A Gender Analysis of the Democratic Republic of Congo’s Health System Reform: An Opportune Moment to Build a Just and Inclusive Health System

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Dedication

I dedicate this thesis in loving memory of my late grandfather, Ronald Walter Bilsky.
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Abstract

The Democratic Republic of Congo (DRC) has experienced a near-total collapse of its healthcare system, resulting in an overwhelming majority of the population lacking access to lifesaving healthcare services. Since the mid-2000s, the DRC’s Ministry of Public Health has engaged in extensive healthcare system reform efforts under the long-term vision of achieving Universal Health Coverage. Although the literature on institutional health reform has steadily increased over the past decade, there has yet to be an in-depth analysis of the healthcare system reform efforts using a gender perspective. Previous research suggests that across their lifespan, Congolese women have poorer health outcomes than men, linking health disparities to women’s relative power, rights and access to resources. This thesis fills this gap, examining key institutional and structural interventions for their implications on health experienced by Congolese women from conception to beyond their reproductive years. This thesis suggests that healthcare reform efforts over the past eleven years have had severe deficits for Congolese women’s health. As the DRC government aims to strengthen its capacities to provide quality healthcare to its population, it is more important than ever to identify how and to what extent intervening variables of the health systems reform efforts are normatively and consequentially reflective of differential gendered experiences of health.
Chapter 1: Introduction

1.1 Background of the Problem

The Democratic Republic of Congo’s (DRC) healthcare system was considered one of the most advanced public sector industries on the African continent. It was described in the 1980s as a “global leader in health reform focusing on integrating primary care and referral services at the Health Zone level” (Carlson et al., 2009, p. 15). However, the combination of thirty years of weak management corruption and patronage under the rule of President Mobutu and an ongoing civil war prolonging vast population displacement and the destruction of infrastructure has witnessed a near-total collapse of the healthcare system. Using data collected in 2000, the DRC’s healthcare system ranks 188 out of 190 countries surveyed by the World Health Organization (Tandon et al., 2000, p. 21). The system continues to suffer from a fragmented distribution of essential medicines and supplies, inadequate implementation of health policies, unpaid salaries and the destruction of health centres and hospitals (Van Herp et al., 2003). As such, the deterioration of the health sector has devastated the health status of the Congolese people.

A collection of data suggests Congolese women and girls disproportionately bear the burden of poor health outcomes. As elaborated in further detail in Chapter 4, Congolese women across their lifespan are adversely vulnerable to one of the highest perinatal and maternal mortality rates in the world, incidences of sexually transmitted diseases, gender-based violence and experiences of malnutrition. According to a gender analysis undertaken by the International Rescue Committee concerning access to healthcare in the DRC, social and biological determinants combine to increases women’s greater vulnerability to poorer health outcomes than men (“Experiences of Refugee Women and Girls from the Democratic Republic of Congo”),
For example, women’s health risks in the DRC can be directly associated with gender-specific barriers, including a lack of prioritization of their healthcare needs by husbands who control household finances, the need to ask permission to leave the village and go to the health center, discrimination perpetuated by health practitioners, sexual harassment and assault in health centers, among others. The prevalence of gender inequities in the Congolese health system thus reflects more general inequities in its society that impact the utilization of healthcare.

The relative unmet health needs associated with the healthcare system has encouraged the Ministry of Public Health to engage in health system reform and health system strengthening efforts. Beginning with the inclusion of the health sector as a pillar of socioeconomic reconstruction in the mid-2000s, the Congolese government has embarked on a long-term development plan by way of multiple strategic health initiatives, despite the continuation of emergency operations in the eastern part of the country. Most importantly, there is a growing political will to establish an equitable and harmonized healthcare system in preparation for the adoption of Universal Health Coverage (Barroy et al., 2014, p. ix). Unfortunately, while it appears that there has been a significant shift by the Congolese government to take greater accountability in ensuring access to healthcare, it is unclear if women’s gender-specific health needs have been incorporated into the health system reform agenda.

1.2 Study Area

The DRC is in Central Africa and as of 2015, inhabits a total population of approximately 77.27 million people (The World Bank, 2015). As a former Belgian colony, the DRC gained independency in 1960 and has since suffered a long history of ethnic strife, civil war and dictatorship. This history has forcibly situated the large Congolese population in chronic poverty.
and vulnerability, corroded by corruption, inequality and robust insecurity. Despite its relative high annual growth rate of 9.5% in 2014, this growth has failed to translate into an improved quality of life for most of the population; the DRC’s social indicators remain among the poorest in the world (The World Bank, 2016). According to the United Nations Development Program’s (2015) Human Development Index, the DRC ranks 176 out of 187 countries (p. 272). This ranking is based on poor overall health, gender and overall poverty status that has plagued the population. Approximately 72.5% of the population is living in multidimensional poverty, with 87.7% of the population living on less than USD 1.25 a day (ibid, p. 228). Women are known to be amongst the poorest of the poor. Furthermore, with the average life expectancy at birth only reaching 50.0, the Congolese population remains trapped in an ever-expanding humanitarian and development crisis (United Nations Development Program, 2014, p. 163).

1.3 Research Question(s)

This thesis is guided by two primary research questions:

1) To what extent have gender-specific health needs of women been recognized in the health sector reform efforts in the Democratic Republic of Congo?

2) To what degree have systemic and institutional health sector reforms been consistent with the DRC’s commitments at the national and international level to gender equity and non-discrimination in health?

1.4 Thesis Outline

This thesis is comprised of six chapters. Chapter two, the literature review, explores the existing literature on health system reform, gender equity and related research in the DRC. This chapter begins by providing the definitions of relevant keywords and phrases. This is followed
by a brief overview of the DRC’s health system. Research on health systems and gender equity is reviewed in relation to literature on health system reform and women’s healthcare in the DRC. The existing gaps in women’s healthcare research are presented and this thesis’ original contribution is highlighted. Finally, I offer an overview of the theoretical framework of this thesis.

Chapter three outlines the research method used within this thesis. The objectives of the study are presented, followed by an outline of the research procedures. Limitations to the methodology chosen and the data collected are also presented.

The complex contextual factors pertaining to Congolese women and their health are presented in Chapter four. This chapter adopts a life course approach, breaking down women’s health needs in the DRC as detailed within the following stages of life: birth, adolescence, reproductive years and beyond reproductive years. The status of Congolese women’s health is analyzed in relation to corresponding social inequalities and biological variables.

Chapter five discusses the findings presented in Chapter four in relation to various institutional and systemic reforms pursued in the DRC between 2005 and 2016. The following elements of health system reform are analyzed using a gender perspective: leadership, governance and intersectoral action; access to healthcare; health system financing; management of human resources and quality of care; participation, accountability and empowerment; and the fulfillment of international commitments. The emerging theory of the thesis is presented in light of the findings.
The conclusion of this thesis is presented in chapter 6. This chapter begins by providing a summary of the findings found in this thesis. This is followed by recommendations for further research.
Chapter 2: Literature Review

2.1 Introduction

In this chapter, definitions of relevant keywords and phrases are provided. This is followed by a brief overview of the DRC’s health system. Next, varying interpretations of gender equity as it pertains to health systems are presented. This chapter then reviews research on health system reform and women’s healthcare in the DRC, identifying an existing gap. Lastly, I present an overview of the theoretical framework that this study is analyzed against.

2.2 Definitions of Keywords and Phrases

2.2.1 Social Determinants of Health

In *Closing the gap in a generation: Health equity through action on the social determinants of health* (2008), the World Health Organization’s (WHO) Commission on Social Determinants of Health defines the social determinants of health as conditions in which people are “born, grow, live, work and age” and notes that these conditions directly affect the quality of an individual’s health (as cited in Raphael, 2016, p. 3). The Commission observes both the conditions of daily life (behaviour determinants including poor health activities) and the underlying structural determinants (a person’s demographic characteristics such as race, gender and class and wider set of forces such as economic, social policies and politics) as determining factors of health inequity (Chapman, 2010, p. 13). In this case, health equity is defined as the absence of systemic disparities in health. The Commission emphasizes that:

The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people’s lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life (“Closing the Gap in a Generation”, 2008, p. 1).
This perspective places the responsibility of health equity and strong health outcomes in the realm of governance, politics and policies, firmly suggesting that social determinants are most powerfully addressed when leadership and governance recognize the health impacts of policies (Shim et al., 2015, p. 4). As a prominent focus in the field of public health, addressing social determinants of health, such as gender discrimination, is known to improve health equity and health outcomes over time.

2.2.2 Health Systems

The WHO defines health systems as “all organizations, people and actions whose primary intent is to promote, restore or maintain health” (“Everybody's Business”, 2007, p. 2). Health systems aim to improve health and health equity in ways that “are responsive, financially fair, and make the best or more efficient use of available resources” (as cited in Savigny et al., 2009, p. 30). In many respects, reforms intended to strengthen health systems have become a top priority within national and international agendas due to an absence of necessary institutional and systemic requirements on which equal health outcomes are conditional (Singh, 2006, p. 328). Target areas include government and leadership, health services, health financing, health information, the health workforce, quality of care, amongst others.

It is noteworthy to mention that health systems are not monolithic entities (Savigny et al., 2009, p. 32). The attributes that make up the framework of health systems strengthening efforts are sub-systems of a system; they are a dynamo of interactions, synergies and shifting sub-systems imbedded within an array of a larger system (ibid). As such, health systems are uniquely influenced and organized by the contextual intersection of different social hierarchies. Furthermore, health systems are made up of various state and non-state actors, including the
private sector, non-governmental organization, civil society organizations and the state. These entities intersect to constitute a complete, and indeed, complex service system.

2.2.3 Gender, Women, Equity and Equality

The contextual understanding of “gender”\(^1\) as a system of oppression has been widely defined, analyzed and critiqued. Gender refers to socially constructed roles, activities, behaviours and attributes assigned to each sex to systemically reinforce differences in well-being and degrees of social, economic and political hierarchy (Reeves & Baden, 2000, p. 30). At its core, gender is a system that creates and maintains gender distinctions and organizes relations as it relates to social status and identity, interactions, and systems (Wharton, 2011, p. 8). In most societies, men are assigned a greater degree of power and control over resources than women. Gender norms\(^2\), as such, not only govern how each sex is viewed; gender as an analytical tool highlights economic, social and political institutions that systemically reinforce experiences of inequality in relation to men. Gender is also a multi-level phenomenon, as Patricia Hill Collins notes (1991). It interacts with other statuses or “matrix of domination” to inform the location of individuals or communities within societal hierarchies.

In the context of health, gender is a key social determinant. According to the WHO, gender relations govern health risks experienced by women and girls (“Gender, women and primary health care renewal”, 2010). This is further elaborated by Percival et al. (2014) whom argue that men and women experience differential health outcomes because of biological differences, individual behaviour, societal norms, environmental influences and access to services (p. 3). As such, men and women have differential exposures to risks; they also interact

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\(^1\) Gender within this context is not restricted to women; the health effects of gender are relative to both men, women and beyond the gender binary. This thesis will specifically look at the relationship between men and women.

\(^2\) Referring to generational beliefs about men and women through the process of socialization.
differently with health systems as a result of varying socioeconomic status and cultural norms and responsibilities (Payne, 2009, p. 5). For example, despite being predisposed to live longer than men, women suffer ill-health because of pervasive discrimination that attaches a lack of value to their wellbeing (ibid). Defining gender in health policy therefore offers opportunities to address gender norms and roles, in which data has shown, impedes a woman’s complete and full enjoyment of good physical and mental wellbeing.

A gender approach to health is guided by the concepts of equality and equity. For the purposes of this thesis, I will be referring to gender equity in health as opposed to gender equality in health. The concept of gender equity directly addresses the complex set of social and economic factors that lead to unequal health outcomes; an element that is missing within the term equality (Percival, 2014, p. 3). While gender equality aims to achieve the same rights, opportunities and access to resources awarded for groups of women and men, gender equity demands that: resources are allocated according to the particular needs of women and men, bearing in mind that women have reproductive health needs associated with pregnancy and childbirth that demand additional resources; that services are received according to the particular needs of each sex regardless of ability to pay; and the financial burden of healthcare is distributed in society on the basis of citizens’ economic capacity and the risks associated with sex, age, socioeconomic status, or “preexisting” health conditions (“Guide for analysis and monitoring of gender equity in health policies”, 2009, p. 18).

2.2.4 Gender Equitable Health System

In their article “Health Systems and Gender in Post-Conflict Contexts: Building Back Better”, Percival et al. (2014) argue:

[…] health systems research has not provided policy makers with clear guidance on how the functioning of health systems is impacted by gender inequalities and how
strengthening health systems can improve gender equity. There is little clarity on what a gender equitable health system would look like nor have key indicators been identified to measure how health systems could promote such equity. Without a definition of a gender equitable health system, those planning and funding the reconstruction and rebuilding of health systems in post-conflict context have no guidance or incentives to implement gender sensitive reforms (p. 12).

The failure of health systems research to engage with and define aspirational objective prompted the following definition. According to Percival et al. (2014), a gender equitable health system is a health system that:

- provides healthcare services that address the most urgent healthcare needs of men and women across the life span in an appropriate manner;
- ensures men and women across the life span are able to access and utilize those services unimpeded by social, geographic and financial barriers;
- produces relevant, sex disaggregated health information that informs policy;
- ensures equitable health outcomes among women and men, and across age groups and;
- provides equal opportunities for male and female health professionals working within the health system (p. 11).

The significance of this proposed definition is two-fold. First, it acknowledges that the likelihood of a health system ensuring equal health outcomes between men and women is not as straightforward as originally assumed. The provisions of health services and the system in which they are distributed from are never gender neutral; health services and health systems seemingly reflect their surrounding social contexts (ibid, p. 12). To guarantee better health outcomes there needs to be a greater focus on forms of discrimination and bias inherent within health institutions. Finally, the identification of attributes of a gender equitable health system not only marks the first steps in measuring how health systems can promote equitable outcomes; it
provides guidance, incentives and opportunities to those organizing and developing the health system to recognize and implement equity within their reform efforts (ibid).

2.3 A Brief History of the DRC’s Health System

The historical development of the DRC’s health system is marked by the role of its established order, by its institutional character, and by the system’s ad hoc approach. When the DRC gained independence in 1960, it inherited a health system from its colonizers that relied heavily on health centres and hospitals (“Strategie de Renforcement du Systeme de Santé”, 2006, p. 11). This would prove catastrophic as a combination of the gradual collapse of the economy and the manifold of political crisis that overwhelmed the country immediately after national sovereignty would gravely impact the health system. The DRC experienced its first taste of neglect and deterioration as its hospitals and clinics were stripped of their supplies, breaking down the drug-supply and essential human resources for health (ibid).

Most of the earliest reforms post-independence to the health system took place in the 1980s. In 1984, the DRC defined a new health policy targeting primary healthcare, in addition to developing a new operational structure responsible for directing and monitoring its national health policy (ibid). The National Health System was divided into three levels. The central level, which includes the Minister of Health Office, the General Secretaries Office and seven divisions and specialized programs, became responsible for the design, coordination and organization of health policy; in addition to interventions of national scope (Johnson & Stoskopf, 2010, p. 294). The intermediate level, which includes the provincial health division and the health districts, emerged as responsible for organizing and providing technical support for the Health Zones. Finally, the periphery level developed into “zones de sante” (Health Zones), operating as the basic units of primary healthcare (ibid).
The creation of the periphery level was one of the most important reforms that came out of the 1980s. With the adoption of a new health policy that placed primary healthcare at the centre of its in-depth restructuring, Health Zones emerged as the system’s first decentralized entities. This development occurred prior to the Alma Ata Declaration, whereby the Ministry of Public Health, together with national and regional level church-affiliated medical directors, “adopted the principles of integrated care and proposed the creation of geographically-defined health zones and the decentralized management of health care services” (The World Bank, 2005, p. 57). As a result, the national territory became subdivided into 306 Health Zones (a number that has increased to 516), whereby operational units for the provision of primary care are divided based on geography, with each Health Zone covering a total population between 100,000 to 150,000\(^3\) (ibid, p. 58). It was this reform that led the primary health system of the DRC to be considered at the time one of the most efficient in Africa.

Unfortunately, the period between 1987 and the mid-2000s witnessed a shift from great enthusiasm for the extension of health coverage to a complete deterioration of the country’s healthcare system (“Strategie de Renforcement du Systeme de Santé”, 2006, p. 12). Beginning in 1998, the DRC’s two civil wars would have the biggest impact on the healthcare system itself as well as the overall health of the Congolese population\(^4\). It has been documented that healthcare services were violently targeted as part of a larger strategy aimed at punishing a population’s “perceived allegiance to an armed group, or creating an uninhabitable ‘no-man’s land’ on disputed territory” (Terry, 2013, p. 30). Health facilities, resupply vans and churches were looted

\(^3\) Each health zone contains on average 1 referral hospital, 1 to 3 reference health centres, and 15 to 25 standard health centres (Johnson & Stoskopf, 2010, p. 294).

\(^4\) This war continues in Eastern DRC despite the signing of signing of international peace agreements. According to the McGeeral (2008), 5.4 million excess deaths have occurred since 1998, with an estimated 2.1 million people displaced by the conflict (para. 1)
as a way for armed forces (who do not receive a regular salary) to support themselves through illegal trading of goods (ibid). The conflict waged so severe that during times of active fighting, many citizens put off visiting their healthcare providers based on fear of becoming caught in the crossfire (Médecins Sans Frontières, 2014, p. 17).

According to DRC’s Ministry of Public Health, the distinctive feature of the health system became its disintegration (“Strategie de Renforcement du Systeme de Santé”, 2006). This was reflected in the “breakdown of links between its components, uncontrolled practice of medicine, production of health services of dubious quality and their dehumanization” (ibid, p. 13). As such, the delivery of healthcare services has predominately been left to external organizations, including international non-governmental organizations (INGOs), non-governmental organizations (NGOs), academic institutions, private and religious groups. This long-standing involvement, while essential, manifested a more ad hoc approach to the country’s health problems, giving priority to certain diseases rather than addressing the healthcare system in its entirety.

Since 2005, the DRC has committed to reforming its healthcare system. This grew out of the frustration of a group of Congolese decision-makers in the healthcare sector. It was recognized that the Ministry of Public Health needed to: 1) outline a comprehensive plan for strengthening districts; and 2) identify funds to implement the plan (Rajan et al., 2014, p. 2). The first National Health Development Plan was released in 2006. This document not only came to reflect a commitment to a vision of a national health system; it symbolized the DRC reclaiming political leadership and governance over its health sector (Ntembwa & Van Lerberghe, 2015, p. 28).

2.4 Health Systems and Gender Equity
There is a growing body of empirical research recognizing the gender dimensions of health systems. As outlined by Payne (2009), differences between men and women in terms of their experiences of health are well known. Most notably, men tend to experience higher mortality and lower life expectancy, whereas women are known to have poorer health conditions (*ibid*). For scholars, such as but not limited to MacPherson et al. (2014), differences between men and women in their access to services and their exposure and vulnerability to illness are directly influenced by biological sex differences and gendered societal inequalities (p. 4).

Division of roles by sex and the differential value assigned to men and women together function as a structural determinant of health due to the inherent influence of gender on the development of hierarchies. According to the WHO, recognizing the root causes of gender inequities in health is critical as there is “increasing recognition that health polic[ies] may exacerbate gender inequalities when [they] fails to address the needs of either men or women” (as cited in Payne, 2009).

Correspondingly, there is emerging evidence that gender inequalities are endemic in healthcare systems globally. According to Östlin (2009) health systems have paid insufficient attention to the differential needs of men and women in health policies and interventions (p. 3). For instance, government budgets, staffing patterns, drug allocations and training curricula tend to shortchange women’s and girl’s health issues unrelated to their reproductive roles (*ibid*). For Baum et al. (2009), this is because dominant biomedical imaginations of health have isolated wider determinants of an individual’s health. Yet, for scholars such as Freedman (2005), health systems themselves are core social institutions that function at the interact between people and the structures of power that shape broader society (p. 21). According to Freedman, health systems communicate and enforce societal values and norms though inter-persona relationship,
in addition within the very structure of the health system (*ibid*). It is therefore critical for policymakers to be mindful of the fundamental social, culturally embedded, political contingency of health systems in and of themselves.

Additionally explained by Mackintosh and Tibandebage (2004), health systems are observed to be gendered institutions. By this, they claim that gender permeates the social institution of health, embedding its constructed social hierarchy into the structures, practices and behaviours that define the organization of the system itself (p. 6). As such, it is argued that a discriminatory and inequitable health systems have the ability of reinforcing other aspects of women’s relative lack of rights and dignity in societies that are highly unequal in terms of both gender and social class.

Sen and Östlin (2007, 2008, 2009) interrogate these arguments further by suggesting that gender intersects with economic inequality, racial or ethnic hierarchy, caste domination, differences based on sexual orientation, and a number of other social markers (p. 2). Gendered systems, structural processes and their co-existing relationship constitute the gendered structural determinants of health that permeate the organizational structural of governments, international organizations and the mechanisms in which policies and strategies are manifested and carried out (p. 3). Biases are formed within health systems as policies, strategies and interventions fail to improve gender equity based on a lack of awareness of gender discrimination outside and within the system. In this sense, Baum et. al. (2009) suggest that health equity – including but not limited to gender equity – must be envisioned in policy statements, planning and systemic approaches within the healthcare sectors (i.e. its leadership and stewardship characteristics).

Consequently, in their article entitled “Promoting Health Equity in Conflict-Affected States”, Bornemisza et al. (2010) recognize that the post-conflict period represents a unique opportunity
to redress these issues as it is easier during the rebuilding period to address health inequities by means of actions within the health system (p. 85).

Yet, literature on health sector reform in Africa continues to be relatively silent on the topic of gender and health. Specifically, Percival et al. (2014) argue in the context of post-conflict and fragile states that research has not sufficiently identified the differential health issues experienced by men and women, analyzed the response of health systems to those differences, nor provided recommendations for how to build a gender equitable health system (p. 11). They contend that without such an analysis, health system reform efforts in fragile and post-conflict states fail to not only improve the operation and responsiveness of health systems to health outcomes; a state’s inability to facilitate a gender equitable healthcare system can manifest gender inequality that enables broader social and economic instability (ibid). As a response, Percival et al. suggest that gender equity is integrated and analyzed as a specific objective within the reconstruction of healthcare systems in post-conflict society (ibid).

2.5 Health System Reform and Women’s Healthcare in the DRC

Literature analyzing the reconstruction and reform of the DRC’s health system has steadily increased over the past couple of years. However, studies have predominately focused on specific processes, procedures and mechanisms aimed at improving isolated health concerns. For example, in an analysis of the impact of the commercialization of healthcare on inequities between the rich and the poor in the Kisantu district, Stasse et al. (2015) describe how financial barriers to access healthcare of good quality is directly related to the association of a fee-for-service payment system linked to a lack of regulation throughout the country. This study highlights the achievements of the Belgian bilateral development aid agency’s technical and financial reforms, such as providing reducing user fees by applying a subsidy at the general
hospital. It explicitly emphasizes the need for a systems approach to address complex health issues; namely, that the complexities of the health system and its unintended consequences must be viewed holistically with an understanding that the interconnectedness beyond a components approach (*ibid*, p. 5 and 12). However, the authors fail to analyze in-depth the complex set of social and economic factors that lead to unequal health outcomes experienced between the rich and the poor or between men and women. They simply focus on abstract structural means related to health financing necessary to reform the DRC’s healthcare sector.

Furthermore, Ho et al. (2015) review the implementation of a community scorecard approach to increase participation in health in Katanga and South Kivu provinces in eastern DRC. The aim of this study was to see if community scorecards increase accountability and responsiveness of service providers to the needs of their patients. Hoe et al. reveal that scorecards represent a structured space for open dialogue, bridging communication gaps between users and healthcare providers. Unfortunately, data collection was based on a thematic analysis of stories, translating the results found into categories on significant changes to processes and procedures of quality of care rather than the substance or context of the communication. As such, any indication of social, biological, cultural or physical barriers are not engaged in the analysis. Other related studies include: Mbeva et al. (2014) on the context and impact of decentralization dictated by the National Constitution on the provincial health system; and Rajan et al. (2014) on how rational operational planning based on health systems strengthening strategy has contributed to policy dialogues on affordability of the essential health services package in the DRC. In each study, the notion of gender remains silent.

Separately, there has been an overwhelming amount of literature on gender inequity published with respect to experiences of maternal mortality and gender-based
violence in the DRC. Mafuta et al. (2015) provide an analysis on the mechanisms and the experiences on social accountability in maternal health services in the provinces of Bas-Congo and Equateur. Specifically, this article addresses the way in which women’s concerns are expressed and responded to by health providers in local settings. In their study, it became evident that women did not often voice their concerns/complaints about health services, citing uncertainty on how to voice their concerns without a risk of reprisal (ibid, p. 6). Yet, while Mafuta et al. provide suggestions on possible ways for women to channel their concerns and complaints to their healthcare providers, the development of these mechanisms are not considered in light of larger health system reform efforts. Other studies include: Ntambue et al. (2016) and their analysis on the determinants of maternal health services in urban areas of the DRC, Warren et al. (2013) on access, knowledge and utilization of family planning and the impact of beliefs, attitudes and behaviours that support or prevent family planning in rural DRC and Rybarczyk et al. (2011) on the needs of and barriers to healthcare for survivors of sex- and gender-based violence in Eastern DRC. In each of these studies, the notion of gender in health is observed separate from healthcare system reform efforts.

2.6 Filling the Gap on Women’s Healthcare Research in the DRC

As stated above, the availability of knowledge on women’s health conditions and their access to health services in the DRC is gradually becoming more visible. However, there has yet to be a systemic, in-depth analysis of the healthcare system and its subsequent reforms efforts from a gender perspective. The contribution of this thesis is to thus analyze the extent key institutional and structural interventions and reforms in the DRC acknowledge the gender dimension of health. This is significant as there are negative consequential and normative outcomes relative to gender-blind health systems. On the one hand, gender-blind strategies,
policies and actors involved will not help reduce the gender gap in the country, nor will they succeed in responding gender specific healthcare needs of the Congolese population (as presented in Chapter four of this thesis). The DRC’s failure to address gender disparities in health, in this sense, may exacerbate unnecessary, avoidable and unjust health inequalities, perpetuating severe deficits for the health of Congolese women. On the other hand, the DRC may be in violation of its international agreement to protect, respect and fulfill the right to health without discrimination. This thesis’s considerations of the gender dimension of health within a comprehensive review of the DRC’s healthcare reforms will fill this gap and contribute to the growing body of literature arguing that the systemic nature of gender inequity can no longer be overlooked in a state’s health rebuilding period.

2.7 Overview of Theoretical Framework

The theoretical framework of this thesis is grounded in the human rights-based approach to health. The right to “the highest attainable standard of physical and mental health” is explicitly recognized in several core international and regional human rights treaties and national constitutions, including Article 12 of the International Covenant on Economic, Social and Cultural Rights (UN General Assembly, 1965). The nature of the right itself embraces a wide range of factors including the availability, accessibility and acceptability of facilities, goods, services and conditions essential to obtain this standard of living (“CESCR General Comment No.14”, 2000). It highlights the importance of underlying social determinants of health, including gender, and determinants of health, such as food, housing, safe and portable water and health related information, among others. Most significantly, at the heart of the right to the

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highest attainable standard of physical and mental health is “an effective and integrated health system encompassing medical care and the underlying determinants of health, which is responsive to national and local priorities and accessible to all” (Hunt & Backman, 2008, p. 82).

A human rights-based approach to health specifically aims to realize the right to health. In its institutionalization, human rights standards inform and strengthen the capacity of governments to fulfill their obligations as duty-bearers while empowering and mobilizing rights-holders to exercise their freedoms. This approach is most appropriate for this thesis because at its core, a human rights-based approach to health demands the elimination of all forms of discrimination. According to the Committee on Economic, Social and Cultural Rights’ General Comment No. 20 (2009), the prohibition of discrimination is of immediate effect and is not subject to the principles of progressive realization or availability of resources recognized as core obligations of the State (as outlined in Article 2(1) of the ICESCR) (UN General Assembly, 1965). The recognition of non-discrimination and equality as minimum core obligations of all state parties is an important variable in recognizing gender as a structural determinant of health within health system reform efforts. In the context of identifying the nature and relevance of the health system reform agenda in the DRC as it pertains to Congolese women, I consider the human rights-based approach to health as the most appropriate for this study.

2.7.1 International, Regional and National Human Rights Commitments

Commitments of the State to a Women’s Right to Health

The DRC has consented to the obligations enshrined in several international, national and regional declarations and treaties to improve women’s health. At the national level, women’s health is protected in the DRC Constitution. Articles 5, 14, and 15 legitimize any policy of equality and equity in the DRC. Article 14 states that “the State shall have the duty to ensure the
elimination of all forms of discrimination against women and ensure the respect and promotion of their rights” (Democratic Republic of Congo, 2006, art. 14, para. 1). The State must “take measures to address all forms of violence against women in public and private life”, and assure the “full participation of women in the development of the nation” (ibid, para. 2 & 3).

Additionally, Title II “Human Rights, Fundamental Freedoms and Duties of Citizen and the State” ensures the protection of economic, social and cultural rights, with emphasis on the right to health under Article 47 (ibid, art. 47, para. 1 & 2). The right to health includes:

Timely and appropriate health care, underlying determinants of health, such as access to safe and portable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health as well as the participation of the population in all health-related decision making at the community (CESCR General Comment no. 14, note 1, Para 11).

The Constitution thus opts for a broad and holistic approach to a woman’s right to health.

At the international and regional level, the DRC has also committed to most of the protocols and treaties protecting and ensuring the right to health without discrimination. Table 1 provides a list of each international and regional treaty agreements the DRC has signed, ratified or acceded to in relation to gender equity and health.

<table>
<thead>
<tr>
<th>International Bill of Human Rights</th>
<th>Relevant Article(s)</th>
<th>Level of Principle Approval</th>
<th>Entry into Force</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Declaration of Human Rights</td>
<td>Art 2: Freedom from Discrimination; Art 25: Right to Adequate Living Standard</td>
<td>Signed</td>
<td>1960</td>
</tr>
<tr>
<td>Prevention of Discrimination on the Basis of Race, Religion, or Belief;</td>
<td>Relevant Article(s)</td>
<td>Level of Principle Approval</td>
<td>Entry into Force</td>
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<tr>
<td><strong>and Protection of Minorities</strong></td>
<td><strong>Relevant Article(s)</strong></td>
<td><strong>Level of Principle Approval</strong></td>
<td><strong>Entry into Force</strong></td>
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<tr>
<th><strong>Women’s Human Rights</strong></th>
<th><strong>Relevant Article(s)</strong></th>
<th><strong>Level of Principle Approval</strong></th>
<th><strong>Entry into Force</strong></th>
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<tr>
<th><strong>Rights of the Child</strong></th>
<th><strong>Relevant Article(s)</strong></th>
<th><strong>Level of Principle Approval</strong></th>
<th><strong>Entry into Force</strong></th>
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<tr>
<th><strong>African Regional Conventions</strong></th>
<th><strong>Relevant Article(s)</strong></th>
<th><strong>Level of Principle Approval</strong></th>
<th><strong>Entry into Force</strong></th>
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<tbody>
<tr>
<td>African Charter on Human and Peoples’ Rights</td>
<td>Art 16: Right to Health</td>
<td>Signature and Ratification</td>
<td>1987</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa</strong></th>
<th><strong>Relevant Article(s)</strong></th>
<th><strong>Level of Principle Approval</strong></th>
<th><strong>Entry into Force</strong></th>
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<tr>
<th><strong>The African Charter on the Rights and Welfare of the Child</strong></th>
<th><strong>Relevant Article(s)</strong></th>
<th><strong>Level of Principle Approval</strong></th>
<th><strong>Entry into Force</strong></th>
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<tbody>
<tr>
<td>The African Charter on the Rights and Welfare of the Child</td>
<td>Art 14: Health and Health Services</td>
<td>Signature</td>
<td>2010</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th><strong>SADC Protocol on Gender and Development</strong></th>
<th><strong>Relevant Article(s)</strong></th>
<th><strong>Level of Principle Approval</strong></th>
<th><strong>Entry into Force</strong></th>
</tr>
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<tbody>
<tr>
<td>SADC Protocol on Gender and Development</td>
<td>Art 20-25: Gender Based Violence;</td>
<td>Signature</td>
<td>2008</td>
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Of the 9 international and regional instruments listed above that recognize the human right to health and the human right against sex discrimination, the ICESCR, the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the SADC Protocol on Gender and Development hold particular significance. The ICESCR recognizes women as a group that faces specific hurdles in relation to the right to health. The realization of this right requires the elimination of discrimination against women in healthcare as well as guarantees equal access for women and men to health services (“The Right to Health”, n.d). As a fundamental objective of treating health as a human right, the ICESCR authorizes a redress of discrimination in all its forms. The CEDAW specifies state obligations in the prevention of maternal morbidity and mortality; it also sets out clear provisions of appropriate healthcare services for women (“Human rights-based approach to reduce preventable maternal morbidity and mortality”, n.d, p. 2). These two international agreements are paired regionally with the DRC’s commitments to the SADC Protocol on Gender and Development. This document warrants a legally binding agreement compelling the state to hasten efforts on gender equity in the country, including health.

It is also worth mentioning that the DRC has additionally committed to several global partnerships aimed at ending extreme poverty in all its forms everywhere. The DRC first pledged to align its development strategy with a wide range of global issues, including health and gender equality established under the Millennium Development Goals (MDGs). The DRC agreed to promote and invest in Goal 3, gender equality and empower women, and Goal 5, improve maternal health. Between 2000 and 2015, the DRC did achieve some progress regarding the number of births attended by skilled health personnel, the rate of maternal mortality, the gender
parity index and the number of women receiving prenatal care from a trained provider (United Nations Development Program, 2015b). Yet, despite these improvements, the DRC’s final report to the UN indicated that much remained to be done to ensure health and gender indicators succeed in the future. As of 2016, the DRC has committed to the 2030 Agenda for Sustainable Development. The aspiration for global health is set out in Goal 3: “Ensure healthy lives and promote wellbeing for all at all ages”; in addition to the aspiration for gender equality set out in Goal 5: “Achieve gender equality and empower all women and girls.” As a promising international frameworks, it is unknown to what extent the DRC will adopt procedures to implement these international agreements. The achievement of these goals will depend on the meaningful commitment of the DRC, a commitment that has yet to be fully embraced.

*Perceived Limitations to Fulfillment of the Right to Health*

The application of the right to health without discrimination is assumed to be compromised by several limitations in the DRC’s national legal framework. First, unlike the ICESCR, the DRC’s Constitution “does not subject the implementation of the right to health either to the qualification of progressive realization or to that of the availability of resources” (as cited in Mbwisi, 2014, p. 441). As such, the State’s unqualified obligations are challenged as being unrealistic due to many economic, social, human and infrastructure restraints experienced in the DRC (Dady, 2016, p. 186). Furthermore, unlike the ICESCR, which provides the adoption of legislative and other necessary measures to give effect to the right to health, the DRC Constitution claims that these obligations are guaranteed through a combined reading of Articles 47 and 60. Article 60 states that the respect of human rights guaranteed by the Constitution is incumbent on the public authorities and all persons (Democratic Republic of Congo, 2006, art. 60). Yet, the DRC has failed to adopt legal and non-legal implementation measures to uphold the
right to health as an elusive right (Mbwisi, 2014, p. 440). Finally, the DRC’s constitutional framework for the advancements of women’s health remains weak. This is because it remains contradictory and discriminatory towards women with respect to marital life, political participation and labour rights, among others. For instance, as long as article 215 of the Family Code continues to limit the autonomy of the wife and article 444 contends that the man is the head of the household and the woman must obey him, access to healthcare will remain restricted for Congolese women (Democratic Republic of Congo, 1987).

Yet, it is important to note two factors. First, the DRC’s obligation to ensure the right to health of Congolese women exists independently of resource availability. This is because the realization of any socioeconomic right does not only depend on an increase in resources. Even when resources are inadequate, the state is obligated to ensure the equitable and effective use of and access to available resources. For example, in its concluding observations on the DRC, the CESCR acknowledges the difficulties faced by the State, yet argues that the “budgetary constraints should not be invoked as the only justification for the lack of progress” towards the establishment of frameworks such as social security (CESCR General Comment No. 20, 2009, para. 56). Unfortunately, as demonstrated in Chapter five, there has been little systemic attempt by the Ministry of Public Health to ensure Congolese women are able to enjoy equitable access to health services and healthcare.

Furthermore, the DRC has a monistic legal system. According to Article 215 of the Constitution, international treaties or agreements are awarded higher authority than that of domestic laws (Democratic Republic of Congo, 2006, art. 215). As such, individuals are legally entitled to invoke the provisions of the obligations listed in article 1.2(a) of the ICESR to guarantee respect for their indivisible rights (UN General Assembly, 1965). In the context of
Congolese women’s right to health, the DRC is obligated under the Covenant to undertake specific protective or preventive actions to progressively realize this right without delay. The State’s failure to adopt any legal and non-legal implementation measures to uphold the right to health as an elusive right is a direct violation of this commitment.
Chapter 3: Methodology

3.1 Introduction

As discussed later in this chapter, this thesis uses a quantitative research methods approach to assess the extent health sector reform efforts in the DRC improve, disregard or exacerbate gender inequities in health. Data was collected from published and gray literature on the DRC’s health systems strengthening policies and women’s health needs, including country-level policies sourced from the Government of the DRC’s Ministry of Public Health. Measurable results of the initial post-conflict policies were also reviewed against contemporary indicators.

3.2 Objective of the Study

The overall purpose of this paper is to analyze the present challenges of applying a preventive gender-focused perspective to the healthcare system in the DRC based on available data sources, to outline the data gaps and policy failings and to provide a basic evaluation of the efficiency of the healthcare system reform in its promotion and protection of Congolese women’s health. This thesis draws attention to the health situation of Congolese women between 2005 and 2016. It uncovers to what extent systemic and institutional responses within health sector reform efforts in the DRC reflect disparities in health related to gender. Overall, the intention of this thesis is determine if the state is acting on its minimum obligations of non-discrimination and equality in its efforts to strengthen its national institutional capacity to respond to the present gender-informed health disparities.

3.3 Outline of Research Procedure

The first step in a gender integration process is to conduct a gender analysis of the context being evaluated. This entails an examination of the differences in roles, norms and
relations for women, girls, men and boys; the differing needs, constraints and opportunities experienced between the sexes; the amount of power relatively held; and the consequences of these varying risks, exposures and vulnerabilities to health. Chapter four adopts this systematic methodology to uncover, comprehend and evaluate key gaps between the health of Congolese men and women, with a focus on the specific context of Congolese women. A life course approach to women’s health is used to reveal specific health challenges faced by Congolese women over the course of 4 stages in their lives: birth, adolescence, reproductive years and beyond the reproductive years. Data will be derived from reports and documents published by international non-governmental organizations, such as Doctors without Borders, International Rescue Committee (IRC), HEAL Africa, Partners in Health, Integrated Health Project, among others. Reports include: “Everyday Emergency: Silent Suffering in Democratic Republic of Congo” by Doctors without Borders, “Access to Health Care & User Fees: Experience with Fully Subsidized Health Care for Targeted Groups in the Democratic Republic of Congo” by the IRC, and “A Gender Analysis in the DRC” by the Integrated Health Project, among others. Furthermore, data will also be collected from periodic reviews submitted to the Committee on the Elimination of Discrimination Against Women, country reports submitted to UNAIDS and varying supplementary reports and needs assessments.

The following section of this thesis uses the Pan America Health Organization’s *Guide for analysis and monitoring of gender equity in health policies* to evaluate key institutional health system reform efforts that have taken place in the DRC between 2005 and 2016. As a conceptual and methodological framework for evaluating the degree to which health policies remain consistent with the commitments assumed by Member States to work towards achieving the objectives of gender equality in health and health management, findings from this
methodology will be applied against Percival et al. (2014) articulation of a ‘gender equitable health system’.

Data is collected from several sources. These include, but are not limited to: 1) country-level policies sourced from the Government of Democratic Republic of Congo. These include the following strategic health initiatives: National Health Standards (2000); Health Financing Strategy (2005); National Human Resources for Health Development Plan (2011-2015); Health Systems Strengthening Strategy (2010); National Health Development Plan II (2011-2015); Growth and Poverty Reduction Strategy (2011-2015); National Malnutrition Reduction Strategy (2013); Health Facility Enhancement Program (2013); and the third national Health Development Plan set for 2016-2020, among others. Indicators on women’s health status in relation to the accessibility, sufficiency and effectiveness of DRC’s health system are drawn from reports from the United Nations Economic Commission for Africa, the World Bank, Demographic and Health Survey Program, United Nations Population Fund and the African Development Bank, in addition to relative needs assessments and project/programs conducted by the World Health Organization, USAID, CARE, SIDA, MSF, and IFC. Finally, data will be drawn from published literature on gender and health in DRC collected from Google Scholar, Google, CLIO, PubMed, PMC, EBSCOhost, among others.

3.4 Limitations

There are several limitations to this research. The most notable being the lack of published information on health system reform efforts in the DRC. While some studies have been found, they are limited to a few regions in the DRC and fail to take into consideration the health reform efforts comprehensively. The DRC is also a large country with extensive
differences between regions, within ethnic groups (with approximately 450 different ethnic
groups) and between the rich and poor. As such, what happens in one region to one individual
may not necessarily reflect experiences of another individual in a different region of the country.
This thesis thus cannot identify general truths about women’s health needs. It can, however,
elaborate on some of the dominant trends throughout a women’s life and how those trends are or
are not represented in healthcare sector reform efforts (as illustrated in Chapter five).

Furthermore, there is a lack of available data on the health experiences of Congolese
men. It is for this reason that I opted to undergo a gender analysis that only focused on the health
conditions of Congolese women. Further studies might focus on the experiences of health
outcomes as it pertains to both Congolese women, men and beyond the gender binary. Finally,
the reliability and lack of disaggregation of data poses a significant challenge. Poor state
information management, ongoing instability and an overall lack of accountability within the
government has made data collection a persistent issue for years. As a result, valid demographic
information is not one-hundred percent reliable.
Chapter 4: Complex Contextual Factors in the DRC

4.1 The Reality of Women’s Health Needs

A gender analysis is crucial to design a well-informed and inclusive health system that is responsive to the local context, universally accessible and upholds the right to health for all. As a core development outcome in its own right, gender integration in health un masks different pressures, opportunities, concerns and interests of both men and women rooted in socially constructed gender roles, norms and behaviours (“Responding to intimate partner violence and sexual violence against women”, 2013, p. 36). It also reveals how differences in power and privilege result in differential health exposures, vulnerabilities, risks and outcomes for men and women respectively. As such, the process of creating knowledge and awareness of gender demands the responsibility of international and national actors to acknowledge these differences and ensure they do not manifest unequal accessibility, affordability and availability of health policies, programs and services (Jhpiego, 2016, p. 9). In the context of the DRC, conducting a gender analysis is vital as discrimination against women and girls remains one of the most pervasive forms of inequalities and one of the most important underlying causes of poor health outcomes for Congolese women and children (“Responding to intimate partner violence and sexual violence against women”, 2013, p. 36).

By adopting the Commission on Women’s Health in the African Region’s life course approach to understanding health outcomes, this chapter contextualizes how gender disparities in health pose constraints for Congolese women beginning at the moment of conception, continuing through to adolescence, into reproductive years, and beyond reproductive years. It is found that gender roles, relations and opportunities specific to the context of the DRC operate to the detriment of the mental and physical health of Congolese women across their lifespan.
4.1.1 The Health Status of Women: Birth

The determinants of women’s health in the DRC begin from the moment of conception. Based on the fact that the growing fetus, whether a boy or a girl, is solely dependent on the health of its mother, the child is conditioned by the same environmental and social challenges experienced by the mother. In the DRC, the degree of status of power experienced by Congolese women has long been characterized under the notion of domesticity (Yates, 1982, p. 143). Belgian colonialism formally and institutionally organized the lived experiences and performance of gender within the concept of masculine and feminine spheres – men within the public, economic space and women in the home as caretakers (Bouwer, 2010, p. 16). This would not only accord men more privileges within political, economic and social domains – inscribing the position of the Congolese man as the patriarchal head of the family; it instilled a culture whereby a woman’s status and dignity is determined by her gender-specific roles and responsibilities to provide her husband with multiple children.

Rigid social customs, pervasive gender roles and expressions of patriarchy act as strong predictors to indicators of health outcomes experienced by infants in the DRC. Most relevant to the health status of infants relates to the fact that the process of childbirth is more than often an obstructed fate for both the mother and the infant. According to Save the Children’s State of the World’s Mother’s report (2015), the DRC is the second-to-worst place in the world to be a mother; only positioned higher than Somalia (p. 61). Data indicates that mothers have a 1 in 23 lifetime risk of maternal death (*ibid*). An overwhelming majority of these deaths directly relate to complications experienced during pregnancy and/or childbirth. Statistics from the WHO note that 21,000 women died in 2013 in the DRC (one every 25 minutes) due to complications during pregnancy and childbirth (‘Democratic Republic of Congo: Maternal and Perinatal Country...
Profile”, n.d). This is particularly apparent in eastern Congo where women who suffer complications in labour rarely reach decent health services and are often left to die (Gaestel, 2015, para. 7).

As one of the most dangerous regions to be born, the DRC also has one of the highest perinatal mortality rates in the world, 40 per 1,000 births (Wang et al., 2014). With a stillbirth rate at 29% (“Trends in Maternal Mortality”, 2014), 104,604 children died before, during or within the first 28 days of their life in 2013 (“Democratic Republic of Congo: Maternal and Perinatal Country Profile”, n.d). For children who survive past their first month of existence, 30 out of every 1,000 children die between 1 month and 12 months\(^6\) (“Democratic Republic of Congo: Demographic and Health Survey: Key Findings”, 2014, p. 7). This rate increases for children under-5 who have a mortality rate at 98 per 1,000 live births\(^7\) (“Democratic Republic of Congo: Factsheet of Health Statistics 2016”, 2016, p. 3). In comparison, mothers in Norway, which ranked first by the Save the Children’s State of the World’s Mothers report (2015), have a 1 in 14,900 lifetime risk of maternal death, with an under-5 morality rate of only 2.8 per 1,000 live births (p. 63).

Findings of a prospective, population-based study by Matendo et al. (2011) identify multiple potential-modifiable factors leading to an increase in perinatal deaths in the DRC. These include: challenges posed by breech presentation, poor availability of emergency obstetric care, a lack of prenatal care and the absence of male partners (ibid). Babies born to poor mothers in rural

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\(^6\) The direct causes of post-neonatal (under-five) and neonatal (< 1 month) vary in terms of conditions and percentages. Estimated distribution of cases of neonatal death have determine that 34% of children die from prematurity, 29% from birth asphyxia and birth trauma, 16% from sepsis and other infectious conditions, 6% from pneumonia, 5% from congenital anomalies, 5% other conditions, 2% from tetanus, 1% from injuries and 1% from diarrheal diseases (Liu et al., 2015)

\(^7\) In contrast, it is estimated that the main cases of post neonatal deaths occur because of malaria at 22%, followed by pneumonia (20%), diarrheal diseases (15%), other conditions (15%), measles (7%), injuries (7%), non-communicable diseases (6%), meningitis/encephalitis (4%), HIV/AIDS (2%), and pertussis (1%) (Liu et al., 2015).
areas face great challenges to survival, as women’s limited control and access over financial resources makes them unable to pay for emergency care such as a caesarean surgery; there have been reports of some women being detained until their families find the money (as cited by Boseey, 2014, para. 8). Even if a mother and child in the DRC survive childbirth, the babies born to mothers living in the greatest poverty face the utmost challenges to survival (“Surviving the First Day”, 2013, p. 7).

Throughout sub-Saharan Africa, maternal health status (the health of women during pregnancy, childbirth and the postpartum period) also acts as a contributing factor determining the latter outcomes of pregnancy. As indicated above, Congolese women are largely defined by their caretaker role. This makes an infant’s health and chances of survival dependent on the health conditions of mothers. Unfortunately, women’s health in DRC is overwhelmingly undermined by men’s control over their bodies, their lack of freedom to move and their limited access to financial resources (Davis et al., 2014, p. 23). Women are required, as property of men, to be obedient, and ultimately do not possess the social, political, legal or economic autonomy necessary to mobilize effectively for their health (an element elaborated in more detail in Chapter five). In many instances, men’s health within the household is prioritized over women’s health, as their healthcare options are largely determined by religious norms rather than need (ibid, p. 24). The latter has precarious health consequences for infants in the DRC, with a strong predictor being the nutritional status of the mother.

According to the country’s 2013-2014 Demographic and Health Survey, a large percentage of Congolese women suffer from acute malnutrition; more than half of the women reporting eating only one meal per day (51.5%) (Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité, 2014, p. 183). With the average BMI of women estimated at
21.9, 14% of women aged 15-49 were found to have a BMI below 18.5 cm, indicating chronic energy deficiency: 11% were found to have thinness light, 4% moderate and severe emaciation (ibid, p. 184). The proportion of malnourished women was gaged to be higher in rural areas than in urban areas (18% against 9%), with the situation most critical in Badudu province with 26% (ibid). One of the main demographic groups most at risk of malnutrition in the DRC is pregnant and breastfeeding women, particularly women living with HIV. Nutrition surveys indicate that more than one million pregnant women need urgent nutrition interventions (“High malnutrition rates, a silent emergency in DRC”, 2010). This is because most women in the DRC are not consuming enough quality food, particularly iron-rich foods. Overall, 43% of pregnant women are anemic (one of the most prevalent nutritional deficiencies in the world), placing women at higher risk of death during delivery and the period following childbirth (“Democratic Republic of Congo Demographic and Health Survey: Key Findings”, 2014, p. 12).

As outlined by a study of undernutrition and gender in 56 African countries, there is a strong connection between high levels of undernutrition in adult women and high levels of undernutrition in children, poor fetal development, preterm births and low birth weight (Nube, 2005). The correlation between the risk of preterm delivery and maternal anemia was also found in several other studies, including a hospital-based study in Argentina that concluded preterm births decreased with the increase of BMI (Hauger M. et al., 2008). The Commission on Women’s Health in the Africa Region consequential argue that if a mother is malnourished, her child is more likely to suffer growth retardation in the uterus and to be born undersize and underweight (“Addressing the Challenge of Women’s Health in Africa”, 2012, p. 12). This increases the chances of a baby dying in the first few days of their life, in addition to creating
future health complications (ibid). Compared with 2007, the 2013-2014 nutrition indicators have not seen significant improvements. In the DRC, nearly half of children under 5 suffer from chronic malnutrition (more than 6 million), with level of morbidity of undernourishment leading to the following conditions: 43% of children under 5 are stunted (or too short for their age); 23% are severely stunted; 60% age 16-59 months are anemic; 8% are wasted (or acutely malnourished); and 23% of children under age five are underweight ("Democratic Republic of Congo Demographic and Health Survey: Key Findings", 2014, p. 13).

Infants are also particularly vulnerable to infections or diseases as their immune systems have not sufficiently developed to protect him or her from contamination by bacteria (Kandala, 2009, p. 1735). Since infants are solely dependent on their mothers for food, there is a positive association between early feeding practices and the prevalence of disease. Breastmilk is considered the ideal food for newborns to improve their health and chances of survival; it ensures newborns intake all of the necessary nutrients, promotes the child’s growth and harmonious development and strengthens the immune system against illness. However, conditions of poverty, insufficient household sanitary conditions and the limited autonomy of women have prevented mothers in the DRC from being able to feed infants with enough clean breastmilk. This is reflected in the DRCs suboptimal breastfeeding habits. In most cases,

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8 For pregnant or lactating women in complex emergency, post-conflict or rural settings, the likelihood of limited mobility and access to quality food increases experiences of undernourishment (Mucha, 2012, p. 3).
9 According to the Demographic and Health Survey (2013-2014), stunting "decreases as the mother’s level of education increases; 51% of children whose mothers have no education are stunted, compared to 13% of children whose mothers have more than secondary education" ("DRC Demographic and Health Survey: Key Findings", 2014, p. 13).
10 According to UNICEF, only 52% of mothers initial early breastfeeding, 48% babies are exclusively breastfed up to 6 months and 8% have a minimum acceptable diet between 6 months and 23 months ("The State of the World's Children 2016 Statistical Table", 2016). The Demographic and Health Survey (2013-2014) additional states that while nearly all children born in the 5 years before the survey (98%), with more than half (52%) breastfed in the first hour of life, 11% of children received other food or liquids before beginning breastfeeding ("DRC Demographic and Health Survey", 2014, p. 12).
particularly in eastern DRC, many mothers have resorted to mixed low quality food or contaminated water (*ibid*); 60% of infants aged 0-2 months are given water, other liquids or even solid foods (as cited in Owino et al., 2011, p. 1301). Although reasoning for supplementation varies dependent upon location, class, and overall knowledge, the consequences are common and grave.

A study by Kandala et al. (2009) shows that there is a direct correlation between the contamination of complementary food, including infant formula, and the water which it is mixed, and conditions of diarrhea, fever and acute respiratory infection in children in the DRC (p. 1735). For example, research from Ahiadeke (2000) discovered that diarrhea was prevalent for infants aged 4-6 months in households with poor sanitary conditions, unless mothers exclusively breastfed their children (as cited in Kanadal et al., 2007, p. 775). Although the existence of sex disaggregated data is sparse in the DRC, statistics collected on the main causes of death in the African Region for females 0-4 years suggests that supplementation acts as a direct cause of premature death in girls in the DRC: the leading conditions being respiratory infections, perinatal conditions and diarrhoeal diseases (“Addressing the Challenge of Women’s Health in Africa”, 2012, p. 14). It is also important to note that in the case of mothers living with HIV – in which there is a risk of HIV transmission through breastfeeding, most children do not die from HIV; as formula milk is not a sterile product and can easily be contaminated, most children die from undernourishment, and other non-HIV-related ailments (*ibid*).

Although the conditions and indicators listed above are not gender-specific, demanding gender-specific expectation for women to bear children and act as the primary caretaker (particularly in the context of overwhelmingly poverty and poor infrastructure) and limited autonomy have resulted in precarious health consequences for infants. Given the importance of a
mother’s health for the growing fetus she carries, births and takes care of, it is apparent that delivering better health outcomes for Congolese women can reflect positively on the health status of their children from the moment of conception.

4.1.2 The Health Status of Women: Pre-Adolescent and Adolescent Girls

According to the report “Start with a Girl: A New Agenda for Global Health” (2009), the wellbeing of girls in developing countries is “compromised by poor education, violence and abuse, unsafe working conditions, and early marriage – all manifestations of poverty and gender inequality” (Temin & Levine, 2012, p. 2). As such, while there are a host of factors that jeopardize the health of young girls, experiences of inadequate health of pre-adolescent and adolescent girls are shaped more by social forces than biological ones (ibid, p. 1).

In the DRC, there is a strong correlation between domestic duties, education, illiteracy and the health status of Congolese girls (Lwambo, 2013, p. 56). Once girl children reach a level of physical capability, they become consumed with the burden of gender bias within household work. This form of gender discrimination assigns girls day-to-day housework such as cleaning, washing, food processing, in addition to the responsibility of caring for the mentally ill or elderly. Deeply rooted in patriarchal civilian structures, the overwhelming burden of care restricts Congolese girl’s access to education. In a 2012 study conducted by UNESCO and UNICEF, of the 7.3 million children out of school in the DRC, 52.7% - some 3.8 million children – are girls (Ministry of Primary, Secondary and Vocational Education, 2013, p. 9). Among this percentage, 15% of women (compared to 4% men) age 15-49 have no education, 48% of women (compared to 74% of men) have secondary or higher education and 37% of women (compared to 22% of men) have primary education11 (“DRC Demographic and Health..."

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11 It should be noted that children in urban areas are more likely to attend school than children in rural areas. For example, one 2014 government demographic study estimated that 35% of women have no education in South Kivu,
This prioritization of boys over girls within education is based on the consolidation of individual gender identities; boys require skills, knowledge and opportunities to take care of their families, while girls will marry and her husband will take care of her and control the family resources (Davis et al., 2014, p. 25).

According to the Commission on Women’s Health in the African Region, there is a strong correlation between education and the health status of girls (“Addressing the Challenge of Women’s Health in Africa”, 2012). Pressured to assume their gender specific role as bearers of children, a lack of education is the strongest predictor of marriage age and a key determinant of health. In the DRC, despite basic education being compulsory and free until the age of 14 under the Constitution, poverty, economic vulnerability and societal pressures have prevented children, particularly girls, from receiving an education (Democratic Republic of Congo, art. 43, para. 5). Young girls are regularly removed from school and married off (often against their will), based on her family’s economic needs or to secure her economic future (“Marrying Too Young”, 2012, p. 6). As one of the 10 countries with the highest absolute number (in thousands) of girls married before 15, data collected from the 2013-2014 incites that 10% of girls are married by 17 and 37% are married by 18 (Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité, 2014, p. 4).

Based on desired family sizes of men wanting, on average, 7 children, while Congolese women would like 6 children, high rates of early marriage directly influence rates of teenage fertility (ibid, p. 4). The DRC has the second-highest rate of adolescent childbearing in sub-Saharan Africa (United Nations Population Fund, 2012a, p. 40). The Demographic and Health Survey 2013-2014 results show that nearly 1 in 5 (27%) of women age 15-19 have begun with 5.6% of women having completed primary education, 1% secondary education, and only 0.7% had access to higher education (Davis et al., 2014, p. 25).
childbearing: 21% are already mothers and 6% are currently pregnant (ibid, p. 3). In 2010, approximately 757,596 women aged 20-24 were known to have given birth by age 18 (Loaiza & Liand, 2013, p. 18); the period between 2006-2015 witnessed an adolescent birth rate per 1,000 women aged 15 to 19 at 138 (“The State of World Population 2016”, 2016, p. 95). It has been reported that adolescent fertility is nearly three times higher among young women living in the poorest households (42%) than among those living in the wealthiest households (15%); women without formal education are also seen to initiate sexual intercourse more than three years earlier than women with more than secondary education (ibid). With the median age at first birth as young as 19.9 years and 37% of women age 20-24 married before 18 (in contrast to 6% of men in the same age group), the extent of female child marriage and adolescent fertility is so high that the country is ranked 176 on the Gender Equality Index with a score of 0.833 (0/0 being an equal score, and 1 being unequal) (United Nations Development Program, 2015a, p. 222).

In a National Survey regarding out-of-school children and adolescents in the DRC, women who marry very early in life are exposed to greater risks for negative health outcomes (“Marrying Too Young”, 2013, p. 10). First, the majority of young brides in the DRC have limited access to reproductive health services, including contraception and abortion. In a recent Status Report on Youth in Sub-Saharan Africa, only 4 per cent of currently married female adolescents use a modern method of contraception in the DRC, one of the lowest rates in the region (United Nations Population Fund, 2012a, p. 40). These young women are at higher risk of contracting a sexually transmitted disease; only 14% of females between the ages of 15 and 19 have comprehensive knowledge of HIV, and only 3% of adolescent women have had an HIV test in the past 12 months (Wong et al., 2015, p. 19; International Youth Foundation, 2013, p. 17). Among the foremost problems of adolescent health are the low use of condoms during risky sex
(26.5%) and Family Planning services (5%) (‘Plan National de Développement Sanitaire 2016-2020’, 2016, p. 26). Analyses of schooling and its relationship to reproductive health behaviour conclude that adolescents enrolled in school, especially girls, are better informed and empowered to prevent STIs and pregnancy (Lloyd, 2010).

Furthermore, adolescents in the DRC are at risk of unsafely performed abortions. According to Mabuza, et al. (2010), adolescents are one of the largest demographics of women who choose abortion; this is directly related to premature sexual intercourse resulting in high incidence and prevalence of pregnancy (p. 1). While no study has been conducted on the number of girls who die as a result of illegal abortions in the DRC, a few common factors can be assumed to directly relate to the situation in the DRC. To start with, there is an overwhelming knowledge of consequences of abortion when not carried out safely, such as tubal damage, pelvic infection, hemorrhaging, and ultimately death. Furthermore, a study by Barnett (1993) found that because adolescents lack the knowledge of where to go for a safe procedure, they were more likely to become victims of these complications. He also found that the risk of complications is higher in adolescents because their bodies are not physically mature to endure the process of birth (ibid). Thus, it can largely be assumed that based on the number of abortion undertaken daily and similar understandings of complications outline in studies by Silberschmidt and Rasch (2001), poor access to reproductive services has a devastating impact on the lives of adolescent girls in the DRC – particularly girls who become pregnant out of wedlock.

Finally, the State of World Population notes that complications from pregnancy and childbirth as an outcome from child marriage together represents the main cause of death among girls in the DRC.

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12 Abortion is still illegal in the DRC, except when the life of the mother is in danger.
13 The World Health Organisation estimates that “at least 33% of all women seeking hospital care for complications related to abortions are under 20 years of age” (Mabuza et al., 2010, p. 1).
adolescent girls 15-19 in developing countries (“Marrying Too Young”, 2012, p. 6). The high risk of maternal morbidity and mortality associated with adolescent pregnancy is exacerbated by the psychological and biological immaturity of females – in most cases a girl’s pelvis and birth canal have not reached full development. The main causes of maternal death reported in various African studies highlight hypertensive disorders, prolonged obstructed labour, anaemia harmorrhage, malaria, septic abortion and puerperal sepsis (as cited in Okonofua & Olagbuji, 2014, p. 106). The State of World Population reports that physically immature mothers are particularly vulnerable to obstetric fistulae; girls under 15 face significantly higher rates of obstetric fistulae than their older peers as well (“Marrying Too Young”, 2012, p. 19). As with the relative data on the mortality linked to illegal abortions in the DRC, there is very little data on the complications related to adolescent births in the DRC. However, it can be assumed that with the DRC ranking 5th in the number of adolescent maternal deaths worldwide, the factors listed above are a reality faced by too many Congolese girls (Nove et al., 2014, p. e159).

Another factor that contributes to the poor health outcomes experienced by adolescent Congolese girls is sexual and gender-based violence. For instance, the widespread sexual abuse of girl students has long been an issue in the DRC. This phenomenon, labelled by the Congolese as “sexually transmitted grades”, denotes the possibility of female students trading sexual favors to obtain good grades (Lwambo, 2013, p. 18). In many cases, failure to comply with unscrupulous male professors demanding sex for a passing grade has seen some young girls receiving lower grades than they deserved (p. 8). According to one young girl in Province Orientale, “… I also faced sexual harassments by a teacher who forced me to go out with him…” (International Youth Foundation, 2013, p. 8). Unfortunately, this abuse largely remains unreported. This is due to sexual coercion against women being normalized and also justified on
the account that male sexuality should be aggressive and forceful (Baaz & Stern, 2009). In health terms, this sexual violence committed against girls in primary and secondary school leads to unwanted pregnancy, major psychological trauma and the transmission of sexually transmitted diseases, especially HIV/AIDS (Devers et al., 2012, p. 11).

Congolese girls are also vulnerable to sexual violence outside of the education system. In a cross-sectional, population-based survey of 1,305 adolescent girls aged 11-23, Verelst et al., (2014) found that 38.2% reported experiences of sexual violence (p. 1141). Furthermore, a report by UNICEF found that approximately 56% of adolescent girls aged 15 to 19 years experienced any physical violence since age 15 and approximately 21% of adolescent girls aged 15 to 19 have experienced forced sexual intercourse or any other forced sexual acts (United Nations Children’s Fund, 2014a, p. 7, 12). As previously mentioned, experiences of sexual violence during childhood or adolescence hinder all aspects of health development of girls, including physical, social and psychological (ibid, p. 11). It is therefore apparent that adolescent Congolese girls bear an unacceptable burden of poor health, a level of disease and death that can notably be distinguished from their male peers.

4.1.3 The Health Status of Women: Reproductive Years

The determinants of women’s health in the DRC continue into the reproductive years. As Congolese girls transition into adulthood, their gender-specific roles and responsibilities become of greater importance, often essential to a family’s preservation. Regrettably, women continue to be viewed as possession under the paternal forms of male hierarchy and control. As such, these patriarchal gender roles and relations continue to mediate and determine conditions of health of Congolese women.
As noted above, in many African cultures, including the DRC, there are high expectations on women of reproductive age to give birth and to nurture children (Amadium, 1987); cultural pressures associated with pre-existing sexual division of labour have normalized bearing children as the main purpose of a woman’s life. It is common in these regions for women to suffer severe stigmatization if they have fail to live up to their primary role. As such, the low acceptance of contraceptive use and the high value of fertility, combined with a lack of infrastructure and geographical inaccessibility – which will be discussed later, has placed Congolese women in their reproductive years in precarious health situations.

Women in the DRC have the third highest fertility rate in the world (behind Niger and South Sudan), averaging 6.5 children per woman (Population Reference Bureau, 2016, p. 2). According to the Demographic and Health Survey, fertility varies from urban (5.4 children) to rural (7.3 children) and between provinces (with a minimum of 4.2 in Kinshasa to a maximum of 8.2 in Kasi Occidental) (“DRC Demographic and Health Survey: Key Findings”, 2014, p. 3). It is therefore not surprising that the DRC’s population has grown five-fold over the past five decades. The high rates of fertility arise from several determining factors, including being strongly linked to adulthood status, socioeconomic security and the social repercussions of infertility (Maguiraga et al., 2012, p. 27). Most significantly, the DRC’s high fertility is a direct consequence of unequal access to methods of contraceptives (ibid).

The DRC does not have a population policy (as cited in Kandala et a., 2015, p. 346). As such, the practice of family planning – as seen with the socioeconomic benefits of controlled fertility – has yet to be accepted as a universal health strategy. According to the Demographic and Health Survey, while the vast majority of women (88%) and men (95%) know at least one modern method of contraception (the most widely known method being the male condom),
reproductive health services in addition to comprehensive and accurate sexual education remains inaccessible to most Congolese women (“Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité”, 2014, p. 5). For instance, just 20% of married women are using any method of contraception, and only 9.5% of women use a modern form of contraception (ibid, p. 5-6). In a country where only 1.8% of women have access to reproductive health services (a 53% reduced likelihood for women in rural areas), the issue of unmet family planning needs is significantly influenced by cultural constraints (Kandala et al., 2015, p. 352). For instance, Congolese women often require the authorization of men to use family planning methods.

According to the WHO (2014), the DRC is one of ten countries that accounts for nearly 59% of global maternal deaths (p. 19). With an approximate 693 deaths per 100,000 maternal deaths, the DRC has one of the highest rates of maternal mortality in the world (“Democratic Republic of Congo: Factsheets of Health Statistics 2016”, 2016, p. 3). While maternal health appears to be slowly improving, witnessing a 21.2% reduction since 1990, there are several, gender-specific determinants of these figures (ibid).

To begin with, it is a simple fact that being a woman in her reproductive years in the DRC is dangerous. Ongoing reports on conflict-related rape as a ‘weapon of war’ highlight the persistence of sexual- and gender-based violence in the DRC\(^\text{14}\). As a gender-specific crime, directly motivated by a desire to dominate and humiliate the victim, gender- and sexual-based

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\(^{14}\) It should also be noted that while little research has been conducted so far on the phenomenon of domestic violence in the DRC, equally pervasive to sexual violence in the DRC are the high rates of intimate partner and domestic violence. According to the Demographic and Heath Survey (2013-2014), among ever-married women age 15-49, 57% have ever experienced spousal violence (emotional, physical, or sexual) committed by their current or former husband/partner (p. 18). While experiences of domestic violence vary from one region or another, domestic violence against women in the DRC is considered is considered a normal part of martial relations (“The Democratic Republic of Congo (DRC) Country Gender Profile”, 2009, p. 46). As reported by the Integrated Health Project in their Gender Analysis of the DRC, a shocking 75.6% of women believe men are justified in beating their wives, for reasons as burning food or leaving the house without first asking permission (Maguiraga et al., 2012, p. 32).
violence has and continues to be overwhelmingly experienced by Congolese women\textsuperscript{15}. An estimated 1.80 million\textsuperscript{16} of the country’s women and girl allege to be victims of sexual violence (as cited in Kasangye et al., 2014, p. 1). As such, women have come to bear the burden of immeasurable health consequences.

In their article, “Sexual Violence at the Eastern Region of the Democratic Republic of Congo and its Public Health Implications”, Kasangye et al. (2014) detail health outcomes including chronic pelvic pain, bleeding during pregnancy, sexually transmitted diseases such as HIV/AIDS, traumatic rectal and vaginal fistula, and even death. In addition to long term physical health consequences associated with sexual and gender-based violence, many women suffer psychological distress in the aftermath of the assault. According to a study conducted by Johnson et al. (2010), of the women who were subjected to sexual during conflict, 67.7\% met symptom criteria for Major Depressive Disorder (MDD) and 75.9\% for PTSD (p. 560). Finally, the nature of these sexual assaults in the DRC has also increased the risk of unintended pregnancies and consequentially, unsafe methods of abortion. Pregnancy termination is highly restricted in the DRC; abortion is completely prohibited under Congolese law, with no legal exception to save the life of the mother\textsuperscript{17}. Limited access to safe abortion has been found to increase maternal morbidity and mortality as women are driven to alternative care, including traditional medicine or drug/self-medication, to induce abortion (Maguiraga et al, 2012, p. 12).

\textsuperscript{15}While most perpetrators are men and boys, there is a growing body of research exposing the use and consequences of sexual violence perpetrated against men and boys.
\textsuperscript{16}This number has been supported by estimates made by Peterman et al. (2011), whom claim that 1.69 to 1.8 million women reported having been raped in their lifetime (p. 1063). Additionally, these reports have been supported by a number of UN estimates, including the United Nations’ High Commission for Refugees’ reporting 25,000 cases of sexual violence in 2013, in addition to statistics collected by the United Nations Population Fund from January 2014 to September 2014 reporting 11,769 cases of sexual and gender-based violence in the provinces of North Kivu, South Kivu, Orientale, Katanga and Maniema, appear to support the latter claim ("Conflict-related sexual violence", 2015, p. 7).
\textsuperscript{17}The 1982 DRC Penal Code stipulates that abortions are illegal and subject to 5 to 15 years’ imprisonment (Democratic Republic of Congo, 1940).
Congolese women, irrespective of how they become pregnant, additionally experience a greater risk of maternal mortality during their pregnancy. According to Patricia Lledo, MSF gynaecologist and expert in reproductive health, there are three delays in maternal health identified in the 1990s that apply perfectly to the DRC (“DRC: One fewer mother every 25 minutes”, 2014). The first “refers to the delay in making a decision because women fail to see that there is something wrong in their pregnancy, or they do, but for cultural reasons, do not ask for help” (ibid, para. 4). For instance, the WHO recommends that pregnant women should receive ANC service at least 4 times starting in their first trimester of pregnancy18 (Ndosimao Nsibu et al., 2016, p. 1). While the clear majority of Congolese women attend at least one antenatal care visit (89%) (“DRC Factsheet of Health Statistics”, 2016, p. 3), the Demographic and Health Survey (2013-2014) showed that in the 5 years preceding the survey only 48% of women who had given birth attended ANC at least 4 times19 (an increased from 46.7% in 2007) (p. 8). To a large degree, compliance with the recommended four visits to ANC service, in addition to other health services, is undermined by culturally-determined norms limiting women’s control and decision-making power. According to a study by Women for Women International (2007), married women are unable to travel health clinics without the confirmed approval of their husband or a male in charge of the family in her husband’s absence (p. 65). In many instances, men have even been known to deny permission of their wife as a form of punishment for disobedience20. A husband’s presence or prior approval is thus perceived as

18 Not only do women fail to become informed and treated of symptoms (danger signs) during their pregnancy, a lack of ANC attendance impacts Congolese women’s overall health; women receive most of their health information during ANC visits, including messages about hygiene, nutrition, the importance of vaccinations, breastfeeding and STIs/HIV (Maguiraga et al., 2012).
19 Coverage for ANC remained lower and stagnated among rural women (42% in 2007 and in 2014), in comparison to urban women (53% in 2007 and 60.7% in 2014) (Ministère du Plan et Macro International, 2008; Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité, 2014).
20 A young woman in Kasai Occidental noted that “when you are insubordinate, your husband will not take care of you. But when you obey and respect his will, he will respect your rights” (as cited in Maguiraga et al., 2012, p. 65).
essential for women’s health, limiting a women’s accessibility to all areas of service, including prescribing family contraceptives\(^{21}\) (*ibid*).

The second delay “affects their arrival to the health centre, which in Congo poses an enormous risk for women” (“DRC: One fewer mother every 25 minutes”, 2014, para. 4). It has been well-addressed that the DRC is one of the most challenging environments for health development. While urban areas and provinces such as Bas-Congo, Katanada and Kinshasa have witnessed growing development, rural areas and provinces such as Bandundu, Maniema, North and South Kivu continue to lack the health infrastructure required to address pervasive health issues (Kandala et al., 2014). As such, this rugged and inaccessible geography complied with a lack of investment has left the country’s physical and health infrastructure mostly obsolete poses challenges for women in their reproductive years. For example, delays in arrival to a health centre not only affects antenatal consultations – as detailed above, personal and structural barriers have resulted in unequal access to postnatal services\(^{22}\). The Demographic and Health Survey details that overall, only 44% of mothers received postnatal care within two days of delivery, but 52% did not receive postnatal care within 41 days of delivery\(^{23}\) (“DRC: Demographic and Health Survey: Key Findings”, 2014, p. 8). This is illustrative by an observation made by MSF Head of Mission, Christine Buesser: “Imagine you are a pregnant woman, and you may even have to carry another child on your back. These distances are very difficult to overcome. This is a daily challenge – just to get to a health facility” (“Democratic Republic of Congo: Condition still critical”, 2011, para. 3). While additional factors including

\(^{21}\) Health workers require a husband’s presence or prior consent before prescribing family planning contraceptives. Particularly in health centres, women who come in alone are refused all contraceptive methods except condoms, as they used as a preventative against STIs (Maguiraga et al., 2012, p. 66).

\(^{22}\) Postnatal care helps prevent complications after childbirth.

\(^{23}\) Mother’s with an unintended pregnancy have been reported to use less and delay prenatal and postnatal care (Dhakal et al., 2016, p. 2).
physical abuse, absenteeism, corruption, poor communication and a lack regard for privacy undermine women seeking healthcare post-birth, the geographical inaccessibility tied with a women’s caretaker role strongly contributes to a women’s unequal access to maternal care (Mannava et al., 2015, p. 4).

Finally, Lledo defines the third delay as “receiving proper, timely care at health centre level because of the lack of human or material resources” (“DRC: One fewer mother every 25 minutes”, 2014, para. 4). According to the U.N. Population Fund report on the State of the World’s Midwifery (2014), the DRC has about half of the necessary health workforce to effectively manage its birthrate (a rate of approximately 4,048,000 pregnancies a year) (p. 86). Despite 80% of births taking place in the presence of a skilled birth attendant, the scarcity of trained medical staff leaves pregnant women vulnerable to complications during pregnancy and childbirth (ibid). Concerns regarding untrained medical professionals go together with high rates of preventable deaths, particularly among women as a vulnerable population. As further detailed in Chapter five, this is intrinsically linked to health professionals and their limited knowledge and skills when it comes to gender-specific procedures, and an overall lack of awareness on the ways gender come to affect people’s health and the healthcare they receive. Since women seek out healthcare to a larger extent than men, limited access to good-quality essential medical products – including blood, drugs and appropriate equipment – is also a contributing factor to the delay in providing care, and sometimes the women’s death (Kabali et al., 2011).

Congolese women during their reproductive years face many additional health challenges, including high rates of HIV, communicable diseases and non-communicable diseases. However, as the previous section has demonstrated, it is a Congolese woman’s gender-specific roles and relations that exposes them to ill-fatal health circumstances.
4.1.4 The Health Status of Women: Beyond the Reproductive Years

As a women’s life course continues, especially in conflict-prone or developing nations, the health status of older people is challenged by new physical, psychological and socio-economic risks. Unfortunately, the availability of complete and reliable information on elderly women in Africa in general is difficult to obtain as the social realities of populations aging in Africa are often overlooked or not identified in data. For example, while the Demographic and Health Survey represents an important source of health data of developing countries, it typically excludes health data of older populations (Maharaj, 2012, p. 4). This poor quality of data is reflective of the situation and profile of the older population in the DRC.

According to the Demographic and Health Survey (2013-2014), just over half the population (52%) in the DRC is under 15 years, with the proportion of older people (60 and over) only making up 4% of the population (with virtually no noticeable gender gap or between rural and urban residence (“Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité, 2014, p. 26). The distribution of the population according to age is relative to the overall life expectancy in the DRC. In comparison to newborns from Japan, who have the longest life expectancy at almost 84 years, the latest data collected by the WHO reports that the life expectancy for women in the DRC does not reach beyond the age of 62 (“DRC WHO Statistical Profile”, 2015). Women in the DRC face a 79% chance of dying before age 70; in the entire African region, women only have a 17.2% life expectancy at age 60 (Global Health Observatory Data, 2015). Despite the elderly in the DRC being accorded with great respect, in which family members are required to take care and provide for their elders physical and medical needs, factors such as war, economic incapacitates and societal expectations have left this population increasingly vulnerable to mortality and morbidity.
The years that follow a women’s reproductive period bear many of the same gender stresses and pressures experienced since birth. Generally speaking, in the DRC, elderly women are extremely vulnerable to sexual violence. Reports from Human Rights Watch detail the extraordinary brutality of rapes committed against elderly women in the DRC – with women as old as 80 reportedly being shot in the vagina or mutilated with razor blades (Human Rights Watch, 2002). Reports by International Alert contend that the Rally for Congolese Democracy and the Rwandan Patriotic Army forces specifically target elderly women – who are assumed to have magical powers – to acquire more “power before battle” (as cited Carlsen, 2009, p. 481). In one of the few studies inclusive of experiences of sexual violence by elderly women in the DRC, Harvard Humanitarian Initiative and Oxfam International found that in South Kivu, 10% of women survivors between 2004 and 2008 were 65 or order (Harvard Humanitarian Initiative & Oxfam America, 2010). It also detailed that over 15% of the seeking health services for sexual violence at Panzi Hospital were over 55 and women over 49 experienced rates of sexual violence on par with the rest of the population (ibid). The fear of being raped has deterred many elderly women from even going into the forest in search of food, plaguing many with hunger (Zhindula & Maharaj, 2009, p. 95). As a situation often excluded from mainstream narratives, the burden of sexual violence among elderly women in the DRC is one that requires further record and attention.

Similar to earlier stages in their life course, elderly women also come to bear the responsibility for taking care of domestic tasks, including care-giving. According to a rapid assessment of the general situation of older people in the DRC, HelpAge International (2009) found that almost two-thirds of older people are caring for children (as cited in Zhindula & Maharaj, 2009, p. 92). This has ultimately been exacerbated by relatives displaced or killed in
the country’s ongoing conflict. The transforming of the burden of care to elderly women has placed this population at higher risk of poorer health outcomes relative to men, as it is within this social role come with it a predisposed exposure to diseases with little access to treatment.

Unfortunately, there is relatively little data on the full extent in which elderly women in the DRC experience health inequality. Yet, overall trends from sub-Saharan Africa provide relative insight. For example, women in the African region are at greater risk of suffering from trachoma infection, the leading cause of blindness in the region (“Addressing the Challenge of Women’s Health in Africa”, 2012, p. 41). This is a gender-specific infection as children are the reservoirs of trachoma infection and contact with them results in more frequent interactions (Cromwell et al., 2009, p. 7). Furthermore, as the main providers and processors of food, elderly women experience one of the highest domestic fuel-related disease burdens in the world (“Addressing the Challenge of Women’s Health in Africa”, 2012, p. 42).

A study conducted by Maharaj (2009) found that most of the elderly in the DRC do not visit a health centre when they fall ill. This poor health seeking behaviour of elderly Congolese women is largely constrained by their economic situation. Similar to experiences of women in their reproductive years, Congolese elderly women are dependent on the male heads of the house who control the families financial budget. While it has been found that men will involve women in aspects of financial management, the degree in which woman in the DRC can manage household finances depends on “what level of responsibility… given [to] her” (Maguiraga et al., 2012, p. 66). For the most part, men do not typically involve their women in any aspect of duties related to financial management. Thus, as elderly Congolese resume their care-taking role, they are not only limited in their access to family resources; they are often unable to find work in the formal sector to pay for health services (“Addressing the Challenge of Women’s Health in
Africa”, 2012, p. 42). According to Zihindula and Majaraj (2009), while the majority of elderly report never receiving any assistance from the government, many remain unaware of any social grants for the elderly (p. 97). One IDI stated that: “No, we have no government grant, because I have not heard of anyone receiving any form of grant since I was born” (ibid). In a system where fees are payable, accessibility and affordability of healthcare services represents a major obstacle for elderly women’s utilization of services. Some women have quoted additional barriers such as distance, the limited number of health facilities that cater to this population's needs and an overall disrespect of elderly in society\textsuperscript{24} (ibid).

Finally, non-communicable diseases continue to be a distraction from the business of prevention and control of infectious diseases (Miranda et al., 2008, p. 1225). However, contrary to the conventional wisdom that noncommunicable diseases are a problem of developed nations, the Commission on Women’s Health in the African region states that they are in fact a matter of growing concern in low-income countries for older men and women (“Addressing the Challenge of Women’s Health in Africa”, 2012, p. 40). The WHO has backed this statement by confirming that if nothing is done to address the issue of noncommunicable diseases, they will account for at least 50% of mortality in the African Region by 2020 (“Achieving Sustainable Health Development in the African Region”, 2010). Non-communicable diseases are particularly relevant for aging African women, including Congolese women, as their chances of procuring cancer, heart disease, cardiovascular diseases, among others, increase overtime. This vulnerability is linked to a host of factors. For example, studies conducted by Ali-Risasi et al. (2014) on uterine cervix cancer – the most frequent gynecological cancer found in women in the

\textsuperscript{24} The Demographic and Health Survey 2013-2014 notes that distance is an issue for 48% of women in rural areas (against 25% in urban areas) to reach health services (as cited in “Plan National de Développement Sanitaire 2016-2020”, 2016, p. 35)
DRC, and Mvila et al. (2014) on early breast cancer detection, confirm that incidences of cancer-related mortality are linked directly to an overall lack of knowledge and inefficient screenings and treatment. Poor health education is additionally notable with regards to tobacco. According to the Demographic and Health Survey (2013-2014), smoking is most common among older Congolese women in rural areas and in communities where access to the health consequences of tobacco is limited (Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité, 2014, p. 53).

There is still much to be learned about the health experiences of elderly women in the DRC. HelpAge International (2009) reports that not only do older people in the DRC suffer from sexual violence, noncommunicable diseases, a significant number were experiencing sight and hearing difficulties as well as physical mobility problems, in addition to suffering from some form of emotional and physical problem (as cited in Zihindula & Maharaj, 2009, p. 94). Moving forward, there not only needs to be greater investment in the collection of data of older Congolese women; gender-specific elder health outputs must be given attention within the system so that the most vulnerable can live a life with dignity and respect.
Chapter 5: Institutional and System Responses to Women’s Health Issues in the DRC

5.1 Introduction

Since 2005, the DRC has formally and systemically engaged in healthcare system reform to improve the accessibility, affordability and availability of its healthcare services. However, it is unclear if the DRC’s health system reform efforts have adequately focused on gender and gender inequity in health. As Chapter four demonstrates, gender-specific roles, relations and responsibilities operate to the detriment of the mental and physical health outcomes of Congolese women. This is particularly evident as it relates to Congolese women’s reproductive and maternal roles and the personal and structural barriers subsequently reinforced. Across their lifespan, Congolese women are susceptible to precarious health outcomes fortified within a culture where their status and dignity is dependent on their role as mothers and caretakers.

A health system that responds adequately to health conditions associated with gender disparities is a system that has the capacity to address the latter gender norms, roles and relations in policies, programs and health services from design, through to final evaluation (“Human Rights and Gender Equality in Health Sector Strategies”, 2011). At the heart of the right to the highest attainable standard of physical and mental health, this ensures that concerns and interests voiced by women (and men) determining poor health outcomes for women and children, such as limited physical, economic and social autonomy, are reflected in the operations and institutional structures of the health system. Using the definition of a gender-equitable health system defined in Chapter two by Percival et al. (2014) as a ‘benchmark’, in addition to key health indicators provided in Chapter four, the following chapter adopts the structure of the Pan America Health Organization’s Guide for analysis and monitoring of gender equity in health policies to evaluate key institutional health system reform efforts that have taken place in the DRC between 2005
and 2016. It examines the extent these systemic and institutional responses reflect disparities in health as they relate to gender. Based on this sections findings, this thesis determines whether the DRC has pursued effective accountability in the context of fulfilling and upholding a Congolese women’s right to health.

5.2 Leadership and Governance

Gender Assessment of Health Sector Policies

According to the WHO, leadership and governance in building or reforming health systems involves ensuring that “strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability” (“Monitoring the Building Blocks of Health Systems”, 2010, p. 86). From a gender perspective, Percival et al. (2014) argue that a gender equitable health system requires governments to ensure equitable health outcomes among women and men, and across age groups (p. 11). In order for policy makers to create the required conditions for women across their lifespan to experience better health outcomes, they must establish a framework for policies and interventions that are responsive to gender issues and priority areas. Furthermore, policy makers must also strive to ensure different sectors and various stakeholders, that have an overall impact on the social and health status of women, initiate effective leadership in gender equity.

As a first glance on the attentiveness of DRC policy-makers to the connection between gender and health outcomes, an assessment of seven key health policy and strategic documents is provided in Table 1. Assessment levels are structured using WHO Gender Responsive Assessment Scale (2011) which contains five levels of assessment: gender-unequal, gender-blind, gender-sensitive, gender-specific, and gender-transformative (a description of each level is available in Annex A) (“Gender Mainstreaming for Health Managers”, 2011).
<table>
<thead>
<tr>
<th>Policy/Strategy</th>
<th>Gender-Responsive Assessment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Health Standards (2001)</td>
<td>N/A</td>
<td>• Document unavailable</td>
</tr>
<tr>
<td>Strategie de Renforcement du Systeme de Santé (2006) - Health System Strengthening Strategy</td>
<td>Gender-Blind</td>
<td>• Statement of the problem does not acknowledge the differential aspects of health outcomes for women as they pertain to gender norms, roles and relations. &lt;br&gt;• Mentions the effects of socioeconomic conditions, however cultural angles are not defined. &lt;br&gt;• No specific commitment to gender equity in intervention strategies, specifically in relation to community participation and overall characteristics of the health system.</td>
</tr>
<tr>
<td>Politique Nationale de Santé de la Reproduction (2008) - National Policy on Reproductive Health</td>
<td>Gender-Sensitive</td>
<td>• Analysis of situation relates women’s poor reproductive health status to gender inequalities. &lt;br&gt;• Policy vision includes respect of women and men’s fundamental human rights without discrimination; however, gender equity is not listed as a goal. &lt;br&gt;• Strategic direction includes an understanding of reproductive health across lifespan, including adolescents and elderly people. However, no remedial action to address unequal norms, roles and relations is developed. &lt;br&gt;• M&amp;E does not have indicators on gender.</td>
</tr>
<tr>
<td>Plan National de Developpement Sanitarire (2011-2015) – National Health Development Plan II</td>
<td>Gender-Blind</td>
<td>• No statement regarding commitment to gender equity in goals and principles. &lt;br&gt;• Gender is not emphasized as a determinant of health that directly permeates the social institution of health; rather, gender is perceived as a separate sector outside of the determinants of health. &lt;br&gt;• No statement on intention of understanding different gender roles and norms. &lt;br&gt;• Acknowledges gender in intersectoral action policy; however, ‘gender’ is isolated to issues related to sexual violence. &lt;br&gt;• Data is only disaggregated for HIV, malnutrition and maternal care. &lt;br&gt;• No specific commitment to gender equity in intervention strategies.</td>
</tr>
<tr>
<td>Politique Nationale de Nutrition (2013) – National Nutrition Policy</td>
<td>Gender-Specific</td>
<td>• Vision statement identifies high-risk groups, including young children, women and elderly. &lt;br&gt;• Identifies equity and considerations of gender as key guiding principles, with attention to the need for the</td>
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<tr>
<td>Program</td>
<td>Gender Sensitivity</td>
<td>Details</td>
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<td>------------------------------------------------------------------------</td>
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<tr>
<td>Health Facility Enhancement Program (2013)</td>
<td>N/A</td>
<td>- Document unavailable</td>
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</tbody>
</table>
| Planification Familiale: Plan stratégique national à vision multisectorielle (2014-2020) – National Strategic Plan for Family Planning | Gender-Specific    | - Strategic plan’s objectives specifically recognize the need to identify and address differences between men and women; this includes developing programs targeting men.  
- Selected indicators to monitor objectives and sub-objectives consider men’s and women’s specific needs.  
- Multi-sectoral partnership with Ministry of Gender, Family and Children; however, does not address specific role.  
- Does not explicitly state gender equity or equality as a specific goal.  
- Vision and Guiding Principles recognize the need to have access to family planning for all Congolese people of reproductive age. |
| Programme National de Santé de l’Adolescent (2014) – National Programme for Adolescent Health | Gender-Sensitive    | - Causes and factors include some cultural habits, inequality and gender; however, no statement on gender norms, roles and relations for women and men and how they affect access to and control over resources is included.  
- Mentions specific objective to promote equality and equity between the sexes but does not carry through in strategic interventions; does identify gender-specific issues, including abortion and early and unwanted pregnancies.  
- Multi-sectoral partnership includes Ministry of Gender, Family and Children; however, does not address specific role. |
| Plan National de Developpement Sanitaire (2016-2020) – National Health Development Plan III | Gender-Sensitive    | - Gender equality not explicitly recognized as a goal/objective; however, objectives do acknowledge the need to enable and promote health to all at all age and ensure an equitable distribution of health services. |
Description of socioeconomic situation considers the unequal social position of women and how it affects access to resources.

Indicators recognize women’s and men’s specific needs.

Limited strategic targets ensuring remedial action for women; only considered in government resource allocation to the health sector and improving supply of health facilities.

Of the seven health policies assessed, the National Nutrition Policy and the National Strategic Plan for Family Planning were the most attentive to the social and gender determinants of health and how these impact on health status of women in the DRC; they were assessed as gender-specific. Both policy’s vision statements and guiding principles recognize the dimensions of gender and identify the need to strengthen the state of women by promoting equity between the sexes. Considerations are also given to women across their lifespan, from young adolescents to elderly, and the ways in which gender norms, roles and relations affect access to and control over health resources. The content of these policies reflects a relatively appropriate commitment to human rights, gender equity and the gendered dimensions of health conditions.

Three of the policies were assessed as gender-sensitive because they did not explicitly draw the connection between promotion of gender-specific issues and gender equity as a goal. The National Health Development Plan III and the National Policy on Reproductive Health indicate a moderate awareness of unequal norms, roles or relations; yet, gender equality is not recognized as a goal/objective. In contrast, the National Programme for Adolescent Health specifically mentions the objective to promote equality and equity between the sexes; yet, factors linked to culture and gender do not openly address inequality by constructed gender roles and norms. In all three cases, concrete action to redress health disadvantages experienced by women is not offered.
The final two policies were assessed as gender-blind. Neither the Health System Strengthening Strategy nor the National Health Development Plan II include a commitment to gender equity in its goals and guiding principles, identify gender as a socioeconomic condition that reinforces conditions of ill-health, or provide any indication of understanding gender norms, roles and relations. Interestingly, when gender is acknowledged in the National Health Development Plan, it is perceived outside the determinants of health that directly permeates the social institution of health. This directly influences the ‘gender’ issues identified; only sexual violence is recognized as a priority area.

Since 2006, there seems to be a progression within the content of the DRC’s health sector policies towards a more gender-specific framework. However, as no policy has been assessed as gender-transformative, there is an opportunity for future reforms and approaches to integrate in key policy areas the way gender and health intersect and how actions can address the gender dimensions of norms, roles and relations. As addressed above, the latter is important as policymakers determine the framework for service delivery, resource allocation and key priority areas.

It is worthwhile to mention that it is possible to integrate gender within national health plans. A perfect example is Timor Leste’s 2002 National Development Plan. Gender inequalities are addressed in several of the objectives, strategies and policies in the national plan. As a general objective for the increased access to quality health, the MoH explicitly states the insurance of a woman’s right to health (“East Timor National Development Plan”, 2002, p. 10). Recognizing the importance of gender dimensions, the national plan’s main development strategy also acknowledges traditional divisions of gender roles as barriers restricting the promotion of gender equality in health. For example, the campaign to halt the spread of HIV/AIDS pays specific attention to the vulnerable situation of women because of their
subordinate position within the household (ibid, p. 26). By considering gender inequality as a contributing factor limiting women’s access to and control over social services such as health, Timor Leste’s Plan proves that it is possible to mainstream gender health concerns in all programs and monitor their impact on women’s health, through gender-sensitive indicators.

Intersectoral Action

According to the WHO, investment in social determinants and reduction of health inequalities is a “moral imperative that coincides with the commitments all countries have made to health and human rights through international human rights treaties” (“Health in the post-2015 development agenda”, 2016, p. 6). However, building good governance for action on social determinants in health systems is not an isolated reform; health is a multisectoral issue that requires integrative work between different sectors and various stakeholders (Ng & Ruger, 2011, p. 11).

Objectives to institutionalize and coordinate intersectoral action are identified as critical components of implementation mechanisms within each of the Ministry of Public Health’s National Development Plan (“Strategie de Renforcement du Systeme de Santé”, 2006, p. 33; “Plan National de Developpement Sanitaire 2011-2015”, 2010, p. 74; “Plan National de Development Sanitaire 2016-2020”, 2016, p. 45). Yet, despite support from the National Steering Committee, the latest National Health Development Plan (2016) indicates that intentions to integrate initiatives have not contributed sufficiently to improving the supply and accessibility of health services and care (p. 54). Poor collaboration with related ministries has been linked with relatively low and irregular participation of representatives of related
ministries\textsuperscript{25}, coupled with a weak mechanism of accountability obliging regular reporting of activities (p. 55).

Unfortunately, there is limited research on intersectoral action as it pertains to the integration of gender in health in the DRC. The dearth of systematic evaluation of intersectoral action, not specific to the DRC, ultimately reflects a lack of standardized measurement tools and methods to adequately determine positive or negative outcomes to intersectoral collaborations (“Health Equity Through Intersectoral Action”, 2008, p. v). This limited data ultimately suggests that there has been poor systemic support for intersectoral collaborations that focus on gender inequalities, specifically as they relate to health outcomes. This is evident in the overall failure of the DRC to integrate gender equality across all levels of government (i.e. the limited political will of other sectors to address the underlying causes of gender equality) and the restricted power of the Ministry of Gender, the Family and the Child (MGFE) in relation to other ministries.

As expressed by Freedman (2011), there is, in fact, a legislative and policy framework for advancing women’s rights in the DRC (p. 173). However, putting principles of equality between men and women into practice remains a key challenge. Field consultations collected by Davis et al. (2014) note that while public officials tend to suggest the government considers the needs of women within its policies, “the general feeling… is that nothing is done by leaders to capture and upon the priorities identified by women” (p. 11). As it pertains to women’s and girl’s health, failure to coordinate concerns is particularly apparent within the poor policy and programme commitments of the Ministry of Primary and Secondary Education\textsuperscript{26}.

\textsuperscript{25} According to Kengo\textsuperscript{26}um (2015), political priority is given to security issues and “the preservation of power by the authorities in place” (p. xi).

\textsuperscript{26} Poor intersectoral action for the purpose of improving health outcomes is also evident in a number of other sectors. Most notably within the Ministry of Justice and Human Rights and its poor political will to effectively enforce law protecting the physical integrity of women in the DRC (Mbambi & Faray-Kele, 2010, p. 6).
Illustrated in the Chapter 4, there is a strong correlation between education and the health of adolescent girls. Notably, disparities found between gender have become a focal point of policies and objectives of the Ministry of Primary and Secondary Education. This is highlighted with the sectors most recent Sectoral Strategy for Education and Training (Stratégie sectorielle de l’édération et de la formation) (2016-2025). The Strategy’s overall policy objectives aim to promote a more equitable education system, whereby the disparities related to the pervasive gender gap are eliminated. However, notably absent is the inclusion of plans or programs for sexual health education that emphasizes respect for sexual and reproductive rights and gender equity. Consequentially, sex education in all schools remains out of reach for adolescents in the DRC (Freedman, 2015, p. 37). As detailed in Chapter four, accurate and comprehensive sexual education is necessary to ensure adolescents make informed choices regarding their sexual and reproductive health, particularly in a society with such a high rate of adolescent fertility, rising HIV prevalence and poor sexual and reproductive health knowledge (Bosman et al., 2006, p. 81). Limited communication between the Ministry of Public Health and the Ministry of Primary and Secondary Education has exacerbated this issue.

Furthermore, for young girls able to participate in primary education, specific health issues such as sexual and reproductive health and personal hygiene are common. For example, in an individual NGO report in relation to CEDAW (2013), it was reported that girls suffer from genital infections caused by the products they use as substitutes to sanitary pads; these infections are further aggravated, leading to long term reproductive health problems, as they wash in polluted local rivers (p. 7). Unfortunately, the DRC’s Ministry of Primary and Secondary Education has repeatedly failed to address the issues of sanitary pads in the national budget.

27 According to Nsakala et al. (2014), morbidity and mortality related to STI/HIV/AIDS and other problems of sexual and reproductive health of young people can be reduced by enhancing sex education (p. 2).
Consequently, the decision to ignore the menstrual needs of girls has resulted in many young girls missing up to one week of school per month, leaving their education, and their health respectably, to fall behind (ibid). As with sexual education, there has been little systemic attempt between the Ministry of Public Health and the Ministry of Primary and Secondary Education to ensure these health consequences are reformed.

In addition to the weak political will of other sectors (not limited to, in this regard, the Ministry of Primary and Secondary Education), the “health sector has too often focused on marginal collaborations at the expense of recognizing the impact of the core work of other sectors” (Rasanathan et al., 2015, p. 37). In the DRC, systemic support for international collaboration that focuses on gender inequalities within health is restricted due to the limited power of the Ministry of Gender, the Family and the Child (MGFR). The MGFE is the main body in the government responsible for the promotion of women’s rights, including a women’s right to health. At the provincial level, this Ministry has established Focal Points for Gender, in addition to Gender Committees and Thematic Groups for Gender, to serve as mechanisms to identify gaps in the relevant sector (“Lessons from the Gender-Based Violence Initiative in the Democratic Republic of Congo”, 2016, p. 11; Davis et al., 2014, p. 13). Unfortunately, implementing national policies and strategies highlighting gender equity is difficult. Not only is there an understaffing of gender services and a lack of resources for need assessments, mapping and data collection, resources are highly under-utilized (Davis et al., 2014, p. 13). Furthermore, the ability of the MGFE to work with other ministries is limited due to difficulties in “finding counterparts interested, competent or available to engage on gender-related programming” (ibid).
agenda in other ministries leaves valuable resources and perspectives pertaining to women outside of the mainstream narrative.

There is a strong rationale for an organized and developed intersectoral action to health reform, specifically when it comes to vulnerable populations such as women. A study by Kuruvilla et al. (2014) found that next to investing in the health sector system strengthening, investing in other sectors that influence health can improve health outcomes, particularly for women. Studies, such as but not limited to Kuruvilla et al. (2014), have shown a direct correlation between greater political and socioeconomic participation by women and gains in maternal and child health indicators such as under-five mortality (p. 541). As such, to ensure coherent policies recognize and protect the health interests of Congolese women, it is essential that further research investigate the impact of intersectoral action (or lack thereof) on health equity in the DRC.

5.3 Access to the Healthcare System (Service Delivery)

A primary objective of health system reform is to increase access to services under the guarantee that services will be optimally used. Unfortunately, in many weak and dysfunctional health systems, services fail to address cultural and gender health sensitivities as they pertain women and girls. As outlined in Chapter four, Congolese women and girls experience limited, and often restricted, access to healthcare services because of culturally-informed gender roles, relations and responsibilities. To meet the needs of men and women and ensure they are able, across their lifespan, to access and utilize key healthcare services, Percival et al. (2014) argue that a gender equitable health system removes financial, physical and cultural barriers impeding access to quality care for women (p.11). Additionally, the state produces relevant, sex disaggregated health information to properly inform health policies (ibid).
The DRC has committed to an essential package of health services (EPHS) (see Wright, 2015). On a positive note, the government’s strategy for implementing the EPHS focuses on specific populations, including women and adolescents. Priority has been specifically given to reproductive, maternal, newborn and child health (RMNCH) interventions. This includes: preventative activities such as consultation on desirable births, PNC, among others; and curative activities such as basic emergency obstetric and neonatal care for mothers, and an integrated management of childhood illness for children, among others. However, notably excluded from the DRC’s EPHS RMNCH interventions are the following services: safe abortion, social support during childbirth and women’s groups. Thus far, the achievement of these benchmarks has been undermined by key economic and institutional barriers.

**Economic Barriers**

The DRC has engaged in several reform efforts to ensure economic access to essential health services. In 2005, the government adopted a National Program for the Promotion of Health (Programme national de promotion des mutuelles de santé). This reform set out to provide insurance coverage (social health insurance and mutual health insurance) to the most vulnerable population groups. Most recently, the government adopted a community-based health insurance\(^\text{28}\) (CHI) scheme out of its 2009-2011 National Programme for the Promotion of Community Health Insurance action plan (Programme National de Promotion des Mutuelles de Santé). Despite an increase in (CHI) availability in parts of the country, the health insurance system in the DRC remains disorganized. According to the most recent National Health Development Plan (2016), only a small segment of the Congolese population is covered by

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\(^{28}\) CHI are systems in which people pool funds to cover the health expenses of the members of the mutual health program (Weijs et al., 2012, p. 38).
health insurance\textsuperscript{29} (p. 45). The limited scheme-specific data in the DRC points to the weakness of these insurance schemes in their entirety\textsuperscript{30} (Weijs et al., 2012 p. 38).

From a gender perspective, not only has the health insurance industry been poorly developed in the DRC; the criteria for entitlement of coverage in the Congolese insurance system has profound gender implications. At first glance, the encouragement of health insurance through mutual health organizations and community-based insurance seemingly promote an awareness of the impact of gender roles and relations on access to healthcare. For example, the general benchmark for 2009-2011 plan aims to improve access of both the formal and informal economy, considerate to the fact that the majority of Congolese women occupy informal economic spaces. Designed to promote the inclusion of vulnerable populations, experiences of women in Sud Kivu suggest that the existence of mutual health organizations have somewhat facilitated the accessibility of healthcare for women (Maguiraga et al., 2012, p. 67). The latter is apparent within reports that some women attended ANC in their eighth month of pregnancy by way of these organizations to avoid consultation costs (\textit{ibid}).

Yet, the criteria for entitlement of coverage fosters a problematic environment for the inclusion of Congolese women in MHIs such as CBI schemes. For instance, mechanisms inherent to the development of MHI in the DRC imply that only individuals with enough resources to contribute on a monthly basis can participate; this effectively excludes the vast majority of Congolese women (Bailey et al., 2011, p. 24). As briefly described in Chapter four, a principle barrier amounts to a Congolese women’s socioeconomic dependency on men. Since Congolese men are known to control the household budget, Congolese women are often required

\textsuperscript{29} No systemic data on specific insurance schemes exist.

\textsuperscript{30} The only expectation is that of the Bwamanda scheme, an insurance plan covering hospital care for the rural poor in the district of Bwamanda. Since the 1980s, this program ensured at its peak that 64\% (114,465 beneficiaries) accessed health care (Soors et al., 2010, p. 61).
to have their husband’s authorization to seek consultation for specific health needs (Maguiraga et al., 2012, p. 65). Many reports indicate that Congolese men deny permission to their wife as a form of punishment for disobedience (ibid). As quoted by a woman in South Kivu, “If you do not have money, what will you tell the health provider? Even in this case you could be scared to approach him… For him to treat you, it is absolutely necessary to give him money” (FGD, women, Sud Kivu, as cited by Maguiraga, 2012, p. 67). In the case of Sud Kivu, only 6-10% of the population is involved in a mutual insurance scheme (ibid). Unfortunately, indicators within the national insurance policy do not acknowledge controlled out-of-pocket usage or the understanding that women seek healthcare at a greater rate than men.

Another barrier to women’s participation in insurance coverage is their low purchasing power. In the absence of a well-functioning health insurance system, a clear majority of the DRC’s health institutions have become de facto privatized. User fees, or fee-for-service expenditures is widespread, covering all consultation, medicine and treatment costs; 44% of the cost is spent on hospitalization, 32% to drugs and 13% to consultations health centres (“Plan National de Développement Sanitaire 2011-2015”, 2010, p. 46). The average out-of-pocket expenditure is 60 USD and outpatient costs for sexual and reproductive health is 13USD (Wang et al., 2016, p. 27 and 30). However, these fees are not fixed. The commercialization of healthcare in the DRC remains unregulated, enabling the delivery of health service to meet the needs of the providers rather than the interests of the patients. This system has profound implications for Congolese women.

For example, 25% of households in the DRC are Female-Headed Households (“Democratic Republic of Congo Demographic and Health Survey: Key Findings”, 2014). While there are successful women in business, the majority of Congolese women are rural,
working in precarious conditions with low salaries. The Human Development Index shows that
women’s GDP per capita is much lower than men’s (488 US$ respective 944 US$, in Purchasing
is because the informal sector is predominately the main source of livelihood for Congolese
women (Davis et al., 2014, 30). With little financial autonomy, women are often forced to make
life threatening decisions, choosing between renting land to generate income from small-scale
plots and healthcare, for instance. Unfortunately, no statistical data currently exists on the impact
of user fees on women’s health in the DRC. However, information from two reports submitted to
CEDAW highlight the link between user fees and ill-health. The Congregation of Our Lady of
Charity of the Good Shepard reports that women’s access to healthcare has been denied as men
often restrict their income to pay for services; this deprives them of their fundamental freedoms
(Congregation of Our Lady of Charity of the Good Shepherd, 2013, p. 7). An alternative report
to the Committee on the Elimination of Discrimination Against Women correspondingly
highlights how indigenous Pygmy women, who are generally acknowledged as having a lower
life expectancy to non-indigenous citizens, do not usually have the resources to pay consultation
fees or for medication (2013, p. 25).

The DRC’s most recent National Health Development Plan (2016) offers promising
insight in relation to the future financing strategy of the Ministry of Public Health. A key
intervention strategy to improve the development of health zones and continuity of care focuses
on the development of risk-sharing mechanisms. A combination of prepayment mechanisms and
flat-rate pricing is said to be disseminated, in addition to subsidy mechanisms of logistical costs
of drugs (ibid, p. 72). Regrettably, incidences of catastrophic health expenditures continue to be
isolated in terms of the generic category of the ‘poor’. Moving forward, the Ministry of Public
Health should conduct a study on the impact of the fee-for-services system on the health of women and their service usage to ensure women across their lifespan can access and utilize health services unimpeded by financial barriers.

Institutional Barriers

Institutional barriers, including geography, transportation and infrastructure, limit or impede accessibility to healthcare services in the DRC. However, government commitments to reducing disparities in the accessibility of health is complicated. On one hand, the Ministry of Public Health has expressed its commitments to improve social protection and basic services, specifically in areas in which there is poor coverage of services. Such institutional reforms include: the division of the country into 516 Health Zones (an increase from 306) set out by the Health System Development Plan (2002), with each health zone expected to have a first-level hospital, satellite health centers and community action groups; renewed attention to referral hospitals; and set up of the National System of Supply of Medicines Essentials to ensure traceability, quality and accessibility of drugs supplied to health facilities, among others (“Project Information Document: Concept Stage”, 2004). On the other, there remains a large gap between what is being implemented on the ground and what is stated officially.

Over the last decade, the DRC has witnessed significant progress in geographic coverage. In 2013, recording a total of 8,266 health centres, 393 district hospitals and 5 provincial hospitals, reaching the standard of one center for every 10,000 inhabitants (Barroy et al., 2014, p. 9). However, major deficits remain. Provincial hospitals and national hospitals remain scarce. Less than 30% of local and provincial health facilities are operational. A slim 8 percent of district hospitals are considered capable of delivering care packages. And 22 percent of the hospitals have electricity and 32 percent have running water (ibid, p. 9-10). It is clear that
geographical access and poor infrastructure continue to pose obstacles to the delivery of health services despite significant institutional reform efforts.

From a gender perspective, the DRC has poorly identified or ensured the availability of required services that involve gender factors for Congolese women. While documentation of gendered experiences of physical inaccessibility to health services in the DRC is limited, two reports in the last decade explicitly capture how women amongst the most affected by geographical access barriers to healthcare. According to Maguiraga et al. (2012), physical distance is a principal barrier to women’s access to healthcare (p. 67). Congolese women’s geographical inaccessibility to health services is predominately complicated as a result of their gendered role within the family. For instance, the physical distance between health centers and villages often do not permit women to travel for routine consultations, or receive a basic check-up, as it would interfere with a women’s domestic duties (ibid). This is illustrated in the following testimony from a woman in Kasi Oriental province: “I cannot walk 10km to go to the health center and 10km to return home with my belly. Even if I wanted to, I could not” (ibid).

The report also highlights how a woman’s responsibility as a mother combined with long distances significantly impacts maternal and neonatal mortality. For a pregnant Congolese woman, who may have to carry a child on her back, distances are extremely difficult to overcome and often have dire consequences. It is for this reason that many pregnant women and children go through their life without ever visiting a health center, except in cases of emergency (ibid, p. 67-68). The report quotes a study of two hospitals in North Kivu, detailing how the risk of obstetric complications and neonatal mortality increases for women living more than 90 minutes walking distance from the hospital (p. 23). A report by SIDA complements the findings from Maguiraga et al. (2014). Limited access to health services such as prenatal medical care is
largely due to the fact that primary healthcare centres are often more than 40 km in provinces such as Sud Kivu (“The Democratic Republic of Congo Country Gender Profile”, 2009, p. 51). When delivery is problematic, recourse to professional obstetric care often comes up too late, as women must walk or cycle to the nearest healthcare centre (*ibid*).

Regrettably, reforms to address gender-specific physical barriers to health have not been institutionally addressed by the Congolese government. For instance, there are no mechanisms in place (or in discussion) to facilitate timely transportation to health centres, with special priority given to pregnant women and emergency care; notably, no ambulance services in the country exists (“DRC Road Safety Status”, 2013). It has been organizations such as Memisa that have been at the forefront of putting in place innovative systems of motorcycle-ambulances in several rural health districts to transport pregnant women to hospitals (Medicus Mundi International Network, 2014).

Since young and adult Congolese women who live in rural, hard-reaching areas cannot rely on timely transportation to health centres, referral mechanisms offer a strong alternative. Experts report that referral systems offer much needed assistance to connect many women in their reproductive years to essential, life-saving services such as emergency obstetric procedures (Greene et al., 2013, p.11). Until recently, district or first referral hospitals received little attention from the Congolese government (Karemere et al., 2015). The development of secondary and tertiary referral services has been identified as a central component to revitalizing the health zone or health district in each of the DRC’s health development plans. Unfortunately, referral infrastructures are concentrated in urbans areas, leaving women in rural areas with limited options. For example, in Province Orientale, “29 rural health districts have no referral establishments whereas the city of Kisangani has three” (Barroy et al., 2014, p.10).
The unequal distribution of referral hospitals leaves a clear majority of the population without direct access to a referral establishment; one-third of the rural health districts do not have a single hospital (*ibid*). With distance to services is stressed as an issue for 48% of women in rural areas, poorly distributed referral systems by the government have continued to ensure lifesaving services remain out of reach for many Congolese women (‘DRC Demographic and Health Survey: Key Findings’, 2013, p. 10). Most significantly, for women able to reach referral infrastructure, low coverage\(^{31}\) of services such as emergency obstetric care\(^{32}\) and poor conditions for care regrettably maintain the high rate of maternal mortality (United Nations Children’s Fund, 2014b, p. 1). For example, health centers are “woefully unequipped to provide even the most basic health services, not to speak of specialized services to rape survivors (appropriate antibiotics to treat STIs, emergency contraception, HIV testing, and PEP)” (Maguiraga et al., 2012, p. 24). There is little noticeable effort by the government within policies or strategies on how to improve access for women as a vulnerable population.

The government has also done little to improve access to drugs and contraceptives for Congolese women. For instance, the National Essential Medicine Supply Program (SNAME) was set up in 2002 to ensure traceability, quality and accessibility of drugs supplied to health facilities (‘Plan National de Développement Sanitaire 2016-2020’, 2016, p. 42). The Ministry of Public Health has since registered key drug supplies under its National List of Essential Medicines (‘Liste Nationale des Medicaments Essentiels’, 2013). While advancements have been made with the inclusion of key medicines, such as levonorgestrel (LNG) for emergency

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\(^{31}\) In some health zones, such as in Nord Kivu, the population has no access to emergency obstetric and neonatal care (‘WHO Health Compendium Consolidated Appeal Process 2012’, 2012, p. 10).

\(^{32}\) It is noteworthy to mention that even if women can access referral hospitals that provide, for example, emergency obstetric procedures, only a small portion of those women would be able to afford them; emergency obstetric procedures are quite expensive (Maguiraga et al., 2012, p. 24). Since surgeries for fistulas are often subsidized by international NGOs such as Panzi Hospital, many women present themselves as rape survivors to receive treatment (*ibid*).
contraception and oxytocin for the prevention of postpartum hemorrhage, in addition to both male and female contraceptives, a weak public supply chain and policies that unnecessarily restrict the administration of these medicine have placed Congolese women at risk ("Counting what Counts", 2015).

It is well known that the coexistence of several parallel systems has complicated the drug supply channel in the DRC. The absence of a structure and a coordination mechanism between the Ministry of Public Health and its partners does not allow for optimum development of the National Plan of Supply needed ("Plan National de Développement Sanitaire 2011-2015”, 2010, p. 38). Resulting in duplicated or poorly distributed resources, lack of ownership of SNAME by the government has elevated the inaccessibility of lifesaving medicine for Congolese women. A female health worker in Sud Kivu confirmed that “[a]t times there are many months that will go by during which we have all the products, and then we will be out of stock for as many months” (Maguiraga et al., 2012, p. 63). It is reported that once the stock out is publicly reported, the number of women coming in for ANC services start to diminish and many will self-medicate using traditional medicines and ambulant pharmacies (ibid). In a corresponding shadow report, Congolese women claim that trips to health centres or hospitals result in issuing of prescriptions with a long list of drugs which they could not find or even afford (Congregation of Our Lady of Charity of the Good Shepherd, 2013).

It is also worth mentioning that policies play a significant role in the outcome of women’s health in the DRC. For example, a report by OXFAM found that even with political will to design a policy focusing on condoms in the DRC, there is no specific programme, policy strategy or norms focusing on the use of female condoms in the DRC (Mugisho, 2016, p. 4). This has resulted in most Congolese women remaining unaware of the existence of female condoms
and uneducated on how they can protect their health. Female condoms are considered as a form of contraception or a mode of protection against HIV and Sexually Transmissible Diseases within the category of essential medicines (ibid, p. 5).

At the same time, policies for the protection of women’s health are not always positive. In the DRC, policies exist that unnecessarily restrict the administration of key medicines, including oxytocin, misoprostol, and magnesium sulfate, designed to prevent labour complications to highly skilled health workers (Kade & Moore, 2012, p. 10). For midwives responsible for keeping mothers and their babies safe, their inability to write key prescriptions ensures their inability to fully safeguard a woman’s life during pregnancy and childbirth (ibid).

A determinant factor of the latter barriers experienced by Congolese women regarding access to health services is the lack of availability of sex-disaggregated data. Health information systems, including sex-disaggregated data, are critical to ensure resources are allocated based on needs and to gendered dimensions of health. While gender disaggregated data is available by ways of selective reports and institutions, there is no comprehensive sex-disaggregated data on women’s health in DRC at both the national and provincial level, nor is there an understanding of how gender inequities influence outcomes of data (“The Democratic Republic of Congo: Country Gender Profile”, 2009, p. 37). Health system analysts and policy-makers in the DRC predominately monitor experiences of physical inaccessibility using the rural-urban divide (Makeat et al., 2013). For instance, each of the previous national health development plans stress that in rural areas, distance to reach a service is an issue for most of the community. Notably absent from descriptions and strategies aimed at improving geographical coverage to health is the influence of cultural norms on the ability of individuals to access healthcare. It is thus vital that the DRC engage critically with gender as social determinants of health in health system reform.
This can ensure that geographical and social barriers do not continue to evade Congolese women from accessing lifesaving health services.

5.4 Health System Financing

Health system financing is never gender neutral. Women are especially impacted by a state’s failure to provide adequate funding on a sustainable basis to the health system, given that women tend to utilize health services more frequently than men with a minimal income. This is particularly true of maternal health services where there is a considerable need for increased investment (“Addressing the Challenge of Women’s Health in Africa”, 2012, p. 4). According to Percival et al. (2014), a gender equitable health financial system ensures women receive benefits based on their specific needs, promoting justice by reducing experiences of segmentation in access to care and benefits (p. 11). This entails funding healthcare services that address the most urgent healthcare needs of men and women in a way that reflects key gender dimensions of health (ibid).

Public Financing

Upon initial glance, it can be assumed that the DRC’s Politique et Stratédies de Financement du Santé (National Health System Financial Strategy) (2005) is gender-sensitive. Although the strategy does not specifically address inequalities generated by unequal gender norms, roles or relations, the strategy recognizes the Equity and Gender Policy of the DRC; this policy requires equal treatment of all people. Its situational analysis of the health situation acknowledges the influence of chronic poverty on Congolese families and the enormous difficulties they face when accessing quality healthcare (“Politique et Stratédies de Financement du Santé”, 2005, p. 7). Most significantly, the Ministry of Public Health emphasizes the government’s need to not only increase spending in the sector in order to improve equality and
equity of care; more sustainable approaches to the delivery of social services are needed (*ibid*, p. 14-15). On paper, it therefore appears that the DRC’s health reform efforts have been designed to allocate health financing in a manner that reflects universal access. This framework appears to promote the achievement of greater gender equity in sharing the burden health financial services experienced by Congolese women.

Despite these provisions, the government’s health budget and overall health resource allocation across key programs undermines the achievement of gender equity in health. The most apparent influence relates to inadequate resources. As previously described, Congolese women suffer disproportionately from new financing and cost-recovery schemes such as fees-for-services, yet, budget allocations to the health sector (excluding external funds) have only relatively increased since 2001. The budget allocation of the Ministry of Public Health was a mere US$3 million in 2001, increasing to US$13.5 million in 2002 (about 1.5% of the total State budget (“Democratic Republic of Congo. Health, Nutrition and Population Country Status Report”, 2005, p. 76). Between the period of 2007 and 2013, domestic resources increased 4.8 times in nominal terms to 4.2% (Barroy et al., 2014, p. 35). According to the most recent report on health accounts by the Ministry of Public Health (2014), the state budget allocated to health administration totals 6.92% of the overall budget; this is only $5 USD per capita (“Rapport sur les comptes de la santé RDC 2014”, 2014, p. 10).

While the DRC is keeping up with its commitment upon signing the 2001 Abuja Declaration (requiring states to allocate 15% of the national budget to health), the state’s sub-par investments, as detailed above, sustains inadequate investment in women’s health. For instance, figure one highlights the direct correlation between maternal mortality and public health
expenditures per capita. The maternal mortality rate is much higher in countries, such as the DRC, where governments spend less per capita. It also shows that between 2005 and 2010, the DRC’s slight increase in total budget spending on health has hardly improved the maternal mortality ratio. To safeguard the health of Congolese women, the DRC needs to do more to contribute to the minimum of $35.00 per capita required to fulfill this objective (Barroy et al., 2014, p. 28).

![Figure 1: Maternal Mortality vs. Government Health Expenditures per Capita, 2005 and 2010. Source: Barroy et al., 2014, p. 50.](image)

However, when resources are limited, as in the case of the DRC, assuring coverage for priority services, such as reproductive, maternal, newborn and child health, is not guaranteed. An analysis of two of the DRC’s national health accounts\(^\text{33}\) demonstrates poor budget allocations with respect to women’s health. Between 2008-2009, the government contributed a mere 0.2% to reproductive health services such as maternal conditions, perinatal conditions, contraceptives

\(^{33}\) While the Ministry of Public Health claims that they have regularly account for health financing (covering the period from 2008 to 2014), I was only able to locate two accounts on the Department’s website.
(compared to donors at 31% and households at 68%) (“National Health Accounts 2008-2009 Executive Summary”, 2011, p. 7). In 2014, internal resources dedicated to reproductive health services such as maternal conditions, perinatal conditions, contraception and non-specified only increased to 1% 34; with 13% of the total health expenditures of health services distributed to reproductive health35 (“Rapport sur les comptes de la santé RDC 2014”, 2014, p. 41). Alongside these trends, 79% of the state’s health budget is allocated to hospitals in Kinshasa that are used more by the richest quintile (at a ratio of 5 in the capital to 1 in the rest of the country) (ibid, p. xi). Given the context in which access to health services are particularly limited in rural locations and overall, contraceptive use, complications during pregnancy and access to prenatal and neonatal care remain poor throughout the country, it does not appear that the resources provided by the State reflect these long-standing issues. As such, it can be argued that the DRC’s internal resources and where these resources are allocated insufficiently meet the health needs of majority of Congolese women. In order for the DRC to fulfill its commitment to increase health spending for women, and children and adolescent health, it must strengthen its allocation of public resources in terms of program interventions.

Interestingly, the DRC has engaged in efforts to expand access to voluntary family planning. At the beginning of 2016, the Ministry of Public Health announced that it would be increasing its contributions for contraceptives for 2016 from $300,000 to $2.5 million (“Big increase in DRC contraceptives budget”, 2012). According to UNFPA, the increase in internal resources could not only reduce the current high unmet need for family planning (which stands at

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34 The government’s contributions to other health programs, including noncommunicable diseases, demonstrate a higher contribution of the state’s resources (48% for noncommunicable diseases) (“Rapport sur les comptes de la santé RDC 2014”, 2014, p. 51).
35 The remaining 60% is allocated to infectious and parasitic diseases and 27% to nutritional deficiencies, trauma and non-disease specific (“Rapport sur les comptes de la santé RDC 2014”, 2014, p. 47).
28%) by providing an additional one million women and girls with access to contraceptive services; this contribution could enable the country to reach the demographic characteristics needed to stimulate economic development (ibid, para. 2). In a country where two women die of pregnancy-related complications every hour, increased funding for family planning is a promising first step to improving reproductive, maternal, newborn and child health.

Given the preponderance of private methods of financing health in the DRC, especially out-of-pocket payments, an increase in government spending is not expected to have a large effect on total healthcare spending (Gros, 2015, p. 134). However, studies have found that there is a need for governments to increase amounts allocated to health. This is because healthcare expenditures significantly influence health status through improving life expectancy at birth, reducing death and infant mortality rates (Novignon et al., 2012). Case examples from Rwanda, South Africa, Botswana, Zambia and Togo illustrate that even where resources are relatively scarce, increase to government spending on health is possible and can produce positive health outcomes for women.

For instance, despite suffering one of the worst conflicts in recent history, Rwanda has made significant progress increasing both tax revenue and government health spending; this progress has translated into significant improvements in women’s health (Nakamura & Williamson, 2015, p. 6). Over the past 15 years, Rwanda has observed dramatic improvements in key maternal and child health indicators. The maternal mortality rate has declined from 1,020 deaths per 100,000 in 2000 to 290 deaths per 100,000 in 2015 (“Maternal Mortality in 1990-2015: Rwanda”, n.d). The percentage of women 15-49 using modern contraceptive method rose from 6% in 2000 to 48% in 2014, with a contraceptive prevalence rate increasing from 0% to 53% during the same period. The percentage of births attended by skilled health personnel
significantly improved from 27% in 2000 to 91% in 2014 ("The Development of Community-Based Health Insurance in Rwanda", 2016, p. 47). This progress occurred in a context in which per-capita government spending on health rose nearly seven-fold, from 4 to 26 in constant prices between 2000 and 2013\(^ {36}\) (ibid, p. 4). While improvements to public health spending alone was not the only causative factor that contributed to these improvements, Rwandan government’s strong political support to advancing the health of its population has allowed the sector to benefit from the reprioritization of health within the government budget (Nakamura & Williamson, 2015, p. 6). The DRC could learn a lot from Rwanda’s commitment to improving health financing and its impact on ensuring equitable health outcomes among women, particularly as it was not long ago that Rwanda was merging from a genocide that devastated the country’s healthcare system.

**External Financing**

For many fragile, post-conflict countries, including the DRC, the bulk of health expenditures used to scale-up health indicators and build the foundation of their health system originates from external funding. Accounting for an average 40% of total health financing sources over 2008-2013, (Barroy et al., 2014, p. x) the National Health Accounts indicate an increase from $291 million in 2008 to $462,665,467 million in health aid in 2013 ("Rapport sur les comptes de la santé RDC 2014", 2014, p. 47). This number has since rose to $574 USD million in 2014 (ibid, p. 29). The combination of limited government funding and this level of health financing in the DRC demonstrates a strong dependence on outside assistance to finance crucial health interventions.

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\(^{36}\) Rwanda remains of the only African countries that have surpassed the Abuja Declaration, even after excluding external resources ("The Development of Community-Based Health Insurance in Rwanda", 2016, p. 5).
A key concern of the DRC’s initial National Health Development Plan was to ensure external partners establish a working relationship with the domestic health sector. Several mechanisms have since been introduced. A formal commitment to align international health sector partners with the government was established, making it possible for the Ministry of Public Health to take the following three steps: the creation of a single coordinating mechanism (the National Health Sector Steering Committee) in 2007 to implement the health strategy; the establishment of the Ministry of Planning of the Platform for Aid and Investment Management in 2009 to assemble data from technical and financial partners to increase transparency; and a health financing reform in 2009 to improve the effectiveness and efficiency of deployment of international assistance and domestic resources (Ntembwa & Lerberghe, 2015, p. 17). However, with over 60% of external funding managed directly by external partners, external assistance in health remains fragmented (Barroy et al., 2014, p. 29).

From a gender perspective, the pooling of funding for healthcare initiatives by external actors has not ensured greater awareness of gender norms, role and relations and their implications on health outcomes of Congolese women. To a large extent, fragmented external assistance has led to a lack of coordination between humanitarian and development aid organizations, resulting in opposing systems and uncoordinated approaches to gender and health project activities.

For instance, while the UN system has established gender goals as part of its consolidated appeal process, the gender component of humanitarian programming is very shallow. For example, in an analysis of global humanitarian funding using the IASC Gender Marker and the Financial Tracking Service, 54% of humanitarian projects in the DRC were rated ‘gender blind’ (“A Call to Action on Gender and Humanitarian Reform”, n.d, p. 7). New research by
Development Initiatives also suggests that, as of September 2014, 80% of funding to the DRC is categorized as ‘unspecified’ in relation to gender issues (ibid). As such, while many international aid organizations in the DRC characterize the ‘gender’ component of their humanitarian programming based on their focus on issues such as sexual violence and maternal health, this narrow focus creates severe gaps that limit the ability to adequately address underlying gender norms stimulating these issues.

External assistance to development projects is also rightly concentrated by source. In the DRC, there are five main donors accounting for more than 70% of assistance for health between 2007-2012. The Global Fund contributed 21.5%, USAID 15.6%, World Bank 14.4%, the Government of Belgium 10.3%, and GAVI 9.6% (Barroy et al., 2014, p. 29). The gender policy discourse of each donor agency has received criticism when it comes to the allocation of health financing in a manner that reflects gender dimensions of health. For instance, a closer look at the World Bank’s initial involvement within the health sectors reform efforts in the DRC reveals the direct influence of a business case model to gender equality. In 2005, the DRC received a $453 million loan from the World Bank to rehabilitate the health sector; the initiative became titled the DRC Health Rehabilitation Support Project (2005-2014) (Kisangan, 2016, p. 628). Despite the project’s intention of improving the availability and utilization of quality health services for the population of targeted geographical areas, particularly women and children, the Bank’s initial

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37 This approach has been criticized for its perception of gender – the gender-based divisions of labour, disparities between males and females in power and resources, and gender biases in rights and entitlements – as a means to an end of broader development outcomes, rather than a necessary goal in and of itself (“Gender Mainstreaming: An Overview”, 2012, p. 4).

38 This was followed by an additional $22 million in 2006, and $344 million to rehabilitate social programs in Eastern Congo in 2007 (Kisangani, 2016, p. 628).
assessment of gender-related obstacles to health offered no real solutions to these constraints ("Project Information Document", 2005 p. 5).

For instance, considerable attention was given to strengthening maternal and child health services, sexual violence and reducing financial and behavioural barriers to utilization, the monitoring system also included disaggregated data. However, there was an overwhelming silence on the root of gender-specific barriers experienced by women, both in policy proposals and solutions. The World Bank clearly stated in its initial proposal that for women to take advantage of the upgraded services they intended to reform, such as ensuring that a skilled health provider attends every birth, and ensuring every first-level hospital could provide emergency obstetrical services, physical transportation and financial access would need to be improved. Yet, in the Bank’s Implementation Completion Report, the Bank acknowledges that the project design did not adequately consider these contextual factors ("Integrating Gender into the World Bank’s Work”, 2002, p. 5). This can be seen in the outcome for maternal health, in which the proportion of women in project areas, aged 15-49 years, who are new users of family planning increased from 2% in 2007 to 6% in 2011, but then decreased to 2% in 2014 ("Health Sector Rehabilitation Support Project (English): Implementation Completion Report Review”, 2016, p. 8). Gender as a merely symbolic role in the Bank’s initiatives provided little incentive to monitor project effects for women and thus, failed to challenge deeply embedded gender norms.

Given the large pooling of funding for healthcare by external donors and their consistency of gender blind healthcare programming, it is crucial that external assistance reconcile its multiple objectives and competing demands under a single, gender-transformative framework. This is because health systems are path dependent. They are characterized by inertia, meaning that events which occur earlier in the sequence have greater influence on the path than
those which occur later (Kwamie et al., 2016, p. 358). As such “decisions taken in the immediate post-conflict period have lasting ramifications for the functioning and equity of the health system” (Percival et al., 2014, p. 3). Gender blind programming not only jeopardizes immediate health concerns experienced as a result of gender hierarchies remain invisible, forms of sustainable organization and service delivery required to promote equity health reform are compromised. Thus, a health system’s path dependency makes it essential that programming systemically integrate understandings of gender power relations into their relief efforts. Failing to do so simply continues the cycle of vulnerability that leaves women’s health a prime target of neglect. Regrettably, external assistance in the DRC has failed to holistically provide healthcare services to address the most urgent healthcare needs of men and women across their lifespans, in an appropriate manner.

**5.5 Human Resource Development and Quality of Care**

According to the WHO (2000), human resources represent one of the three vital health system inputs (p. 75). The performance of healthcare systems – specifically the success of individual and public health interventions – depends on the knowledge, skills and motivation of different kinds of clinical and non-clinical staff (ibid, p. 77). Gender issues are especially relevant in the management of human resources. Not only do inequalities and discrimination manifest themselves across all areas of the recruitment and training of human resources, experiences of ill-health derived from constraints on the quality and distribution of human resources for health have gendered consequences. According to Percival et al. (2014), a gender equitable health system not only ensures gender disparities are addressed in the delivery of services by health professionals; it also provides equal opportunities for male and female health professionals working within the health system (p. 11).
Gender Awareness in Human Resources

Addressing human resource constraints has been recognized by the Ministry of Public Health as a general objective in each of the National Health Development Plans. As a corresponding policy strategy, the National de Développement des Ressources Humaines pour la Santé 2011-2015 (National Plan for the Development of Human Resources for Health) (NPDHRH) was adopted in 2011 with the overall objective of providing the health sector with a competent, efficient, sufficient and equitably distributed health workforce to deliver quality healthcare services by 2015 (p. 7). While the NPDHRH provides clear and precise guidance on four key areas of development, including the production of health professionals, career management, retention of human resources and continuing education, the Ministry of Public Health has not prioritized gender in its human resource strategy.

The Ministry of Public Health has defined and adopted its plan for the development of human resources for health through a gender-sensitive lens. The completion of two surveys in 2009-2010 (a national health resource survey and a survey of all public and private teaching institutes under the Ministry of Public Health and the Ministry of Higher Education) revealed inherent connections between key sociocultural experiences and systemic problems of human resources. The plan acknowledges discrimination against women and girls in education (ibid, p. 16); though regrettably, it does not address this inequality as generated by unequal norms, roles or relations. The plan does, however, indicates a gender awareness of health disparities experienced in the DRC. Not only is the health of the mother and newborn identified as a key health concern, conditions such as HIV/AIDS, malaria, noncommunicable diseases are reviewed using sex-disaggregate data. Yet, despite the plan’s relative gender awareness, no remedial action is developed. The Ministry of Public Health’s failure to prioritize gender in its ongoing
institutional and systemic reform strategies continues to disproportionately affect Congolese women’s health conditions.

For instance, a key component of the DRC’s NPDHRH is the production of health professionals. Available data indicates that the steep decline in the number of physicians and health workers in 1998 has not significantly improved since reform efforts began in the mid-2000s. According to the WHO, the DRC had a total of 5,827 physicians, 28,789 nursing and midwifery personnel and 1,042 other health workers in 2004 (“Absolute numbers - Data by country”, n.d). At the time, these health professionals were responsible for serving a population of 52.49 million. By international standards, the DRC continues to have an acute health personnel crisis. In 2013, the country was estimated to have just under 6,000 physicians and 72,000 nurses (Barroy et al., 2014, p. 10). According to WHO standards, the DRC continues to have one of the lowest physician ratios in the world (0.7 per 10,000 inhabitants) combined with an overstaffing of nursing staff and midwives (8.9 practicing per 10,000 inhabitants) (ibid, p. 11). While the country has seen a surge in the production of medical personnel (particularly midwives and nurses), with the number of paramedical training schooling doubling between the period of 1998 and 2013 (ibid), low pay or non-payment of wages and unregulated working conditions has had a perverse impact on Congolese women’s health.

According to a gender analysis in the DRC, health workers repeatedly complain that they do not receive payment from the state. Placing both their livelihood and the health of the community at stake, many health workers are forced to look for other work both within, but predominantly outside of the state (Maguriaga et al., 2012, p. 62). Interestingly, in some parts of the unregulated private sector, many staff no longer show up for work yet continue to draw their

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39 In 2014, only 32.8% of health workers benefited from the salary of the state (“Plan National de Developpement Sanitaire 2016-2020”, 2016, p. 40-41).
salary (Ntembwa & Van Lerberghe, 2015, p. 12). This systemic shortage of staffing particularly effects women because women have specific health needs, such as maternal care, that require greater resources. For instance, women often report the virtual absence of nurses at health centers in rural areas. Given that Congolese women require nurses when they come in for ANC or vaccinations, a lack of guaranteed health providers in rural areas has signaled a diminish of the number of women seeking treatment (ibid, p. 63).

The health status of Congolese women is also gravely impacted by an evaporated regulated health sector. A combination of little public funding and weak national leadership has created conditions for unregulated public and private healthcare. Consequently, women have reported that they were either raped or coerced into having sex with health workers when they could not pay their fees (ibid, p. 12). Unaware of patient rights, health service providers also abuse their position of power by turning women away for healthcare if they do not have the consent of their husbands; this is quite common when it comes to family planning commodities (ibid). While the Ministry of Public Health has recently launched the National Observatory of Human Resources in Health of the DRC, it is unclear if this mechanism will take into consideration the imbalance of power between health personnel and women in the DRC.

*The Application of Gender in the Management of Human Resources*

A gender analysis of limited data suggests that the Ministry of Public Health has failed to fulfill its commitments to ensure equal training opportunities for women as health workers, specifically doctors. In 2004, there were only 1,457 female physicians compared to 4,370 male physicians (“By gender distribution - Data by country”, n.d). While female made up a large percentage of nursing personnel (17,273 female nurses to 11,516 male nurses), women continue to experience barriers to the recruitment as health workers (ibid).
According to data collected in four provinces (Kasi Occidental, Kasai Oriental, Katanga, and Sud Kivu), there is a conspicuous absence of female health service providers. For instance, only one peri-urban health center visited during the study had a female head nurse (Barroy et al., 2014, p. 85). Interviews with female health workers identified several barriers to women’s recruitment, including pregnancy making women less desirable as candidates, a women’s competing domestic duties, restrictions of female nurses working in rural areas if their husbands are not present and marriage impeding their opportunity to complete training (Maguriaga et al., 2012, p. 85). Yet, both health service providers and community members alike agreed on the benefits, if not the necessity, of having female health providers (ibid). Accordingly, women not only have greater insight into the specific health needs of women; a woman’s heightened technical capacity and knowledge combined with their primary role as a mother and caretaker ensures families and communities are taken care of. Notably absent from the recruitment and planning processes of higher education and community health worker programs, the promotion (or lack thereof) of women is a missed opportunity to ensure greater overall health outcomes.

Another component of the Ministry of Public Health’s human resource health sector reform is adapting basic training curricula to the needs of the society. According to both the NPDHRH and a 2014 Health Public Expenditure Review, growth in graduate production has come at the expense of skill levels (p. 12). This was supported by a recent viability survey and audit of various training institutions that showed 22% of Institute of Medical Techniques and 38% of higher education and university training institutions are not viable; graduates are often incapable of improving the health needs of the Congolese population (ibid, p. 26). In the context of women’s health, this has led to a shortage of specialized and skilled personnel to respond to the health needs of mothers and their children. For example, in the province of Equateur, a study
found that surgical repairs for obstetrical or traumatic fistula cannot be performed simply because there is not a single surgeon with the necessary skills in the province (Davis et al., 2014, p. 24). This evidence is supported by an individual NGO report to CEDAW (2013) in which women reported that healthcare workers in these health posts were usually badly trained and unable to provide the required health service (p. 7). In many cases, it has been found that health centres maintained by international organizations have better capacity to respond to cases of sexual violence, versus local hospitals (ibid, p. 25). While this partly has to do with the states’ poor distribution of human resources, I was unable to find any evidence of increased training in key women’s health issues. For example, it is unknown the number of skilled birth attendants who are trained in emergency caesarians (Maguiraga et al., 2012, p. 27).

Of greater significance, health workers in the DRC reportedly do not understand the differences between the sexes in healthcare, nor any notion of gender and its implications on health and healthcare (ibid, p. 62). Thus far, I found no evidence of gender dimensions taken into consideration in health workforce training or deployment. The DRC has yet to develop a national gender training manual for the health workforce or a standard curriculum for gender in the health sector. The process of creating awareness of the ways gender affects people’s health and the healthcare they receive is particularly important because it enables the capacity of all health professionals to address gender issues appropriately; this makes their work more effective. For instance, a study by Newman et al. (2016) found that mainstreaming gender in health preservice education and general tertiary systems can counter disadvantages and discrimination experienced by women in health clinics. Many Ministries of Health, including in countries such as Rwanda, Kenya, Uganda and Ethiopia, have already taken steps to mainstream and institutionalize guidelines and manuals for gender mainstreaming across their respective health sectors. In each
case, gender training is emphasized to address gender-based health inequities, engaging healthcare professionals beyond traditional physiological factors of health. If the DRC is to firmly act against gender inequality that puts the health of millions of girls and women at risk, they must work more efficiently and effectively at: providing equal opportunities for male and female health professionals working within the health system and ensuring health professionals are informed and guided by gender as a social determinant of health.

5.6 Participation, Accountability and Development

Strengthening accountability is widely recognized as a core element to improve health system performance and implement health reform. As one of the four standards specific to economic and social rights, the concept of accountability refers to engagement and responsiveness. According to Caseley, engagement encompasses “a reciprocal relationship between two actors whereby demands are articulated by one actor in a transparent manner to the other” (as cited in Murthy, 2007, p. 11). Responsiveness refers to the extent to which the actor who the demands are placed, acts on them (ibid). Moving towards gender equity in health requires the engagement of women in all levels of decision-making. This is necessary as policy and program decisions relating the conditions, needs and interests of women and their health (particularly how health conditions relate to key social determinants) are often made without the informed consent of women. A gender equitable health system therefore requires power holders in health sectors to exercise accountability in relation to gender and the empowerment of women’s voices.

In 2006, the policy reform of decentralization was added to the DRC’s Constitution, shifting the legal prerogative of public services, including health, from the central level of government to the provincial and local governments (United States Agency for International
Theoretically, efforts to decentralize the health sector offers greater opportunities for an inclusive government that is more responsive and accountable to local needs, facilitates equitable access to services and ensures efficiency and quality (MacLean, n.d, p. 1). Women are said to be amongst the beneficiaries of decentralization, as decentralization offers a spill-over into broader processes of empowerment.

Unfortunately, efforts to decentralize the health system have unsuccessfully created greater public accountability for women’s health in the DRC. At its core, the Congolese government’s failure to uphold its responsibilities within the social contract is based on a mystification of decentralization that ultimately entrenches existing inequalities. Women’s health has been disproportionately impacted as a consequence.

Decentralization has largely been introduced within the health reform efforts in the DRC through a process of ‘mystification’. This is evident in the sharp distinction between the intended purposes and actual efforts to pursue decentralization in the health system. In theory, the Ministry of Public Health has hastily promoted decentralization with the intention of working with local and provincial governments to identify, both within and between districts, inequalities in health. This is particularly important for women’s health outcomes in the DRC as across their lifespan, research shows that women generally have poorer health outcomes than men; evidence suggests this is linked to women’s relative power, rights and access to resources (Maguiraga et al., 2012, p. 12).

However, the healthcare system in the DRC is inadequately decentralized. The centralized government has been reluctant to move ahead with any reforms despite the overwhelming social consensus within the country on the need for decentralized health processes (European Court of Auditors, 2013, p. 28). The vertical, Western model of top-down governance
is largely supported by the current Presidency, whose primary objective is to consolidate power (ibid, p. 27). As such, power and decision-making has remained centralized at the national level, producing “limited advancements with respect to enhancing subnational autonomy, downward accountability and governance capacity” (Englebert & Mungongo, 2016, p. 22). In the health sector, this has meant that provinces are tasked with implementing health programs designed by the central government. The ability of provinces to generate their own legislative health standards based on the differential needs of the population residing in their territory is therefore restricted.

This form of top-down hierarchy affects participation, particularly the inclusion of women’s voices. The latter is explicitly illustrated in several exploratory case studies, including by Mafuta et al. (2015) and Mafuta et al. (2016). Both demonstrate that social accountability initiatives aimed at increasing the capacity of community members to be engaged with maternal health services in the DRC replicate existing bureaucracies that have little connection to contextual factors limiting women’s ability to voice their health concerns.

For instance, in their situational analysis of social accountability mechanisms in Bas-Congo and Equateur, Mufuta et al. (2015) show that while community associations and health committees were willing to promote collective engagement, few women expressed their concerns and complaints to health professionals (p. 5). This is even though the DRC is among the lowest indicators for maternal health services in the world (ibid, p. 11). Respondents acknowledge fear of reprisals, a lack of formal system to present complaints or concerns of health professionals, thoughts of inability to influence healthcare functioning and avoidance of trouble within the community as primary reasons for expressing their concerns and complaints (ibid, p. 6-7). Most significantly, women believe that they have less knowledge than health professionals,
considering themselves as laypersons unable to judge the quality of healthcare (ibid, p. 5).

Findings show that little collective action has been taken by community health workers or management to make women aware of their rights or create “a safe space to express [these] concerns when these rights are unmet” (p. 15).

In a follow-up case study, Mufata et al. (2016) address the effects of contextual factors, such as societal values, gender relations and health system characteristics on shaping, implementing and running social accountability initiatives, such as interventions aimed at empowering communities, individuals or groups for maternal health in the DRC. With respect to the status of Congolese women, this study found that women were not necessarily marginalized in the community as they often occupied leadership positions in community groups (ibid, p. 7). For instance, women often hold important positions in the communities that are not solely consigned to domestic tasks; this includes participation in general assemblies and governing bodies. (ibid). However, even in these appointed positions, “they were still subject to the local male dominance culture, which restrains their involvement in decision-making, as they tend to be less educated, unemployed and suffer from a lack of resources or specific skills” (p. 1). One female health provider noted that “women are not really involved in decision making”; the latter is only the case if she had led a business, was well-educated, occupied a political or economic position in society or possessed specific skills (ibid, p. 8). Unfortunately, women at the local level rarely satisfy the above-mentioned conditions (ibid).

The latter two case studies suggest that even in experiences of decentralization which highlight features of social accountability, existing top-down gender hierarchies limit greater participation in healthcare decisions. Principles of participation inherent to decentralized health reform in the DRC tend to treat women as objects for charity and not rights-bearers (Davis et al.,
This is reflected broadly in women’s exclusion not only in day-to-day observances of rights, but also at the level of political representation. Women face widespread discrimination both in law and practice. For example, while the Article 14 of the DRC Constitution asserts that “women are entitled to equitable representation in national, provincial, and local institutions,” there has yet to be legislation passed implementing these provisions (United States Agency for International Development, 2012, p. 13). In healthcare, participatory interventions are not framed or implemented as part of a continuous political engagement to promote systemic change so that “women and girls are able to access the services to which they are entitled as a matter of course” (Davis et al., 2014, p. 41). As illustrated in Mafuta et al. (2016), there is a tendency to prioritize the palliative over the preventative; the latter marginally improves the plight of individual women, leaving the status quo in check (ibid, p. 1).

In the DRC, women in decentralized reforms have yet to be treated as citizens in which the government is obliged to protect. In order to produce a more gender equitable health system, the Ministry of Public Health must place greater priority on producing relevant, sex disaggregated health information informed by women as key beneficiaries.

5.7 Fulfill of International, Regional and National Human Rights Commitments

Based on the analysis above and the indicators listed in Chapter 4, it is apparent that there has been little systemic and institutional attempt by the DRC to ensure gender-specific health needs of Congolese women are adequately recognized in the health sector reform efforts. While the DRC’s latest National Health Development Plan and their newfound prioritization of family planning offer promising hope towards a more equitable and harmonized health system, each of the observation fields that provide the framework of the DRC’s health system feature little awareness of gender as an underlying determinant of health. It can therefore be argued that the
health system reform efforts since 2005 have operated to the detriment of Congolese women’s health. Congolese women and girls continue to face overwhelming gender-informed vulnerabilities that impede their access to adequate nutrition and sanitation, a healthy and clean environment and timely, acceptable and affordable medical services. Thus, in begging the question to what degree have systemic and institutional health sector reforms therefore been consistent with the DRC’s commitments at the national and international level to reflect gender equity and non-discrimination within health, it is apparent that Congolese women, of all ages, do not enjoy the right to the highest attainable standard of physical and mental health. Gender as a biological and socio-economic precondition must be considered in the DRC’s health system reform efforts if the notion of the highest attainable standard of health is to be recognized and upheld. Until then, Congolese women will continue to experience unprecedented levels of poor health outcomes across their lifetime.
Chapter 6: Conclusion

There is often an overwhelming belief that efforts to strengthen and reform health systems will inevitably guarantee greater health outcomes for all populations. Yet, as previous research suggests, health and health system reform efforts do not safeguard the same rights, opportunities and access to resources generally assumed to emerge as a byproduct.

This thesis focused specifically on the social and biological concept of ‘gender’ as one of the most important underlying causes of poor health outcomes, particularly when it comes to pervasive health consequences experienced by women and girls. As a social determinant of health, gender shapes both indicators of health and the way in which health systems are defined, organized and experienced. Socially constructed gender roles, relations, norms and behaviours, manifesting differences in power and privilege, produce unequal health exposures, vulnerabilities, risk and outcomes between the sexes. Gender additionally permeates the social institution of health, embedding its constructed social hierarchy into the structures, practices and behaviours that define the organization of the system itself (Mackintosh & Tibandebage, 2004, p. 6). To overcome these challenges, growing evidence suggest that integrating gender and gender equity into systemic and institutional reforms is a necessary and essential health strategy. A gender integration process can ensure health systems are designed to be responsive to the local context, universally accessible and upholds the right to health for all.

To reiterate, integrating gender within health systems means to transform the overall health framework from gender neutral (policies and interventions ignorant to different biological and socially constructed health needs of men and women) to gender equitable (taking into consideration and acting on the priorities and needs of gender as a determinant of health). As Percival et al. (2014) state, a gender equitable heath system in this regard is a health system that:
“[p]rovides healthcare services that address the most urgent healthcare needs of men and women across their life span in an appropriate manner; [e]nsures men and women across the life span are able to access and utilize those services unimpeded by social, geographic and financial barriers; [p]roduces relevant, sex disaggregated health information that informs policy; [e]nsures equitable health outcomes among women and men, and across age groups; and, [p]rovides equal opportunities for male and female health professionals working within the health system” (p. 11).

The formation of a gender equitable health system not only guarantees greater health outcomes as a result of improved operations and responsiveness; it grounds systemic and institutional health reform within the realization of the right to health as laid out in the Universal Declaration of Human Rights and other international human rights instruments.

This thesis has attempted to bring attention to the role of gender within the healthcare system reform efforts in the DRC. A gender analysis was conducted to understand how gender disparities in health exacerbate unnecessary, avoidable and unjust health inequalities specifically as it affects the health status of Congolese women across their lifespan. Several key themes were found. Beginning at the moment of conception and continuing beyond their reproductive years, Congolese women are culturally pressured to live up to their reproductive and maternal roles and responsibilities. These pre-determined gender roles expose Congolese women to gender-specific health concerns, including maternal and prenatal mortality, physical trauma related to childbirth, and malnutrition. At the same time, societal gender norms manifest economic, physical and institutional barriers to treatment, placing Congolese women throughout their life in precarious health situations. One of the main takeaways from this chapter was that for Congolese women, the past eleven years has seen very little improvements to key health indictors, including malnutrition, mortality and morbidity.
To meet the specific health needs of Congolese women and girls and ensure they have a fair chance to experience a healthy life, this thesis then examined to what degree a gender perspective has been supported in health system reform policies and programs since 2005. After observing various fields within the DRC’s health system, it is apparent that the past eleven years have poorly transformed the systemic and institutional framework of the health system to meet the visible gender disparities in health. In fact, it appears that a direct correlation can be made between the process of rebuilding the healthcare systems and the severe deficits in health experienced by Congolese women (as illustrated in Chapter four). As previously stated, a health system that responds adequately to health conditions associated with gender disparities is a system that has the capacity to address the latter gender norms, roles and relations in policies, programs and health services from design, through to final evaluation (“Human Rights and Gender Equality in Health Sector Strategies”, 2011). Overall, the Ministry of Public Health’s efforts to improve leadership and governance and intersectoral action, access to care, health system financing, management of human resources and quality of care, or participation, accountability and empowerment have not been attentive to gender equity or gender as a determinant of health.

Consequently, a clear and undeniable trend in relation to accountability and human rights also became apparent. The Ministry of Public Health’s ill-fated inclusion of gender and gender equity act as a direct violation of the State’s obligation to design and implement a responsive and equitable health system. From a human rights-based perspective, the recognition and institutionalization of gender-specific health needs in health systems is an essential component a women’s right to health. This not only strengthens and empowers women to lead healthier lives and ensure their families are well taken care of, it contributes to closing pervasive gender gaps
that lead to poorer health outcomes. By failing to recognize and address expressions of gender inequity in its health reforms, the DRC is guaranteeing quality healthcare remains out of reach of vulnerable populations, such as women and girls. The ongoing weak health indicators of Congolese women clearly demonstrate that if DRC is to live up to its international, national and regional commitments to health as a human right, it can no longer remain blind to the ways in which gender relations between couples, families and households determine health and social outcomes.

Yes, the DRC is still struggling to emerge from a situation of chronic crisis. Movements towards a democratic transition of power and sincere post-conflict stabilization are riddled with tension. The east continues to experience a seemingly eternal environment of violence, and opportunities for sustainable human development appear illusionary at best. Although there are significant obstacles to overcome, the healthcare system offers an opportunity for sustainable progress. Despite progress being fragile, hazardous and, to a large degree, susceptible to disappointment, the opportunity is tangible. The pursuit of a more gender equitable health system will require difficult decisions and a large external support network aimed at creating long-term change. As this thesis has demonstrated through examples of other reformed health systems, while the barriers to the inclusion of gender in health systems are unnerving, they are not beyond the bounds of possibility.
Annex A

WHO Gender Responsive Assessment Scale: criteria for assessing programmes and policies

Level 1: Gender-unequal
- Perpetuates gender inequality by reinforcing unbalanced norms, roles and relations
- Privileges men over women (or vice versa)
- Often leads to one sex enjoying more rights or opportunities than the other

Level 2: Gender-blind
- Ignores gender norms, roles and relations
- Very often reinforces gender-based discrimination
- Ignores differences in opportunities and resource allocation for women and men
- Often constructed based on the principle of being “fair” by treating everyone the same

Level 3: Gender-sensitive
- Considers gender norms, roles and relations
- Does not address inequality generated by unequal norms, roles or relations
- Indicates gender awareness, although often no remedial action is developed

Level 4: Gender-specific
- Considers gender norms, roles and relations for women and men and how they affect access to and control over resources
- Considers women’s and men’s specific needs
- Intentionally targets and benefits a specific group of women or men to achieve certain policy or programme goals or meet certain needs
- Makes it easier for women and men to fulfil duties that are ascribed to them based on their gender roles

Level 5: Gender-transformative
- Considers gender norms, roles and relations for women and men and that these affect access to and control over resources
- Considers women’s and men’s specific needs
- Addresses the causes of gender-based health inequities
- Includes ways to transform harmful gender norms, roles and relations
- The objective is often to promote gender equality
- Includes strategies to foster progressive changes in power relationships between women and men

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