The levers of change in government policy toward family planning in the Democratic Republic of the Congo

Thibaut Mukaba, Arsene Binanga, Sarah Fohl, and Jane T. Bertrand

I. Rationale

The Democratic Republic of the Congo (DRC) – with a population estimated at 67.5 million (UN, 2013) [1]– is the third largest country in Sub-Saharan Africa and the third largest francophone country. The country has had a tumultuous history since its independence from Belgian in 1960. During the dictatorship of President Mobutu Sese Seko (1965-1997), the country was named Zaire; his repressive government provided periods of relative stability, but at great cost to the country and its citizens. In 1991, Mobutu lost control over the population; political turmoil and social unrest known as the *pillage* created a highly volatile environment that caused foreign investors and international donor agencies to withdraw completely or reduce support to the country, plunging the country further into poverty. The First Congo war (1996-97) resulted in the overthrow of Mobutu by the Rwandan-backed rebel leader Laurent-Desire Kabila. The so-called second African World War (because it involved nine neighboring countries) occurred primarily in the eastern part of the country between 1998 and 2002, and resulted in further economic devastation to the socioeconomic development of the country. By the early 2000s, life in the capital city of Kinshasa and some other provinces began returning to normalcy, although the threat of war continued to simmer in the eastern countries bordering Rwanda and Uganda. Because the ravages of war, political uncertainty, external exploitation, and inadequate investment in human capital, the DRC - one of the richest countries in the world in minerals - ties for last place with Niger (186 of 186 nations) on the Human Development Index. [2]

The DRC is typical of African countries that are just beginning the demographic transition, with a total fertility rate of 6.6 as of 2013[3], a doubling in population size every 2.9 years, and a very young population (50% under the age of 15). Almost three-quarters (71.3 percent) of the population live below the poverty line, and 45.9 percent live in severe poverty.[4] With its high maternal mortality rate of 540 per 100,000 women and large population base, the DRC is among the five countries that contribute the greatest number of maternal deaths to the global total.

[1] United Nations (2013). Population Division, World Population Prospects: The 2012 Revision. Retrieved April 30, 2014 from http://www.un.org/en/development/desa/population/publications/pdf/trends/WPP2012_Wallchart.pdf

[2] Malik, K. (2013). The 2013 Human Development Report The Rise of the South: Human Progress in a Diverse World. Retrieved March 4, 2014, from http://hdr.undp.org/sites/default/files/reports/14/hdr2013_en_complete.pdf

[3] MEASURE DHS, ICF International. (2014). *République Démocratique du Congo Enquête Démographique et de Santé 2013-2014, Rapport préliminaire*.

[4] Ibid

Although the country established a national family planning program (Projet National des Naissances Desirables or PSND) in the early 1980s, it became inactive in the early 1990s in the wake of the pillage during which most international donors withdrew support from the DRC and all sectors of the country were in virtual turmoil. In the mid-2000s, external donors and technical organizations tentatively began to resume operations in the DRC. With a myriad of challenges facing the government from every sector, family planning was low on the priority list; the government had more important problems to address. Although the government established the National Program of Reproductive Health (Programme National de Santé de la Reproduction, PNSR) in 2001 to address maternal mortality, family planning, and related issues, it drew little attention or support at higher levels of government. After decades of civil unrest and neglect, the health infrastructure was in shambles; and family planning competed with other higher profile programs for the few available resources invested in public health. While maternal mortality did register as a national priority, family planning did not during the first decade of the millennium. The National Health Development Plan released in 2010 failed to mention family planning, although it did touch on leprosy, onchocercosis, and tuberculosis. As recently as 2011, there was little evidence of government interest in family planning.

Yet since 2012 the DRC government has taken a number of actions to demonstrate its commitment to family planning, which have taken the international family planning community and many local observers by surprise. The purpose of this article is to document the evolution of policy change in relation to family planning in the DRC, to analyze events that led to this change, and to identify factors that could influence the durability of this change.

II. Previous well-intentioned by ineffective attempts to heighten the profile of family planning

It is useful to begin this analysis in 2004, as the country was beginning to return to normalcy after the pillage and subsequent warfare. Two major events occurred in family planning that typify the lack of high level support for FP and inability of the PNSR to mobilize and sustain political support for family planning. Both were conferences to reposition family planning. The first (Conference pour le Repositionnement de la Planification Familiale), held in 2004, was funded by USAID and executed by the PNSR with technical assistance from Advance Africa. Given the country's ongoing struggle to return to normalcy, perhaps it was premature to expect tangible results to come from this gathering.

A second "National Conference on Repositioning Family Planning in the Democratic Republic of Congo," took place in 2009, again with support from USAID and UNFPA. This costly event, held at the Ministry of Foreign Affairs' conference room, took place under the auspices of the First Lady of the DRC. At a time when programs in other health sectors (e.g., HIV, malaria, vaccination) were receiving major funding and government attention, this conference was designed to heighten visibility for family planning (with the high level endorsement of the First Lady) and promote public dialogue around its importance. Although cited in subsequent reports

about FP in the DRC, it produced no immediate results in terms of political support or programmatic action. In retrospect, a major investment of time, effort and resources went into planning and implementing this event, with insufficient attention to substantive follow-up. For example, the First Lady was not engaged to play a role in subsequent events, although she is still cited as a champion of FP. However, the 2009 conference did produce a list of recommendations, at least two of which proved instrumental in mobilizing support for FP several years later: (1) to establish a multisectoral committee of FP stakeholders (Comité Technique Multisectoriel Permanent, CTMP), and (2) to develop a strategic plan for family planning in the DRC.

Between the two FP conferences, in 2007 USAID created a Family Planning Partner's Group, including its own implementing partners and the PNSR. This group improved coordination within the USAID program; however, the PNSR lacked the capacity to organize the coordination at a national level. In 2008, the PNSR created the Family Planning Task Force, and members from USAID's Family Planning Partner's Group joined the new task force. Later, when the CTMP was established, it included many of the same players, at which point the FP Task Force ceased to exist.

III. 2012: a turning point in government support for FP

Since 2012 the DRC government has boldly endorsed family planning in a number of actions outlined in Box 1.

Box 1. Evidence of DRC government commitment to family planning

2010:

- Poverty Reduction Strategy Paper (PRSP) 2010: contrary to the PRSP 2006, the PRSP 2010 explicitly stated that family planning is a pillar for the country's growth and poverty reduction [5]

2012:

- A Promise Renewed: inclusion of family planning as one of six elements in the DRC plan to accelerate achievement of Millennium Development Goals 4 and 5
- The Minister of Health launched the First Family Planning campaign (consisting of intensified mass communication and the free distribution of contraceptives) organized by the PNSR with the support from UNFPA and other partners.

2013:

- National budget allocation of $800,000 (U.S.) toward the procurement of contraceptives and an additional $500,000 (U.S.) for family planning operational costs.
- Letter from the Prime Minister to the Minister of Health to prioritize family planning (July 29), which combined the demographic rationale with the reduction of maternal mortality
- Declaration of Commitment to Family Planning by the Government of the DRC, at the Third International Conference on Family Planning in Addis Ababa (November 15)
- Second letter from the Prime Minister requesting the Minister of Health to take explicit steps toward further strengthening work in family planning (August 21)
- Third letter from the Prime Minister declaring the importance of finalizing the Strategic Plan, formalizing the Permanent Multisectoral Technical Committee (CTMP), and developing performance contracts for PNSR staff

2014:

- Official approval of the Strategic Plan for FP in the DRC: 2014 – 2020 (January 10)
- Official launch of the Strategic Plan by the Minister of Health (February 13)
- Technical review and approval by the Government (through the Ministry of Health) of the law favorable to Family Planning (April 7)

[5] Democratic Republic of the Congo: Poverty Reduction Strategy Paper—
Progress Report October 2010, International Monetary Fund Country Report No.10/328

IV. Factors that contributed the evolution of support for FP by the DRC government

How did this change occur: from near virtual neglect to explicit, strong support of family planning by the DRC government in a period of approximately two years? This question does not lend itself to statistical analysis, but a review of relevant events points to the following factors:

(1) Heightened awareness of family planning as a means to reduce maternal mortality

In June 2012, the Minister of Health and other technical advisors attended the first meeting on Child Survival Call to Action - A Promise Renewed[6], which included participants from the five countries that contribute the highest number of maternal deaths to the global count. One aim of the meeting was to make the participating countries more accountable for these high levels of maternal mortality and discuss strategies for taking action. Each country was asked to develop a plan to address the question of "what are you doing to reduce maternal mortality?" These same parties as well as the director of the Health Office, USAID/Kinshasa, participated in a follow-up meeting in Kinshasa in October 2012.

The DRC Government with support from UNICEF and WHO responded by developing a Plan for the Accelerating Achievement of the MDGs, in which family planning was one of six actions to reduce achieve MDG 4. This plan provided one of the first signs that the DRC government intended to pay more than lip service to family planning.

(2) Strengthened ties between the MOH, PNSR, and implementing agencies working in FP

Although the PNSR is a government entity, historically its dealings with higher levels of government were limited and perfunctory. However, in 2012 ties between the PNSR and the bodies of government which it represents (10ème Direction, Ministry of Health) have strengthened. Also, an expert was identified within the Division des Etudes et Planification (DEP) who came forward as a champion for family planning. Although responsible for multiple areas of health, he strategically used his time and influence to participate in key meetings, intercede on behalf of the PNSR, and liaise with higher level government officials on issues related to FP. He recognized the role that external partners could play in advancing the FP agenda within the country, and embraced their participation, though doing so on his own terms.

(3) Increased awareness about best practices from other African countries

[6] UNICEF. *Committing to Child Survival: A Promise Renewed, Progress Report 2012*. (2012). Retrieved from http://www.unicef.org/eapro/A_Promise_Renewed_Report_2012.pdf

Between 2008 and 2012, USAID invited PNSR, PNSA and key implementing partners to participate to successive regional family planning meetings that brought together up to 14 African countries. The following themes were developed: (1) 2010 Kigali Regional Family Planning Meeting: Meeting the Family Planning Demand to Achieve MDGs: Vision 2015; (2) 2011 Nairobi Regional Family Planning Meeting: Effective Community Approaches to Family Planning; (3) 2012 Dar es Salaam Regional Family Planning Meeting: Using Mobile Technology to Improve Family Planning and Health Services. In addition, the same DRC organizations attended the International Family Planning Conference in 2008 and in Dakar in 2010. Attending these conferences not only improved the knowledge on successful family planning models from across the continent, it also reinforced ties among Family Planning activists in the DRC and facilitated the collaboration within coordination bodies that were created later.

(4) Greater cohesiveness and teamwork among the technical partners implementing FP programs

Prior to 2010, some 10 organizations (funded by USAID, UNFPA, World Bank, DFIF, IPPF and others) implemented family planning service delivery in Kinshasa and elsewhere in the country, albeit in relatively isolated manner. Each diligently pursued individual project or institutional objectives, but no one (including the PNSR) was addressing the larger questions: how can we increase the availability of contraceptive methods; can we increase contraceptive use? The PNSR was unable to operate effectively in its convening capacity, given insufficient human and financial resources.

Two mechanisms based in Kinshasa helped to bring greater cohesiveness among these different partners and greater collaboration with the PNSR. The first was the CTMP – mandated by the 2009 Conference to Reposition Family Planning – which became operational in planning of a conference in Kinshasa in June 2012 on "Advocacy for the Financing of Family Planning in the DRC," aimed at increasing awareness of the work of different partners in promoting FP.[7] This group went on to tackle additional tasks. In late 2013 it became the main liaison between the organizers of the International Conference on Family Planning in Addis Ababa and the delegation from the DRC, which numbered over 40 participants. In addition, the CTMP served as a key intermediary in organizing the presentation of the Government of DRC Declaration of Commitment at the Addis meeting. Once in Addis, the CTMP arranged meetings with the DRC delegation (including government and NGO representatives) and foundation representatives, as well as a press conference with international correspondents.

A second group that has brought greater cohesiveness among the organizations implementing FP service delivery is the Kinshasa Family Planning Coalition. Since its creation in December 2012,

[7] Meeting of Advocacy for the Financing of Family Planning in the DRC. (n.d.). Retrieved July 7, 2014, from http://familyplanning-drc.net/meeting-of-advocacy-for-the-financing-of-family-planning-in-the-drc.php

this group of 10 service delivery organizations and four key donors has met quarterly. The goal of activities in 2013 was to increase the percentage of health structures offering "3 star" quality services from 44% (determined by a 2012 baseline survey) to 80%. Results from a follow-up survey showed that by the end of 2013, the number of health facilities reporting to provide FP services increased from 184 to 396. The percentage of health facilities with a 3 star quality rating increased from 44% to 63% among the total number of sites surveyed in 2013.[8] Although short of the 80% aspirational goal, this significant increase provided evidence that local organizations could effectively increase access to and quality of FP services in Kinshasa.

Donor-funded implementing partners have had a major role in advancing the FP agenda to date. For example, the costs of contraceptive procurement in the DRC are born 85% by external donors, 15% by households and less than 1% by the DRC government. However, the eventual success of the program must involve a solid collaboration between government and the private sector, including international and local NGOs and faith-based organizations. In a

5) Development of a Strategic Plan for FP in the DRC

The National Conference on Repositioning Family Planning in the Democratic Republic of Congo," held in 2009, had recommended the development of a Strategic Plan. In 2012 the CTMP took on this task, soliciting and obtaining financial assistance to support the process from various implementing partners, thus drawing multiple parties into the process. The President of the CTMP led the highly participatory process, consisting of four different workshops from December 2012-October 2013, involving over 200 different participants from the provinces and from different ministries. In the fourth and final workshop, the Provincial Ministers of Health and Provincial Medical Directors ("Médecins Inspecteurs") from the 11 provinces of the DRC were invited to Kinshasa to discuss the key components of the Plan. Because the large majority of FP stakeholders, especially those based in Kinshasa, had participated in one or more of the workshops, the final product had considerable buy-in throughout the FP community. The final draft was ready just in time for the Addis Ababa International Family Planning Conference, which gave added weight and credibility to the Government Declaration of Commitment to FP. That is, the Plan outlined the objectives and sub-objectives, along with concrete activities to achieve them at specified points in time (a roadmap for increasing contraceptive prevalence in the DRC). The MOH participated in the process at regular intervals. Once approved through official channels, the MOH presided over the high profile launch of the Strategic Plan on February 13, 2014 and gave a very impassioned public endorsement of the Plan.

[8] Bertrand, J. T., Kayembe, P., Dikamba, N., Mafuta, E., Hernandez, J., Hellen, J., et al. Using Mapping of Service Delivery Sites to Increase Contraceptive Availability in Kinshasa, DRC. Forthcoming in the June 2014 issue of *International Perspectives on Sexual and Reproductive Health*.

(5) Informed advocacy from international experts interested in the DRC

The presence of international experts with a keen interest in the DRC combined with years of experience in other African countries allowed them to effectively advocate for increased support of family planning from different vantage points. Although our list is by no means exhaustive, we cite three who contributed to the momentum starting in 2012. Dr. Richard Dakam-Ngatchou served as Representative of UNFPA from 2010-2012. Within UNFPA, he gave heightened priority to FP activity. Moreover, he lost no opportunity to advocate for family planning in private meetings with government officials and in public fora with large audiences. At a time when there was too little public discourse on family planning, this one individual ensured that this topic remained part of the public health agenda.

Dr. Jean-Pierre Guengant, demographer and economist, had performed analyses involving population projects, socio-economic consequences, and the demographic dividend in countries throughout Francophone Africa (including for all nine countries participating in the Ouagadougou Initiative). Although he visited the DRC several time in the early 2000s, he returned in 2012 to continue this work in a more sustained manner, meeting periodically with different government officials and presenting his findings to selected audiences. In addition, he directly contributed to the costing section of the Strategic Plan. His analyses are tailored specifically to the DRC, which has yielded relevant evidence for decision-making.

Dr. Sahlu Haile, African Advisor for the Packard Foundation, had worked on family planning programming in Kinshasa in the 1980s. He returned in 2009 for an exploratory visit and again in June 2012 to speak at the meeting on Advocacy for the Financing of Family Planning in the DRC. During his presentation at the conference and in three subsequent visits to the country, he was able to draw parallels between the situation in Ethiopia (in the years before family planning had yet to take off) and the DRC (currently at a similar point in its history). His return visits to the DRC and relentless encouragement to implementing partners – despite the obvious challenges – allowed government officials and implementing partners to believe that increasing contraceptive prevalence at the national level is in fact an attainable objective.

(6) Increased technical and financial support from donors to advance local FP efforts

Historically, USAID and UNFPA have been the primary donors for family planning in the DRC. USAID's budget for family planning increased steadily from 2002 to 2014. The World Bank also funded FP as part of integrated health programming through the PARSS project (through June 2014); similarly, DFID has supported FP through its rural health strengthening project ASSP Projet d'Accès aux Soins de Santé Primaire). In 2012 new donors entered the DRC. The Bill and Melinda Gates Foundation – which supported a project to build the evidence base for FP in Kinshasa, starting in 2010 – expanded its activities to include advocacy work (through the Advance Family Planning Project, which supported work in preparation for the Addis declaration) and improved monitoring and evaluation of contraceptive uptake (through the projects PMA2020 and Track 20). The Packard Foundation funded a major initiative to increase access to, quality of, and demand for FP services in Kinshasa. The Agence Française de

Dévéloppement (AFD) began supporting the demographic analysis of the consequences of population growth, as well as support to the PARSS project of the World Bank. In 2013, the Norwegian government allocated $20 million for a project that focuses on both population and environment. While USAID funding has continued at a fixed level for population activities, the program has benefitted from additional funding from PEPFAR. The identification of FP as the "second pillar of prevention of mother-to-child transmission of HIV (PMTCT) has resulted in the introduction of new FP services in Kinshasa and elsewhere in the country.

Signs of increased government support of FP and the existence of a costed strategic plan provide donors with additional justification to invest themselves, creating a virtual circle. Several other organizations are currently exploring their entry into FP activity in the DRC and recently the European Union has committed $40 million to programs beginning this year.

V. Factors that could influence the durability of this change

Given how recently this change in the FP policy environment in the DRC has occurred (basically, since 2012), the question arises whether it will have staying power or whether it will be reversed as quickly as it came about.

The most positive argument for a sustained commitment on the part of the government is that key authorities and divisions of government have been involved in the development, validation and approval of key documents that signal this engagement (e.g., the General Secretary for Health, the DEP, PNSR, PNSA, D10, and others). Moreover, the current alignment of vision between the government, local implementing partners and external donors serves to reinforce this commitment. Certain groups within civil society (e.g., CAFCO) currently play a key role in advocating laws in favor of reproductive health and sustaining government commitment to family planning.

However, continued government commitment is by no means guaranteed; multiple threats exist. First, the periodic reshuffling of DRC government officials may lead to the departure of key personnel who were instrumental in championing FP in the DRC. Second, although the government allocated funds for the procurement of contraceptives and supplies in 2013, there is no fixed line item for this activity in the national budget. The risk is a possible reduction or loss of this support, due to competing priorities. Third, the country is expected to enter the electoral period when the current presidential term ends in 2016. If the election process is flawed (as it was in 2011), it could signal that the country is facing political instability and uncertainty, which could cause external donors to reduce or suspend their aid to the DRC. Finally, in 2013 the country made large strides in consolidating peace in the East. However, the challenge ahead is demobilizing and reintegrating combatants from Eastern Congo into mainstream society. If the country fails to secure peace, the fragile progress made in family planning (and many other sectors) may be jeopardized by another cycle of violence.

VI. Discussion

For long-time observers of the policy environment for FP, the recent changes in the DRC are unprecedented and ground-breaking. At the high levels of government, family planning is no

longer considered "un programme de luxe des blancs" (a boutique programme brought to us by white people) but rather an activity that carries the promise of improving the lives of the Congolese population.

Although much has been achieved at the central level, this progress has yet to diffuse to the 10 other provinces of the DRC, which is a vast country the size of the United States east of the Mississippi River or of Western Europe. The Provincial Ministers of Health and Provincial Medical Directors have participated in key events relating to the acceleration of the MDGs (including FP) and the development of the Strategic Plan for FP in the DRC: 2014-2020. However, much policy work remains to be done in the provincial capitals, with the aim of translating policy to action (e.g., FP service delivery and demand generation) at the local level.

Similar changes in population policy have begun to occur in other Francophone Africa countries (which generally have made less progress in family planning compared to Anglophone countries). Senegal's policy environment for family planning has shifted to include more concrete and explicit support from leaders in recent years. In 2011 the government hosted the International Conference on Family Planning, and in 2012t made a financial commitment to double the national budget for contraceptive procurement in 2013. The national program has tested and/or adopted innovative programming supported by research, including use of the Informed Push Model and a pilot program for the subcutaneous depo provera, known as Sayana Press.[9]

Additionally, eight francophone countries took part in a regional meeting entitled "Population, Development, and Family Planning in West Africa: An Urgency for Action" in 2011. Also known as the Ouagadougou Initiative, the country delegations from these countries developed action plans for strengthening FP programs and policies in their countries. Subsequently, several of these countries have made additional progress in this realm. In 2011 Burkina Faso committed to a line item in its national budget for contraceptive procurement.

The policy environment is also improving in Cote d'Ivoire. Prior to 1991, the government actively discouraged family planning services. The IPPF member association, the Association Ivorienne Pour le Bien-Etre Familial (AIBEF), was prohibited from publicizing its services, and provision of contraceptive methods to the public sector was restricted. Since then, the government position on FP has improved but the use of contraception remains low. However, as of 2011, the Government made more concrete commitments to improving contraceptive prevalence when President Alassane Ouattara issued a Declaration on Maternal Health including an increase in family planning availability via health facilities from 60% in 2010 to 100% by 2015; expansion of method access for women living with HIV and youth; and an increase in contraceptive commodities by including them in the recommended list of essential medicines to be subsidized and made more affordable.

Niger, considered the fastest growing country in the world, was characteristic of the countries of francophone Africa, which historically gave little priority to family planning. However, in 2013

[9] République du Sénégal Ministere de la Santé et de l'Action Social Direction de la Santé Division de la Santé de la Reproduction. (2012). *Plan d'action national de Planification Familiale 2012-2015*

political commitment to FP changed dramatically with a quadrupling of its FP budget for that year. Also, the government has taken several innovative actions, such as authorizing community health workers to provide injectable contraceptives, creating new mobile clinic services for isolated communities; and integrating family planning in the school health curriculum.

Although not a francophone country, the DRC takes certain inspiration from Ethiopia. This country, which also has a large population and vast physical space, decreased its birthrate in a 10 year period from 5.5 in 2000 to 4.8 in 2011[10].

The larger question is whether policy change leads to effective programmatic action that translates into increased contraceptive use and decreased fertility rates of a country. The literature on this topic is mixed. Some of the most effective programs in the world have been led by countries with strong official population policies (e.g., Indonesia, China, and Mexico, to name a few). In other countries, especially in Latin America, NGOs provided leadership in family planning in the early years when governments still feared political fall-out, especially from the Catholic Church, for endorsing family planning[11]. Conversely, not all countries that promulgated a strong population policy converted this into increased contraceptive use (e.g., Ghana, which in 1969 had one of the first population policies in sub-Saharan Africa)[12]. In earlier years population policy often signaled that FP programming was well underway, rather than a driver of the process. However, in the context of francophone sub-Saharan countries, government commitment would seem to be a prerequisite to meaningful change in FP programming and contraceptive use. However, it is likely to be "necessary but not sufficient."

Observers of the international FP movement will follow the promising policy advances in the DRC with great interest. With strong cultural and financial barriers to FP in the DRC, change – to the extent it occurs – will be gradual. Yet will the recent changes in the policy environment present an unprecedented platform on which to work toward this change.

[10] Ethiopia Demographic and Health Survey 2011. *MEASURE DHS USAID*. Retrieved from http://dhsprogram.com/pubs/pdf/FR255/FR255.pdf

[11] Bertrand, J.T., Ward, W.M., & Santiso, R., 2014. *Family Planning in Latin America: The Achievements of 50 Years.* Forthcoming Chapel Hill, NC: MEASURE Evaluation.

[12] Rosen, J. E., & Conly, S. R. (1998). Africas population challenge: accelerating progress in reproductive health. 23.