelen werd ook een inhoudsanalyse uitgevoerd van de vier belangrijkste beleidsdocumenten.

Belangrijkste onderzoeksresultaten

De bevindingen van dit onderzoek draaien rond drie hoofdzaken:1) de institutionele vooruitzichten van netwerkbesturing in de gezondheidszorg; 2) onderzoek van twee netwerkbestuurde gezondheidsprogramma's; En 3) de impact van NSP-interventies op de percepties van de bevolking en de legitimiteit van de staat.

Institutioneel functioneren en uitkomsten voor staatsopbouw van netwerkbestuurde gezondheidsdiensten

Netwerkbesturing en staatsopbouw (hoofdstuk 2)

Er is langdurige interactie bestaan tussen de overheid en niet-gouvernementele actoren voor de verbetering van de gezondheidszorg in de DRC. In veel gevallen hebben particuliere actoren programma's uitgevoerd om de leemte te vullen die is ontstaan door het gebrek aan overheidszorg. Uit de bevindingen blijkt dat deze interactie in toenemende mate leidt to netwerkbesturing in de gezondheidszorg en dat deze de functionering van het gezondheidssysteem waarborgt ondanks de zwakte van de staat. De precieze invloed van deze interacties op staatsopbouw mag niet onderschat worden. Toch blijkt uit de bevindingen ook dat verscheidene factoren – met name gefragmenteerde interventies van de meerderheid van de internationale NGO's en de onevenwichtige machtsrelaties tussen ontwikkelingspartners en Congolse partijen - de opbouw belemmeren van een samenhangend, veerkrachtig en duurzaam gezondheidssysteem in de DRC. Over het algemeen blijkt uit de bevindingen dat netwerkbesturing wel bij kan dragen aan de opbouw van de overheid.

Het discours over staatsfragiliteit en coalitievorming voor beleid, de programmering van interventies en besturingsmodellen (hoofdstuk 3)

Staatsfragiliteit staat de vorming van een beleidscoalitie in de gezondheidszorg van DRC. De overheid en donoren / internationale NGO's hebben hun percepties over deze fragiliteit niet geharmoniseerd. Deze verschillende partijen hebben geen gemeenschappelijke visie op het

interventiebeleid en er is een botsing van verschillende institutionele logica's in beleidsvorming en interventieprogrammering. De omstreden aard van het begrip staatsfragiliteit heeft de opbouw van een beleidscoalitie voor de gezondheidszorg belemmerd. Donoren rationaliseren benadrukken het doorlopende belang van humanitaire (eigenstandige) interventies, terwijl overheidsambtenaren pleiten voor een paradigmaverschuiving naar een hogere mate van staatscontrole. Het gebrek aan consensus over de fragiliteit van de staat heeft de betrekking van de overheid en internationale NGO's / donoren beïnvloed. Regeringsambtenaren in de DRC zien staatsfragiliteit als een stigma dat uitvoering van het akkoord van Parijs over hulpdoeltreffendheid onnodig belemmert. Overheidsvertegenwoordigers en donororganisaties zijn het er wel over eens dat de financiële bijdragen van donoren – bij gebrek aan overheidsfinanciering van de zorg - de overleving van de sector mogelijk maken.

PGF en versterking van de besturing van gezondheidszorg (hoofdstuk 4)

In deze studie is de doeltreffendheid van PGF onderzocht op drie gebieden van besturing: structurele besturing vanuit een capaciteitsopbouwperspectief, beheersing van de gezondheidszorg en vraagontwikkeling voor effectieve aansprakelijkheid van de zorg. Uit de studie bleek dat PGF in het algemeen een positieve invloed heeft op de opbouw van de gezondheidszorg op deze drie gebieden. Hoewel er nog steeds veel ontbreekt, zijn gezondheidszorg en dienstverlening verbeterd, en de patiëntgerichte zorg en maatschappelijke aansprakelijkheid hebben de relatie tussen de gezondheidsinstelling en de patiënten versterkt. Het onderzoek heeft positieve resultaten gevonden voor PGF. Donoren, ambtenaren en andere belanghebbenden betwijfelen echter de duurzaamheid van het model. PGF wordt belemmerd door obstakels die verband houden met de fragiliteit van de staat. Uiteindelijk bleek dat PGF de opbouw van de staatsopbouw op de gezondheidszorg ondersteunt, maar het kan geen alternatief bieden voor staatsbestuur van de sector.

CBHI en de gezondheidszorg op lokaal niveau (hoofdstuk 5)
De MUS CBHI-regeling begon pas na de oorlogen in Zuid-Kivu. Uit de onderzoeksresultaten blijkt dat MUS-programma's alleen leiden tot verbeteringen in toegang tot zorg voor een deel van de bevolking. De geconstateerde belemmeringen voor een duurzame opbouw van gezondheidszorg leiden ook tot tal van uitdagingen voor MUS-regelingen. Deze worden gecompliceerd door de fragiliteit van de staat. Om doeltreffend bij te dragen tot universele gezondheidszorg, moet de overheid zijn rol versterken in de besturing van MUS.

NSP's en lokale percepties van de staat (hoofdstuk 6)

Gezondheidszorg vormt een publiek domein, een arena voor interacties en multi-stakeholder processen. Uit de bevindingen blijkt dat de percepties van de bevolking wijzen op het ontbreken van een sociaal contract. De staat voldoet niet aan de noden en verwachtingen van de bevolking. De aanwezigheid van NSP's kan negatieve effecten hebben op de perceptie van de staat van de bevolking, omdat de prestaties van NSP's positief worden bekeken wat een negatief beeld van de staat bevestigt. Dit is afhankelijk van de wijze waarop de diensten worden geleverd. Wanneer de overheid een zichtbare rol speelt, krijgt ze ook krediet wat positief bijdraagt aan legitimiteit.

Over het geheel genomen blijkt uit de studie dat NSP-betrokkenheid sterk bijdraagt aan de besturing en uitvoering van gezondheidszorg in DRC. De fragiliteit van de staat heeft echter een negatief effect op netwerkbesturing en donorinterventies. Niettegenstaande de vele positieve effecten van de inzet van NSP's en donoren, is het onontbeerlijk dat de rol van de overheid in de gezondheidszorg wordt versterkt om de kwetsbaarheid van de bevolking het hoofd te bieden. De fragiliteit van de staat belemmert het succes van netwerkbesturing en ondermijnt de duurzaamheid van interventies van niet-gouvernementele actoren.

ABOUT THE AUTHOR

Bwimana Aembe (1971) was born in Kalinga/Itombwe in the high plateaus of Eastern Democratic Republic of Congo. He earned a bachelor's degree in Christian Theology (2000) at the Université Evangélique en Afrique (UEA). From 2003 to 2005, he served as Senior Pastor over the local parish of the 5th Communauté des Eglises Libres de Pentécôte en Afrique (CELPA), Antiokia Kadutu. In 2005 and 2007, he worked for the Congolese Independent Electoral Commission as an officer in charge of voter and candidate registration for the electoral districts of Uvira and Fizi. In 2007, after five years of working part-time at UEA, Bwimana Aembe was recruited as a full-time junior lecturer in the faculty of Christian Theology. From 2008 through 2010, he completed his master's degree in Peace and Conflict Studies at Makerere University in Uganda. He was then appointed as a junior lecturer in the Department of Peace and Development at UEA. In 2012, Bwimana Aembe began the research trajectory towards this PhD at Wageningen University, Social Sciences Group, in the Chair Group of Humanitarian Aid and Reconstruction. The present thesis is the outcome of this scientific undertaking. While in the Netherlands/Wageningen, seeking to achieve a much-needed positive social impact during his European stay, in 2015, Bwimana Aembe created a peace school in Bukavu/Nyamugo. The peace school has the mission of instilling young people affected by statelessness and war with the values of peace culture, social justice virtues of civic republicanism and principles of good public management through law-abiding ideals for positive social transformation in eastern DRC. Bwimana Aembe is married and the father of four children.

Bwimana Aembe

Wageningen School of Social Sciences (WASS)
Completed Training and Supervision Plan

Name of the learning activity	Department/Institute	Year	ECTS*
A) Project related competences			
Strengthening research Capacity in Conflict Affected States Training,	SLRC-CEPA	2012	4.0
Political Theory (ENP-35306)	WUR	2012	6.0
Critical Perspectives on Social Theory	WASS	2013	2.5
Policy Project and Programs for Development (RDS-33806)	WUR	2013	6.0
Governance, Livelihoods and Resources (RDS-30806)	WUR	2013	6.0
Analysing Disrupted Health Systems (Audited Course)	Royal Tropical Institution (KIT)	2015	4.0
B) General research related competences			
WASS Introduction course	WASS	2013	1.0
Security Guidelines For Researchers in Conflict/post-conflict environments	Disaster studies-SLRC	2013	1.0
Interpretive Methods and Methodologies	WASS	2013	4.0
Qualitative Research: Data Analysing and Writing	WUR and SLRC	2015	1.5
Research proposal writing	WUR	2012- 2013	6.0
'Multi-stakeholders' Health system-building through Performance-Based Financing in Fragile Settings. What health outcomes in the DRC'	World Conference on Humanitarian Studies , Addis Ababa, Ethiopia	2016	1.0
'Whom Does the Population See and How? Non-state Health Service Provision, Population Perceptions and State Legitimacy in the DRC'	Transition and local development in eastern DRC, Bukavu, DRC	2016	1.0
'Networked Health Sector Networked Governance and state-building Outcomes in a Fragile state, the DRC'	Livelihoods and Service Provision in Eastern DRC Conference, Kinshasa, DRC	2017	1.0
C) Career related competences/personal development			
Information Literacy PhD including Endnote Introduction	WGS	2013	0.6
NVIVO Training	Disaster studies	2013	0.3
Total			**45.9**

*One credit according to ECTS is on average equivalent to 28 hours of study load

Cover photo by Bwimana Aembe